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West Midlands Critical Care & Trauma Network Policy for diversion of Adult Major Trauma

The purpose of this policy is to provide guidance in the following 2 situations:

1. Request to the Midlands Trauma Network to divert Major Trauma from one MTC to another based on lack of Critical Care Capacity. Page 2 - 4

2. Request to the Midlands Trauma Network to divert Major Trauma Based on expected triage positive patients which may overwhelm ED Capacity (Not Major Incident). Page 5

This document has been agreed by all 3 Adult Major Trauma Centre's in the West Midlands at the Performance and Quality Group 23rd February 2016 This policy relates to the 3 Adult Major Trauma Centre's and the WMAS Regional Trauma Desk in the West Midlands.

Acknowledgement is made that UHCW and RSUH receive flow from outside this catchment area and therefore: UHCW are responsible for liaising with EMAS and Queens Medical Centre regarding flow if there are capacity issues which affect flow from Northamptonshire. and RSUH are responsible for liaising with NWAA, EMRTS and The Royal Liverpool Hospital and Manchester Royal Infirmary.

1.Major Trauma Escalation of Critical Care Capacity Issues

The purpose of this guideline is to provide an escalation pathway for reference. Each case must be considered individually and MTCs should absorb as much of their workload as possible before escalation.

For assistance to be requested a level 2 (or above) incident must have been declared, in line with NHS England Emergency Preparedness, Resilience and Response Framework. The following checklist must be completed in conjunction with the Critical Care team.

Assessment of situation:

Action	Completed	Comments
Consultant review of all Critical Care Patients, identifying those patients who can be moved to a lower dependency bed to free capacity.		
Cancellation of management time and study days.		
Use of other level 2/ 3 beds e.g. Cardiothoracic critical care.		
Cancellation of elective surgical admissions whichmay require critical care e.g. Cardiothoracic surgery.		
Use Outreach to facilitate caring for ventilated patients either on Critical care or in appropriate recovery area.		
Consider use of agency staff to open further beds if possible.		
Consider transfer of stable patients to other local critical care units.		

(see appendix 1)

This checklist must be completed regularly and forwarded to the Chief Operating Officer or the Exec On Call and then onto the Major Trauma Clinical Lead for audit purposes.

The communication link e.g. the COO or the Exec On Call, will be expected to provide assurance that all the above have been considered / actioned during the network conference call.

<u>Decision to escalate:</u>

In hours: The decision to escalate to the Trauma Network will be made in conjunction with the Chief Operations Officer, the ITU Consultant and the Major Trauma Clinical Lead or Service Manager.

Out of hours: The decision to escalate to the trauma network will be made in conjunction with the Exec On Call, the ITU Consultant and the ED Consultant.

Escalation:

The situation must be discussed with the network MTC's. A conference call can be held on 08447620762 passcode 98995. The following statement should be used:

'This is (State MTC name) we have a critical care capacity issue and are requesting a conference call with (state MTC name(s) to request assistance'.

MTC / TU	In Hours (09:00 – 17:00 Mon – Fri)	Out of Hours (17:00 – 09:00 Mon to Fri, all weekend and BH's)
UHB	Exec: Chief Operating Officer or Deputy via switchboard 0121 627 2000	Duty Director via switchboard 0121 627 2000
UHCW	Chief Operating Officer or Deputy via switchboard 024 76 96 4000	Exec on Call via switchboard 024 76 96 4000
RSUH	Chief Operating Officer or Gold On Site via Switchboard 01782 715444	Gold On Call via Switchboard 01782715444

Delegation of communication link during the escalation period can be delegated to an appropriate person i.e. the Major Trauma Team Service Lead or MT Coordinator but the conference call each hour must include the Chief Operating Officer or On Site Manager as the Trust's overall representative.

Documentation will be completed by the leading MTC who will collect the following information:

Required Information	Details
Date and time of call	
Centre that is escalating	
Name, job role and contact number at UHCW	
Name, job role and contact number at UHB	
Name, job role and contact number at RSUH	
Name, job role and contact number at BCH	
Outcome of conference call e.g. no divert in place or action plan in place	
Additional information	
Each additional contact time and details of caller and plan	
Details of all patients diverted inc Name / DOB / PRF number	
End date and time of escalation	
Please send copy of this information to sarahgraham3@nhs.net	

(see appendix 2)

The outcome of the call will be communicated to the regional trauma desk.

Strategy: *** MTC Divert is a broad concept suitable for certain situations but cannot be a blanket rule. Unstable patients may be brought to the MTC on divert if they require time critical interventions and an ITU bed will need to be sourced post intervention.

*** Usual capacity management process should be followed by the exec team to create capacity and deescalate the situation. In the interim the following steps can be used to assist:

	Step	Primary transfers from scene	Hyper-acute Secondary transfers from TU
Hour One	1.	First Stage 1 or 2 triage tool positive patient to be diverted to nearest accepting MTC. The MTC should continue to admit all stage 3 & 4 triage tool patients or stage 1 & 2 which require immediate lifesaving intervention.	TU Contacts RTD who conference call escalating MTC and nearest accepting MTC for plan on where to divert patient if appropriate (consider time critical element). Patients who do not need critical care but need to be in the MTC should continue to be admitted as usual.
	2.	RTD contact COO or Exec On Call in diverting and accepting MTCs following first patient diverted for sit rep on capacity. If no change step 3.	If urgent surgical intervention required consider following options: • Transfer to accepting MTC with MERIT support • Transfer to escalating MTC direct to theatre with plan for transfer of current ITU patient out whilst in theatre.
	3.	Second Stage 1 or 2 triage tool positive patient to be diverted to nearest accepting MTC.	
	4.	Repeat contact in step 2 following second patient diverted.	
Hour Two	1.	Repeat conference call with all MTC links at beginning of hour two to assess situation.	
	2.	Confirm repeat critical care capacity assessment completed by escalating MTC.	
	3.	Either stand down or identify where next stage 1 and 2 patients in region will go.	
Ongoing Hours	1.	Repeat hour one and two steps hourly until de-escalation has occurred.	

All MTC's

Internal All MTC TTLs and COOs / Exec On Calls must communicate following each diverted patient and at each hour for a sit rep ready for next communication with RTD.

Actions:

1. The escalating Trust must complete a Trauma Related Issues Database (TRID) report.

2. The escalating Trust is responsible for assisting in moving the diverted patients back to their MTC or assisting with TU transfers, if appropriate, within 48 hours of being medically stable enough to transfer. If the TU is unable to take then the MTC must admit the patient.

2. Multiple Patients from Scene: Possibility to overwhelm ED or ITU departments NOT A MAJOR INCIDENT and to be used in extremis only

This may be used when there are a number of casualties presenting at stage 1 or 2 who may overwhelm a department if they arrive simultaneously. The expectation is that MTC's should be able to cope with a number of severely injured patients but there may be times when the department is under significant pressure and the request for assistance is worth considering.

All steps should be taken to receive as many casualties as possible utilising all internal resources before escalating to the network.

Usually a swift decision will need to be made and so in this instance the TTL should be able to have a discussion with their TTL colleagues in the other MTCs to identify any capacity for sharing the burden. A conference call must be made with the other MTC before divert is in place as UHCW & RSUH have traffic from other ambulance services which the RTD may not have sight of.

Actions:

1. Conference call with RTD and other relevant MTC TTLs.

2. Escalating TTL (or delegate senior communication link) they should say (example): 'We are expecting 3 stage 1 triage positive patients and currently have an open thoracotomy in ED. Are you able to assist by taking x number of these patients please?'

3. The TTL at the other relevant MTCs will advise if they are in a position to support divert in this instance.

4. The diverting MTC is responsible for assisting in moving the diverted patients back to their MTC or assisting with TU transfer as appropriate in a timely manner, e.g. within 48 hours of being medically stable enough to transfer. If the TU is unable to take then the MTC must admit the patient.

5. The diverting MTC must complete a TRID and statement sending details of patients diverted to sarahgraham3@nhs.net

Appendix 1

Assessment of Situation For completion in conjunction with Critical Care Consultant.

Date:

Time:

Consultant Name:

Bleep Number:

Action	Completed	Comments
Consultant review of all Critical Care Patients, identifying those patients who can be moved to a lower dependency bed to free capacity.		
Cancellation of management time and study days		
Use of other level 2/ 3 beds e.g. Cardiothoracic critical care.		
Cancellation of elective surgical admissions which may require critical care.		
Use Outreach to facilitate caring for ventilated patients either on Critical care or in appropriate recovery area.		
Consider use of agency staff to open further beds if possible.		
Consider transfer of stable patients to other local critical care units.		

A new checklist must be completed hourly for a sit rep and forwarded to the COO or Exec On Call for information, then onto the relevant Clinical Lead for Major Trauma (insert name of your own clinical lead) for network audit purposes.

Appendix 2

Collection of Information by WMAS Regional Trauma Desk:

Escalation of Critical Care Capacity Issues at MTC

Required Information	Details
Date and time of call	
Centre that is escalating	
Name, job role and contact number at UHCW	
Name, job role and contact number at UHB	
Name, job role and contact number at RSUH	
Name, job role and contact number at BCH	
Outcome of conference call e.g. no divert in place or action plan in place	
Additional information	
Each additional contact time and details of caller and plan	
Details of all patients diverted inc Name / DOB / PRF number	
End date and time of escalation	
Please send copy of this information to sarahgraham3@nhs.net	