NHS Operational Delivery Network

NoECCN

North of England Critical Care Network

Adult Critical Care Transfer Guidelines

Revised 2022

(Working Version March 2023)

Version: Working Version	**December 2022**
Updated:	**March 2023**
Status :	**Working Version 2.5**
Review Date:	**December 2026**

Changes	
2.3	**Transfer groups and mileage chart**
2.4	**Update repatriation guidance and references**
2.5	**Wording edited in Appendix 8**

CONTENTS

All documents can be accessed via the website -www.noeccn.org.uk

Introduction

The transfer of critically ill patients from one hospital to another may be necessary to facilitate access to appropriate levels of clinical care, and or to facilitate specialist investigation or treatment. The transfer of critically ill patients is however not without risk, and provider organisations should make every effort to reduce the need for transfers arising from lack of critical care capacity alone. It is none the less anticipated, that the requirement for patient transfer between organisations for a higher level of care is likely to increase as reconfiguration of specialist services takes place across the North of England and North Cumbria footprint. With this in mind and the increased need for patient transfers for equalisation of pressure during COVID19 the adult arm of NECTAR was developed providing a bespoke Adult Critical Care transfer service.

Where transfer is required three over-arching principles should be observed.

- The potential benefits of any transfer must be weighed against the clinical risks
- No transfer is so urgent as to compromise the safety of the patient or staff
- Staff undertaking transfers must have the required level of knowledge and competence.

Although published standards for transferring critically ill patients' exist [1, 2], evidence suggests that these are not always followed[3]. This additional guidance has therefore been produced collaboratively by the NoECCN transfer group to support safe clinical practice

The guidance consists of a series of locally agreed protocols / standard operating procedures which aim to assist organisations and individuals responsible for the transfer of patients within or between various hospital settings including:

- general wards/emergency departments/theatres and critical care
- general wards/critical care & diagnostic services
- primary, secondary & tertiary sites

The guidance should be used in conjunction with the Intensive Care Society/Faculty of Intensive Care Medicine Guidelines On: The Transfer of the Critically Ill Adult (2019)[1] and the Guidelines for the Provision of Intensive Care Services (Edition 2 2019).[4]

The intention is for trusts to use the guidance when developing and reviewing their own transfer policies as part of an effective approach to clinical governance. Whilst NECTAR are there to support and transfer patients the decision to transfer and selection of patient remains with the units. If NECTAR are not available then the unit is responsible for organising and completing the transfer using transport form NEAS or NWAS as appropriate.

Each trust should have an identified champion for adult critical care transfers and should ensure that appropriate operational procedure and governance structures are in place to provide for safe and effective transfer of critically ill patients.

Principles of Safe Transfer

This document should be read in conjunction with the Guidelines On: The Transfer of the Critically Ill Adult (2019)[1] published by the Intensive Care Society and Faculty of Intensive Care Medicine which details clinical standards required.

- All admission & discharges to / from intensive care must be discussed with a consultant.
- All units should have a capacity management plan in place to optimise bed availability and manage short term capacity issues.
- Non clinical transfers should only occur as a last resort when other options for managing capacity in the referring hospital have been exhausted (appendix 2)
- Non clinical transfers ideally should only occur within the referring unit's unique transfer group (UTG) (appendix 2). Any non-clinical transfers occurring outside agreed UTGs must be recorded as critical incidents on datix and reported to the Chief Executive / executive team of both hospitals
- All transfers between hospitals should be discussed and agreed on a consultant to consultant basis facilitated by NECTAR
- It is the referring consultant's responsibility to ensure that the patient being transferred is suitable for transfer and that an appropriate risk assessment (appendix 4) has been completed and documented prior to transfer
- The staff transferring the patient should have the appropriate skills and experience to enable them to transfer the patient safely
- Standards of monitoring and care during transfer should comply with nationally published guidelines
- All equipment used should be complaint with relevant safety standards and be regularly serviced and maintained
- Check lists should be used to help to ensure that all necessary preparations have been completed, prior to each stage of the transfer (appendix 6)
- All transfers not done by NECTAR, details should be recorded using the Transfer Audit on Survey Monkey. https://www.surveymonkey.com/r/NoECCN_Transfer_Audit_Adults

Nectar – North East & Cumbria Transport and Retrieval

NECTAR is the North East & Cumbria Adult Critical Care Transfer Service (ACCCTS), these services were commissioned during the COVID 19 pandemic response. Prior to this NECTAR was already well established delivering transfers for our paediatric community.

They are a 24/7 service, providing a dedicated, specially trained transport team, using their extensive experience and training in providing expert care for critically ill patients. Officially launched in April 2016 as a children's service we have recently rebranded to become more inclusive of our patient population to include adult transport.

They are a specialised transport service that provides inter-hospital transfer for patients in the North East and Cumbria. If patients require services elsewhere nationally then we will try and facilitate this. Facilitate planned Adult transfers daily 10-10 for upgrade of care, bed pressures and repatriations. Time critical transfers are still delivered via NEAS and should be contacted in the normal way.

nectar
NORTH EAST & CUMBRIA
TRANSPORT AND RETRIEVAL

Telephone NECTAR 01912826699

NECTAR - Newcastle Hospitals NHS Foundation Trust (newcastle-hospitals.nhs.uk)

Appendix 1

Definitions:

Non-Clinical Transfer	Transfer of a patient due to insufficient bed capacity in the referring unit. Includes transfers between different hospitals within the same Trust.
Clinical Transfer / Tertiary Transfer	Transfer of a patient to another hospital for care or facilities that are not available within the referring hospital.
Repatriation	When a patient is transferred back to the host hospital when a suitable bed has become available (appendix 9) and /or when specialist / tertiary care is no longer required.
Unique Transfer Group	A group of hospitals to which non-clinical transfers may be considered from a host hospital. This group is based upon historical transfers, geography and bed capacity. Please check your own unique transfer group listing & priority order (appendix 2).

Appendix 2

Non-clinical transfers & unique transfer groups

All units should have capacity management plans in place to support optimal management of beds at times of peak demand and to avoid unnecessary non clinical transfers. Plans should include options for increasing critical care capacity, e.g. by temporary use of other facilities such as PACU or theatres The Network would recommend that all other resources be explored before transferring a patient to another hospital for capacity reasons alone.

When necessary, patients should be transferred to the nearest available facility capable of delivering the required level of care, within the agreed transfer group[5], but bypassing tertiary centres unless specialist level care is required. This is to protect the Network's tertiary beds from non-clinical transfers and to reduce the risk of these beds becoming unavailable at times of need. This measure was fully supported by the Network Clinical Advisory Board.

The following pages provide details of agreed transfer groups and distances / travel times. The tables are in the order of priority based on the above agreement.

Bed availability

The availability of beds within the Network can be checked using the Critical Care Directory of Services (DoS). This is a national bed information website which all critical care units are required to update as a minimum twice daily - ideally at 08:00 and 20:00. The system provides an overview of available level 2/3 beds by unit across Operational Delivery Networks. The system can be accessed at https://www.directoryofservices.nhs.uk/. All units should have a secure login.

Reporting Non Clinical Transfers

Non-Clinical Transfers within UTGs	These should be reported through local risk reporting procedures/Datix as an adverse incident.
Non-Clinical Transfers outside UTGs	In addition to local incident reporting above, The Lead Clinician / Senior Nurse should report any non-clinical transfers that occur outside of Unique Transfer Groups to the Chief Executive of both hospitals and the NoECCN within 24 hours of the transfer.

NoECCN Unique Transfer Groups and Contact Details

Non-Clincal Unique Transfer Groups

Green Boxes indicate unique transfer group reading in the direction of the arrow →

Transfering Hospital	Receiving Hospital: Royal Victoria Infirmary NE1 4LP	Freeman Hospital NE7 7DN	Sunderland Royal Hospital SR4 7TP	South Tyneside District Hospital NE34 0PL	Queen Elizabeth Hospital NE9 6SX	Northumbria Specialist Emergency Care Hospital (NSECH) NE23 6NZ	Cumberland Infirmary, Carlisle CA2 7HY	West Cumberland Infirmary, CA28 8JG	University Hospital of North Durham DH1 5TW	Darlington Memorial Hospital DL3 6HX	James Cook University Hospital TS4 3BW	Univeristy Hospital of North Tees TS19 8PE	Dumfries and Galloway DG2 8RX	Furness General Hospital LA14 4LF
Royal Victoria Infirmary 0191 2824616		3	14	11	5	9	59	98	19	38	43	38	N/A	N/A
Freeman Hospital 0191 2231014	3		16	12	6	7	62	100	21	40	46	40	N/A	N/A
Sunderland Royal Hospital 0191 5699745	14	16		8	12	19	73	111	13	31	34	28	N/A	N/A
South Tyneside District Hospital 0191 4041030	11	12	8		8	13	70	109	17	37	40	34	N/A	N/A
Queen Elizabeth Hospital 0191 4452007	5	6	12	8		15	66	104	14	33	41	32	N/A	N/A
Northumbria Specialist Emergency Care Hospital (NSECH) 0191 6072011	9	7	19	13	15		66	105	26	45	48	43	N/A	N/A
Cumberland Infirmary, Carlisle 01228 814114	59	62	73	70	66	66		39	70	80	100	93	34	N/A
West Cumberland Infirmary, 01946 523443	98	100	111	109	104	105	39		109	104	121	115	72	49
University Hospital of North Durham 0191 3332019	19	21	13	17	14	26	70	109		22	32	22	N/A	N/A
Darlington Memorial Hospital 01325 743212	38	40	31	37	33	45	80	104	22		19	14	N/A	N/A
James Cook University Hospital 01642 282680	43	46	34	40	41	48	100	121	32	19		26	N/A	N/A
Univeristy Hospital of North Tees 01642 624562	38	40	28	34	32	43	93	115	22	14	26		N/A	N/A

Transfer Groups and contact information (Independent Sector)

Transferring Hospital \ Receiving Hospital	Royal Victoria Infirmary NE1 4LP	Freeman Hospital NE7 7DN	Sunderland Royal Hospital SR4 7TP	South Tyneside General Hospital NE34 0PL	Queen Elizabeth Hospital NE9 6SX	Northumbria Specialist Emergency Care Hospital (NSECH) NE23 6NZ	Cumberland Infirmary CA2 7HY	West Cumberland Hospital CA28 8JG	University Hospital of North Durham DH1 5TW	Darlington Memorial Hospital DL3 6HX	James Cook University Hospital TS4 3BW	University Hospital of North Tees TS19 8PE	**INDEPENDENT SECTOR UNIQUE TRANSFER GROUPS**
Royal Victoria Infirmary 0191 2824616		3	14	11	5	21	59	98	19	38	43	38	
Freeman Hospital 0191 2231014	3		16	12	6	15	62	100	21	40	46	40	
Nuffield Hospital Jesmond 0191 2816131	2	**2**	14	11	4	8			20	38	43	38	
Sunderland Royal Hospital 0191 5699745	14	16		**8**	12	27	73	111	13	31	34	28	
South Tyneside General Hospital 0191 4041030	11	12	**8**		8	21	70	109	17	37	40	34	
Queen Elizabeth Hospital 0191 4452007	5	6	12	8		23	66	104	14	33	41	32	
Spire Healthcare Washington 0191 4151272	12	13	10	10	5	21			8	28	37	27	
Northumbria Specialist Emergency Care Hospital (NSECH) 0191 6072011	12	7	19	13	12		69	110	26	46	47	42.6	**Cumberland Infirmary**
Colbalt Hospital North Tyneside 0191 2703250	9	8	15	9	11	**6**			24	43	47	39	**Dunfries and Galloway =34miles**
Cumberland Infirmary 01228 814114	59	62	73	70	66	74		39	70	80	100	93	
West Cumberland Hospital 01946 523443	98	100	111	109	104	113	39		109	104	121	115	
University Hospital of North Durham 0191 3332019	19	21	13	17	14	37	70	109		22	32	22	
Darlington Memorial Hospital 01325 743212	38	40	31	37	33	54	80	104	22	**x**	19	14	**West Cumberland**
Woodlands Hospital Darlington 01325 341700	38	42	32	39	34	50			22	**3**	17	11	Dunfries and Galloway = 72 miles
James Cook University Hospital 01642 202680	43	46	34	40	41	56	98	121	34	19		11	Furness General Hospital = 49 miles
Tees Valley Hospital Middlesborough 01642 843262	41	43	31	37	37	43			27	16	**2**	8	
Friarage Hospital 01609 764011	59	61	49	55	56	71	89	113	49	17	23	26	
The Hawthorns, Peterlee 0191 5871251	24	27	15	20	21	28			20	32	23	17	
Cleveland Nuffield Stockton 01642 360100	37	39	27	33	34	47			23	14	9	2	
University Hospital of North Tees 01342 624562	38	40	29	34	32	51	93	115	22	14	11		

Green boxes indicates transfer group reading on direction of arrow →

Appendix 3: Booking an Ambulance –NECTAR

Adult Acute Referral

- **Telephone NECTAR 01912826699**
- Initial referral information NECTAR requires:
  - Referrer details -name, position, hospital, phone number
  - Patients details-name, weight, D.O.B, infection control issues, safeguarding, address, GP surgery, NHS number, provisional diagnosis
  - In an emergency please state **"Life Threatening Emergency"** at outset in which case we will proceed to conference call with minimal information.

Conference call

- NECTAR practitioner/admin will add you to call conference - please follow automated instructions
  - All conference calls are recorded for governance and training purposes.
- NECTAR Medic & transport practitioner ± sub-speciality in the conference call
  - use referral proforma for exchange of information
  - use ABCDE.. or SBAR if possible
- Telephone triage follows with decision support and advice given regardless of bed state

NECTAR Team immediately unavailable

- NECTAR Team immediately unavailable to clinical reasons.
- NECTAR internal pathway to be activated under the leadership of the co-ordinator and the Lead Consultant to ensure referring hospital is supported with timely advice and the patient is transferrred in a timely manner.

Critical care bed avalilability

- NECTAR Consultant to confirm patient acceptance
- **If no ITU bed available then NECTAR Coordinator & Consultant** -
  - To look at next nearest available bed in country
  - To ensure local and regional escalation/decompression pathways are activated.
- NECTAR Lead nurse notified.

Accepted for Transfer

- NECTAR confirm patient acceptance for transfer and provide referring hopsital with ETA and emergency contact number
- NECTAR Team to mobilise within 60mins of decision to transfer.
- NECTAR aim to be at patient bedside with 180mins

DGH process

- NECTAR team to get a handover from Consultant/s responsible for patient at referring hopsital
- NECTAR registrar to relay patient status to NECTAR consultant within 30mins of arrival and discuss management plan.
- NECTAR team to call HQ and provide coordinator/consultant with update on progress after 90min with patient.
- NECTAR and referring team to stabilise and prepare the patient for transfer
- Team ensure that patient's family are updated and receiving unit info provided.
- Team to provide receiving ITU with clinical update and ETA at the time of departure.

Booking an Ambulance NHS – NEAS

NoECCN North of England Critical Care Network

North East Ambulance Service NHS NHS Foundation Trust

Adult Critical Care C2 Transfer Request Proforma	
Patient name	
Patient Number	
Consultant Requesting transfer	
Identify and confirm bed with receiving hospital and receiving Consultant	
Hospital:	
Unit:	
Consultant:	
When the patient is stable on the transfer trolley inform NEAS that you need a Critical Care transfer:	
0191 4143144	
"This is a Critical Care Transfer using the Transfer Trolley requiring a C2 response.	
A paramedic crew is not required"	
Dispatch NEAS job number:	
Time:	
Person Requesting Ambulance	Name:
Operator	Name:
Referring Department	
Picking up point	
Receiving Hospital	
Receiving Department	
Name of Patient	
Principle diagnosis	
Who is accompanying the patient.	
How much Oxygen is required	
Ambulance Arrived:	Time:
Ambulance Delayed – Follow-up Calls	
Time:	
Person Requesting Ambulance	Name:
Speak to Duty Manager	Name:
Problem - ETA	
Time:	
Person Requesting Ambulance	Name:
Operator	Name:
Problem - ETA	

NoECCN Transfer Group 04-08-2022

Booking an Ambulance Independent Sector – NEAS

NoECCN North of England Critical Care Network

North East Ambulance Service NHS
NHS Foundation Trust

Adult Critical Care C2 Transfer Request Proforma- Independent Sector	
Patient name	
Patient Number	
Consultant Requesting transfer	
Identify and confirm bed with receiving hospital and receiving Consultant	
Hospital:	
Unit:	
Consultant:	
"This is a Critical Care Transfer you will need to collect a Critical Care Transfer Trolley and Breathing Circuit *from – identify hospital*. A paramedic crew is not required"	
0191 4143144	
Dispatch NEAS job number:	
Time:	
Person Requesting Ambulance	Name:
Operator	Name:
Referring Department	
Picking up point	
Receiving Hospital	
Receiving Department	
Name of Patient	
Principle diagnosis	
Who is accompanying the patient?	
How much Oxygen is required	
Ambulance Arrived:	Time:
Ambulance Delayed – Follow-up Calls	
Time:	
Person Requesting Ambulance	Name:
Speak to Duty Manager	Name:
Problem - ETA	
Time:	
Person Requesting Ambulance	Name:
Operator	Name:
Problem - ETA	

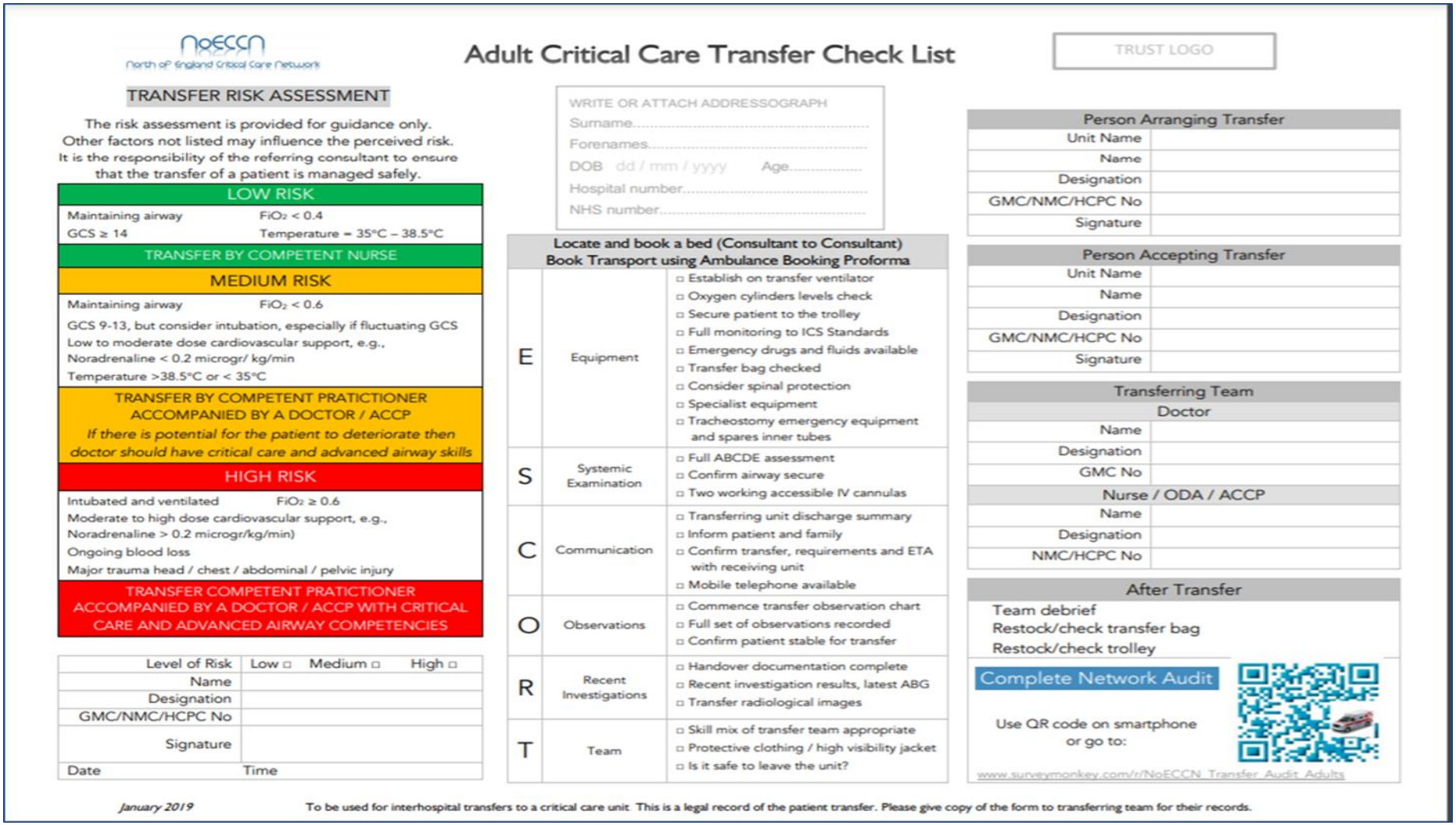
NoECCN Transfer Group 04/08/2022

Contact Numbers for Units with a Critical Care Transfer Trolley

Trust & Hospital	Unit Type	Direct Line
North Cumbria Acute Hospitals NHS Trust		
West Cumberland Hospital	ICU/HDU	01946 523 443
Cumberland Infirmary	ICU/HDU	01228 814 114
Newcastle Upon Tyne Hospitals NHS Foundation Trust		
Freeman Hospital	Ward 21 Cardio ICU	0191 223 1015
	Wd 37 Combined ICU/HDU	0191 223 1176
Royal Victoria Infirmary	Ward 38 General ICU/HDU	0191 282 4616
	Ward 18 Neuro ICU/HDU	0191 282 1788
Northumbria Healthcare NHS Foundation Trust		
Northumbria Specialist Emergency Care Hospital (NSECH)	Combined ICU/HDU	0191 6072513/ 0191 6072511
South Tyneside NHS Foundation Trust		
South Tyneside General Hospital	Combined ICU/HDU	0191 404 1030
City Hospitals Sunderland NHS Foundation Trust		
Sunderland Royal Hospital	Combined ICU/HDU	0191 541 0238
Gateshead Healthcare NHS Foundation Trust		
Queen Elizabeth Hospital	Combined ICU/HDU	0191 445 2007
County Durham & Darlington NHS Foundation Trust		
University Hospital of North Durham	Combined ICU/HDU	0191 333 2019
Darlington Memorial Hospital	Combined ICU/HDU	01325 743212
North Tees & Hartlepool NHS Foundation Trust		
University Hospital of North Tees	Combined ICU/HDU	01642 624 562
South Tees NHS Foundation Trust		
James Cook University Hospital	ICU2/3 General ICU	01642 282 680 (2x trolleys)

Appendix 4

Risk Assessment



NoECCN
North of England Critical Care Network

Adult Critical Care Transfer Check List

TRUST LOGO

TRANSFER RISK ASSESSMENT

The risk assessment is provided for guidance only.
Other factors not listed may influence the perceived risk.
It is the responsibility of the referring consultant to ensure that the transfer of a patient is managed safely.

LOW RISK	
Maintaining airway	$FiO_2 < 0.4$
GCS ≥ 14	Temperature = 35°C – 38.5°C
TRANSFER BY COMPETENT NURSE	
MEDIUM RISK	
Maintaining airway	$FiO_2 < 0.6$
GCS 9-13, but consider intubation, especially if fluctuating GCS	
Low to moderate dose cardiovascular support, e.g., Noradrenaline < 0.2 microgr/ kg/min	
Temperature >38.5°C or < 35°C	
TRANSFER BY COMPETENT PRATICTIONER ACCOMPANIED BY A DOCTOR / ACCP	
If there is potential for the patient to deteriorate then doctor should have critical care and advanced airway skills	
HIGH RISK	
Intubated and ventilated	$FiO_2 \geq 0.6$
Moderate to high dose cardiovascular support, e.g., Noradrenaline > 0.2 microgr/kg/min)	
Ongoing blood loss	
Major trauma head / chest / abdominal / pelvic injury	
TRANSFER COMPETENT PRATICTIONER ACCOMPANIED BY A DOCTOR / ACCP WITH CRITICAL CARE AND ADVANCED AIRWAY COMPETENCIES	

Level of Risk	Low □	Medium □	High □
Name			
Designation			
GMC/NMC/HCPC No			
Signature			
Date	Time		

WRITE OR ATTACH ADDRESSOGRAPH
Surname.....
Forenames.....
DOB dd / mm / yyyy Age.....
Hospital number.....
NHS number.....

Locate and book a bed (Consultant to Consultant) Book Transport using Ambulance Booking Proforma		
E	Equipment	□ Establish on transfer ventilator □ Oxygen cylinders levels check □ Secure patient to the trolley □ Full monitoring to ICS Standards □ Emergency drugs and fluids available □ Transfer bag checked □ Consider spinal protection □ Specialist equipment □ Tracheostomy emergency equipment and spares inner tubes
S	Systemic Examination	□ Full ABCDE assessment □ Confirm airway secure □ Two working accessible IV cannulas
C	Communication	□ Transferring unit discharge summary □ Inform patient and family □ Confirm transfer, requirements and ETA with receiving unit □ Mobile telephone available
O	Observations	□ Commence transfer observation chart □ Full set of observations recorded □ Confirm patient stable for transfer
R	Recent Investigations	□ Handover documentation complete □ Recent investigation results, latest ABG □ Transfer radiological images
T	Team	□ Skill mix of transfer team appropriate □ Protective clothing / high visibility jacket □ Is it safe to leave the unit?

Person Arranging Transfer	
Unit Name	
Name	
Designation	
GMC/NMC/HCPC No	
Signature	

Person Accepting Transfer	
Unit Name	
Name	
Designation	
GMC/NMC/HCPC No	
Signature	

Transferring Team	
Doctor	
Name	
Designation	
GMC No	
Nurse / ODA / ACCP	
Name	
Designation	
NMC/HCPC No	

After Transfer

Team debrief
Restock/check transfer bag
Restock/check trolley

Complete Network Audit

Use QR code on smartphone or go to:

www.surveymonkey.com/r/NoECCN_Transfer_Audit_Adults

January 2019

To be used for interhospital transfers to a critical care unit. This is a legal record of the patient transfer. Please give copy of the form to transferring team for their records.

NHS NoECCN
North of England Critical Care Network

Transfer Observation Chart

WRITE OR ATTACH ADDRESSOGRAPH	Transfer Details
Surname	Transferring unit name
Forenames	Recipient unit name
DOB dd / mm / yyyy Age	Date of Admission to hospital
Hospital number	Date of transfer
NHS number	Departure time

Transfer From	□ Critical Care	Ward □	ED □	Other
Reason for Transfer	□ Upgrade of Care □ Repatriation	□ Non-clinical (no bed) □ Non-clinical (no staff)	□ Other	

HISTORY AND CLINICAL DETAILS				
Patient normal BP / mmHg	Pre-sedation GCS /15	E	V	M
Allergies	Pupils	R	L	
Main reason for critical care admission	Size			
	Reactive			

Stabilisation time	Time Commenced	Time Ready to Transfer	
Ambulance Details	Job Number		
Time Ordered	Time Arrived Unit	Time Left Unit	Arrived at Destination

ABG when patient established on transfer ventilated prior to departure		
pH =	pO_2 =	HCO_3 =
Lactate =	pCO_2 =	Base Excess =

Airway	Monitoring	
□ Own airway	□ SpO_2	□ ECG
□ OETT *size*_____ *length to lips*_____	□ $ETCO_2$	□ NIBP
□ Nasal ETT *size*_____ *length to nostril*_____	□ IABP	□ Temp
□ Tracheostomy *size*_____ *type*_____	□ CVP	□ Other

Ventilation during transfer		Lines (size/location)	NG/OG tube (size /length)
☐ Spontaneous ☐ Mechanical ☐ Manual		Peripheral	
Mode	FiO_2	Arterial	Drains (type/location)
Peak Pressure	Volume (V_T)		
Plateau Pressure	RR	Central	
PEEP	Ratio		

Known Infection Risks

Time / Drugs																	
MONITORING																	
SpO_2																	SaO_2
$ETCO_2$																	$ETCO_2$
200																	200
190																	190
180																	180
170																	170
160																	160
150																	150
140																	140
130																	130
120																	120
110																	110
100																	100
90																	90
80																	80
70																	70
60																	60
50																	50
FLUIDS																	
Urine Output																	

Please list any precautions taken for spine protection at any level

Transfer Doctor Comments / Incidents (to be reported to Trust / NoECCN)

Signature of Escorting Doctor GMC no.

Receiving Doctor Comments / Incidents (to be reported to Trust / NoECCN)

Signature of Escorting Doctor GMC no.

Prior to transfer, a consultant or senior clinician should carry out and document a risk assessment to determine the anticipated risk of the transfer, and the level of support and personnel required.

The risk assessment should take into account the following:

- Patients' current clinical condition
- Specific risk related to patients' condition
- Risks related to movement / transfer
- Likelihood of deterioration during transfer
- Potential for requiring additional monitoring / intervention
- Duration and mode of transfer

It is recognised however that risk assessment is to some extent subjective and other factors not listed on the form may influence the perceived risk. In addition to completing the risk assessment sheet, please record that a risk assessment has been undertaken by indicating in the red box on the front page of the transfer form.

Ultimately, it is the referring consultant's responsibility to ensure that the transfer is appropriate and that the transferring team have the necessary skills to ensure that the transfer is carried out safely.

Critically ill patients (level 2 and level 3) should normally be accompanied by **two suitably trained, experienced and competent practitioners during transfer.** The background of the practitioners (Medical / Nursing / other) and the competencies required will depend on nature of the underlying illness, co-morbidity, level of dependency and risk of deterioration during transfer.

Appendix: 5:

Equipment

All acute hospitals responsible for transferring critically ill patients must have access to a CEN compliant transfer trolley. All monitoring and equipment must be suitable to use in the transfer environment and mounted on the trolley in such a way as to be CEN compliant. It is recommended that the equipment available in transfer bags be standardised across NoECCN to support trainees moving between trusts. The suggested contents list is shown below

Suggested contents list for Transfer bags[7]:

Regional Transfer Bag Contents List

Advanced Airway	**Breathing Pocket**	**Circulation Pocket**
1 x ETT 6	1 x LMA/Igel size 3	2 x IV cannula size 14G
1 x ETT 7	1 x LMA/Igel size 4	2 x IV cannula size 16G
1 x ETT 8	1 x LMA/Igel size 5	2 x IV cannula size 18G
2 x Laryngoscopes handles and batteries	1 x HME filter	2 x IV cannula size 20G
1 x Laryngoscope Blades 3	1 x Catheter Mount	2 x IV cannula size 22G
1 x Laryngoscope Blades 4	1 x C-circuit	5 x non sterile gloves
1 x Elastoplast	1 x Stethoscope	4 x 20 ml syringes
1 x Magill Forceps	1 x Wave form Capnography line	4 x 50 ml syringes
2 x Lubricating gels	1 x Green anaesthetic Face mask	4 x 10ml syringe
1 x Gum elastic bougie	1 x Orange anaesthetic Face mask	10 x chloraprep skin wipes
1 x Scalpel size 10	1 x colorimetric C02	1 x infusion giving set
1 x 10 ml syringe	**Suction Pocket**	1 x micropore tape
1 x FONA pack	2 x Yankauer suckers	4 x gauze
1 x Scissors	2 x 14F suction catheters	4 x cannula dressings
Self-ventilating pocket	2 x 12F suction catheters	12 x ECG electrodes
1 x Guedel Green		10 x Sodium chloride flushes
1 x Guedel Orange	**External Pocket**	5 x Obturators
1 x Guedel Red	1x Self inflating Ambu bag and mask	4 x Drug labels
1 x NP airway size 6	**Inside pouch on side of bag**	**Interventional circulation**
1 x NP airway size 7	1 x fluid 500ml	5 x Green/drawing up needles
1 x Non rebreathe mask size 5		2 x Tourniquets
1 x Oxygen Tubing		
FONA Pack = 1 x size 6.0 ETT + Bougie + Scalpel in polypocket with DAS guideline		

Final agreed Transfer Bag Contents List from The North of England Critical Care Network

Agreed September 2017

Transfer bags should be checked and restocked after each use. All equipment should be regularly serviced and maintained in accordance with manufactures instructions.

Appendix 6

Documentation and Audit

A transfer document has been developed by NoECCN to support the transfer of critically ill patients. Which includes Pre Transfer Risk Assessment, Pre Transfer Checklist and Transfer observations.

The frequency of recording observations will be determined by clinical need and influenced by the length of journey but should not be less than every 15 minutes.

This form should be file in the patient's notes.

Any critical incidents occurring during transfer should be noted on the form, details recorded on the patients' medical records and a local incident report/Datix completed and reported to NoECCN using the NoECCN incident form to enable follow up. (See Appendix 7).

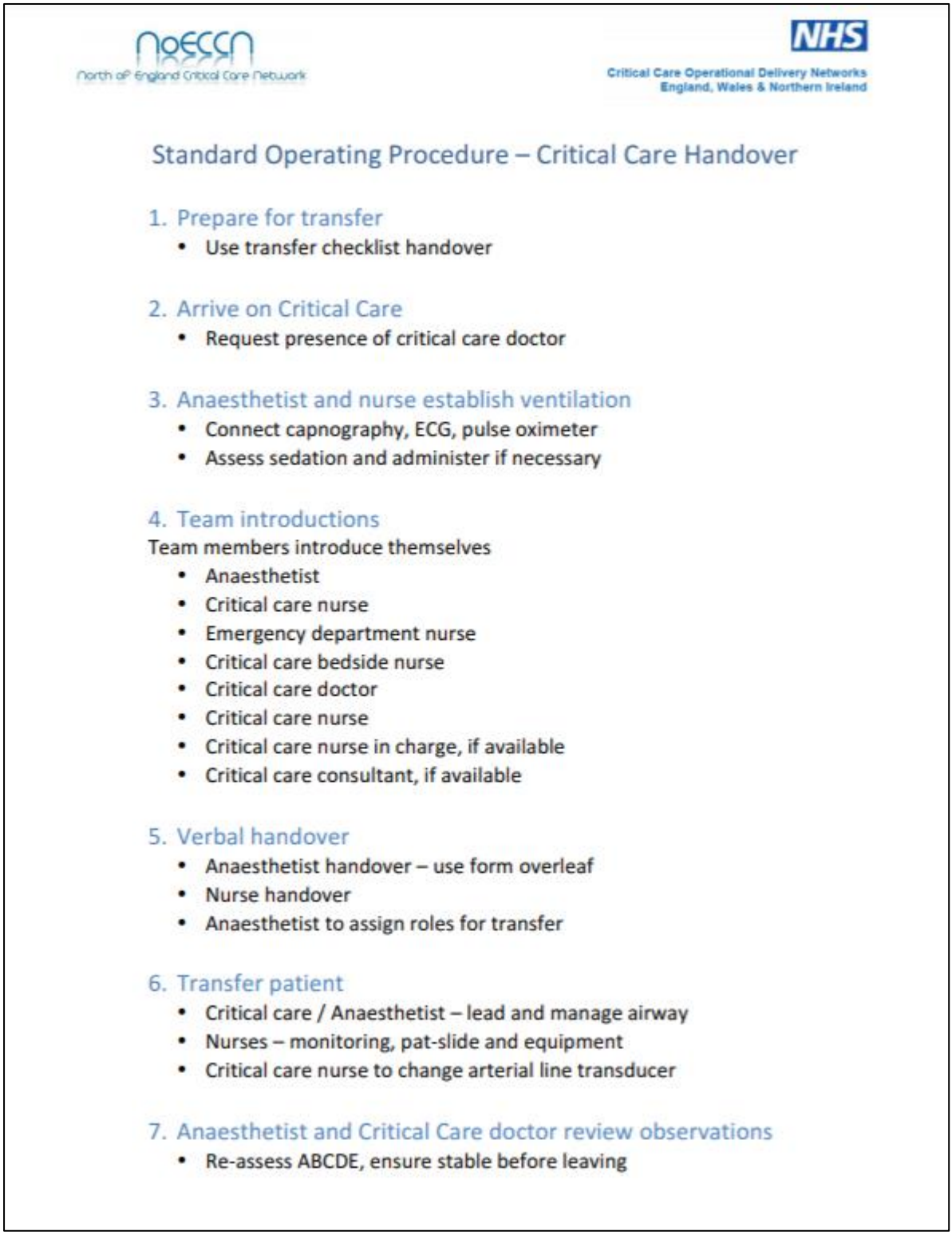
Audit

After completing a critical care transfer please complete the online transfer audit form available on the NoECCN website https://www.surveymonkey.com/r/NoECCN_Transfer_Audit_Adults and also available attached to the trolleys on a label as QR code, or through the network app if you use your smartphone. There is currently no password to access this audit.

Monitoring the number of transfers, identify difficulties and critical incidents is a mandatory requirement from NHS England. It facilitates the development of the service and the tracking and investigation of possible critical incidents.

Handover documentation

To facilitate effective handover at the receiving hospital, handover documentation has also been developed. This is intended to ensure that information that is not strictly relevant to the transfer but is none the less important, is available / recorded.



NoECCN North of England Critical Care Network

NHS Critical Care Operational Delivery Networks England, Wales & Northern Ireland

Standard Operating Procedure – Critical Care Handover

1. Prepare for transfer
   - Use transfer checklist handover

2. Arrive on Critical Care
   - Request presence of critical care doctor

3. Anaesthetist and nurse establish ventilation
   - Connect capnography, ECG, pulse oximeter
   - Assess sedation and administer if necessary

4. Team introductions

Team members introduce themselves

   - Anaesthetist
   - Critical care nurse
   - Emergency department nurse
   - Critical care bedside nurse
   - Critical care doctor
   - Critical care nurse
   - Critical care nurse in charge, if available
   - Critical care consultant, if available

5. Verbal handover
   - Anaesthetist handover – use form overleaf
   - Nurse handover
   - Anaesthetist to assign roles for transfer

6. Transfer patient
   - Critical care / Anaesthetist – lead and manage airway
   - Nurses – monitoring, pat-slide and equipment
   - Critical care nurse to change arterial line transducer

7. Anaesthetist and Critical Care doctor review observations
   - Re-assess ABCDE, ensure stable before leaving

NoECCN North of England Critical Care Network

NHS Critical Care Operational Delivery Networks England, Wales & Northern Ireland

TRANSFER CHECKLIST HANDOVER

Airway

ETT

Intubation grade

Indication for intubation

Breathing

FiO2

Ventilator settings

CXR

ABG

Circulation

Access

Fluids / output

CV support / inotropes

Disability / drugs

GCS and pupils

Glucose / temperature

Antibiotics

Insulin / infusions

Exposure / equipment

Infusions labelled

Log roll

Drains

Other

Date of admission:

Date of transfer:

Patient details
Affix sticker

Patient

PMH

Medication

Allergies

Problem

PC / HPC

Diagnosis

Examination / key findings

Investigation results

Critical incidents

Plan

Surgical

LMWH / UFH

Antibiotics

Drains

Feeding

Family aware

Outstanding issues

Targets MAP UO PaO_2 $PaCO_2$

Consultant critical care _____ Parent speciality consultant _____

Appendix 7

Feedback / Critical Incident Reporting

Transfer of critically ill patients is not without risk and occasionally things will not go as well as expected. Critical Incidents should be recorded on the transfer form, in the patient's medical records and your local incident procedures / Datix.

NoECCN Critical Incident reporting form

NHS NoECCN
North of England Critical Care Network

CRITICAL INCIDENT REPORT FORM INTERHOSPITAL TRANSFER OF CRITICALLY ILL PATIENT		
DATE / TIME INCIDENT REPORTED		
PERSON REPORTING INCIDENT	Name	
	Organisation	
	Contact Phone	
	Contact E-mail	
CRITICAL INCIDENT NUMBER (OFFICE USE)		
CRITICAL INCIDENT DATE / TIME		
LOCATION OF INCIDENT		
NEAS (or equivalent) TRANSFER NUMBER (if available)		
INCIDENT TYPE	☐ Delayed Ambulance ☐ Communication - Ambulance Staff (including ambulance control) ☐ Communication - Referring Staff ☐ Communication - Receiving Staff ☐ Equipment problem – Critical Care Transfer Trolley ☐ Equipment Problem – other ☐ Traffic Accident ☐ Out of *"Transfer Group"* transfer ☐ Other – Please explain below	
BRIEF DESCRIPTION OF INCIDENT		
STAFF INVOLVED WITH INCIDENT		

1

TCIF 1 Transfer Critical Incident Form / NoECCN / Aug 2022

NHS NoECCN
North of England Critical Care Network

SEVERITY OF INCIDENT	☐ No obvious harm / Near miss / Insignificant ☐ Low harm / Minor ☐ Moderate harm / Temporary harm / Additional intervention required ☐ Severe harm / Major permanent harm / Major intervention required ☐ Death / Catastrophic
LIKELIHOOD OF RECURRENCE OF AN INCIDENT	☐ Almost certain ☐ Likely ☐ Possible ☐ Likely ☐ Rare
ACTUAL EFFECT ON PATIENT	☐ None ☐ Other, please specify
ACTUAL EFFECT ON STAFF	☐ None ☐ Other, please specify
CONTRIBUTING FACTORS	☐ Patient factors ☐ Individual (Staff) factors ☐ Equipment factors ☐ Task factors ☐ Team factors ☐ Organisational factors ☐ Environmental factors Comments about contributing factors:
OWN TRUST CRITICAL INCIDENT FORM COMPLETED	☐ YES ☐ NO
CONTACT DETAILS FOR FEEDBACK	NAME TITLE / ROLE ORGANISATION TELEPHONE NUMBER EMAIL ADDRESS

Please email within **48 HOURS** of incident to:
Jan.malone@nhct.nhs.uk or sarah.gray13@nhs.net

2

TCIF 1 Transfer Critical Incident Form / NoECCN / Aug 2022

Management of Transfer related – critical incidents
Standard Operating Procedure

Introduction

A critical incident is any event or circumstance that caused or could have caused (referred to as a near miss) unplanned harm, suffering, loss or damage. The purpose of incident reporting is to learn from the incident to improve practice and safety (ICS, 2006).

Responsibility

Any professional who is involved in the care of the patient during the critical care patient transfer has a responsibility to report incidents either by email or post to the Network Administrator at the relevant locality office who will in turn inform the NoECCN Team and the Chair(s) of the Transfer Group.

Documentation

All incidents should be reported using NoECCN 'Transfer Critical Incident Form' (TCIF 1). The report should be completed as comprehensively as possible, including the patient ID and names of staff involved. The documentation should be completed with 48 hours of the event occurring.

https://www.noeccn.org.uk/Transfer-Group-Guidelines-and-Resources

Process

Action	Time Frame	Responsibility
Complete NoECCN (TCIF 1) and send to the NoECCN	Within 48 hours of the incident	Professional reporting the incident
NoECCN Administrator record the incident on the Excel Critical Incident Database (TCIF log) and inform NoECCN Transfer Clinical Governance Lead Sub Group	Within 48 hours of receipt	NoECCN Administrator
Standard email response (TCIF 2) that incident has been received by the NoECCN and is being reviewed	Within 24 hours of receipt	NoECCN Administrator
Complete a Concise (TCIF 3) Investigation Report Form, **and** for: **Green & Yellow** Incidents: Send standard closure email (TCIF 5) **Red & Orange** Incidents: Complete a Comprehensive RCA Investigation Form (TCIF 4)	According to severity of incident within 1 week	NoECCN Administrator NoECCN Team NoECCN Transfer Chair(s)
Recommendations/feedback to organisations involved and develop action plan if appropriate or close event on incident database	According to severity of incident (green - red)	NoECCN Team NoECCN Transfer Chair(s)
Following investigation of red & orange incidents. Send standard closure email (TCIF 5)	Within 24 hours of closure of incident	NoECCN Administrator
Feedback at Transfer Group	Quarterly Transfer meetings	NoECCN Team NoECCN Transfer Chair(s)

Timescales are referred to 'normal' working days (Monday – Friday 09.00 – 17.00, not including Bank Holidays).

Feedback to NEAS / NEASUS any relevant transfer related incidents as they happen and also a summary on a monthly basis.
Link is David Parkin – Fleet Operations Manager david.parkin@neasus.co.uk

Feedback at the NoECCN Transfer Group Meetings

References:

NoECCN Guidelines for the safe transport of the critical care patient (2013)

National reporting and learning Service. Root Cause Analysis Investigation Tools NPSA (2008)

Standards for critical incident reporting in critical care. Intensive Care Society Standards and Guidelines (2006)

Appendix 8

Repatriation

National standards state: -

- *Where patients have completed specialist care and ongoing intensive care needs can be provided in the patient's home, hospital transfer must take place within 48 hours of referral to the receiving hospital.*

And

- *Regional Intensive Care Networks must have an agreed policy on escalation of care and repatriation between secondary and tertiary units to include escalation and, if required, prioritisation of transfers over local elective activity.*

(GPICS edition 2.1 2022).

These principles should be applied to all patients requiring repatriation within the NoECCN area.

- The timing of the referral / request for reparation from specialist units will be determined by the clinical condition of the patient and the lack of continued requirement for specialist care.

- The timing of the referral / request for repatriation from non-specialist units (for example following non clinical transfer to another centre in NoECCN) will be determined by both clinical condition of the patient and knowledge of prevailing operational pressures on both sites. There may need to be a degree of pragmatism in decision making - there is for example little point in requesting repatriation if this will simply result in the non-clinical transfer of another patient to facilitate the repatriation.

- Once a referral / request for repatriation is made, the receiving unit should aim to repatriate within 48 hours of the patient being accepted.

Guidance for the repatriation of critically ill patients from international hospitals to UK critical care units.

National medical leads, Critical Care ODNs

- All UK residents have a right to timely access to NHS facilities, including those who become ill whilst abroad.
    - The repatriation of all patients to the hospital that serves their home residence should be expected to occur within the timeframe of internal repatriations within that ODN (normally 48 hours).
- Critical care units across the world differ significantly in the resources and care available and, in many instances, may not able to deliver care of a standard that would be acceptable in UK critical care units.
    - Where patients are receiving care that may be expected to be limited all efforts must be made to repatriate the patient immediately.
- All requests for repatriation must involve discussion with the critical care consultant in the receiving hospital, in line with the guidelines for that ODN.
    - Requests for repatriation of UK residents from hospitals abroad may be facilitated by commercial organisations responsible for the transfer of the patient to the UK. Whilst, where possible, the standard of information and communication required for a UK interhospital transfer is desirable, in some cases this may not be feasible and transfer should not be delayed due to incomplete information, particularly in the case where the patient is not receiving care of a standard that would be expected within the UK.
- The organisation and management of international repatriation is often complex and once any patient has left the hospital caring for them the UK receiving hospital is responsible for accepting the patient. If changes in circumstances made admission impossible that hospital is required to manage this just as though the patient was in their own emergency unit.
- The UK receiving hospital should inform their trust infection prevention and control (IPC) team at the time of the request to enable an appropriate risk assessment to be undertaken and relevant control measures implemented on arrival (including potentially isolation and screening). If the trust IPC team require additional advice on risk assessment and management, this can be sought from PHE via their local health protection team (https://www.gov.uk/health-protection-team)
- If a complex multiple patient repatriation across multiple trusts is planned, this should be coordinated through your regional or national NHS colleagues and the UKHPA, via UKHSA local health protection teams (https://www.gov.uk/guidance/contacts-phe-health-protection-teams)

References

1. Faculty of Intensive Care Medicine and Intensive Care Society (2019) Guidance On: The Transfer of the Critically Ill Adult.

2. National Ambulance Clinical Conveyance Group (2011) Inter-hospital Transfer Policy. National Ambulances Service.

3. Droogh et al. (2015) Transferring the Critically Ill patient are we there yet? Critical Care 19:62. DOI 10.1186/s13054-015-0749-4

4. Faculty of Intensive Care Medicine and Intensive Care Society (2022) Guidelines for the Provision of Intensive Care Services. Edition 2.1

5. Comprehensive Critical Care: A Review of Adult Services (Dept of Health: 2000)

6. Association of Ambulance Chief Executives. National Framework for Inter-Facility transfers. 2021 https://www.england.nhs.uk/publication/inter-facility-transfers-framework/

7. A consensus to determine the ideal transfer bag: Journal of the Intensive Care Society: 2016 Vol 17(4) 332-340