

Capacity Transfer of Adult Critical Care Patients

Position Statement

Executive Summary

Intensive care capacity transfers occur because of insufficient staffed beds. They are a temporary measure, attempting to ensure equitable access across the wide range of conditions that require intensive care.

Capacity transfers involve moving a patient to another hospital to enable another patient to receive critical care. They occur for two reasons:

- **Emergency capacity transfer** - used for many years to deal with surge demand to enable the provision of emergency medical and surgical care (e.g. priority 1a procedure; to be performed in <24 hours). The Intensive Care Society and Faculty of Intensive Care Medicine continue to support this position.
- **Planned surgery capacity transfer** – used to enable a post-operative critical care bed to become available for another patient (priority 1b procedure; to be performed in <72 hours and priority 2 procedure; to be performed within 1 month). This has been introduced, through necessity, within some regions during the COVID-19 pandemic.

The Intensive Care Society and Faculty of Intensive Care Medicine believe that planned surgery capacity transfers are not a sustainable alternative to an appropriate increase in adequately funded and staffed critical care (Level 2 and 3) and enhanced care (Level 1) beds.

The Intensive Care Society and Faculty of Intensive Care Medicine support capacity transfers for planned surgery **only** when:

1. They are needed due to exceptional circumstances requiring a national or health board 'command and control' level response e.g. during the COVID-19 pandemic
2. There is a serious risk of increased morbidity or reduced survival if surgery was to be delayed.
3. There are operational and governance safeguards in place, detailed below.

Endorsed by:



Background

The transfer of a critical care patient occurs for one of the following reasons:

Clinical transfer: Provision of specialist treatment (e.g., ECMO, neurosurgery) not available in the referring unit. Transfer for immediate lifesaving interventions must not be delayed by lack of availability of a critical care bed.

Repatriation transfer: Returning someone to their local hospital intensive care unit either because they no longer require specialist treatment, or they had been visiting another area at the time they became critically ill.

Capacity (previously called non-clinical or mutual aid) transfer: Lack of a staffed critical care bed for patients occurs where demand exceeds capacity. When local supply is adequately resourced, fully staffed or able to “flex” up, the need for transfer is removed. Capacity transfers occur to support the provision of emergency admissions to critical care or the provision of planned admissions to facilitate elective surgical procedures.

The backlog of elective surgery requiring either post-operative enhanced, or critical care is putting pressure on critical care services struggling with an historical under provision of staffed critical care capacity. Significant regional differences exist in critical care provision. Pressure applied on critical units to work as a system to provide equitable critical care and to deliver increasing numbers of capacity transfers must be seen in this context.

The development of specialist critical care transfer services can do a great deal to reduce the risks of transferring critically ill patients. There remains a direct risk however, to both patients and staff involved, including the potential for psychological harm from disrupted care continuity and potential conflict with patients’ families.

Requirements before any planned surgery capacity transfer proceeds:

- All attempts at staffing funded capacity must first be maximised at the host site.
- All necessary intensive care ward step-downs must be completed.
- Any possible repatriations of patients to their local hospital have been enacted.
- All alternative measures e.g. outsourcing or inter-regional sharing of non-critical planned work have been considered and exhausted.

There should be executive level representation at both referring and receiving sites. This should include a review of both hospitals' CRITCON status by Trusts or Health Board, to ensure system wide pressure is recorded; that the transferring hospital is accurately declaring CRITCON 2 or above and that as a result of the transfer, the receiving hospital:

- Does not have a more dilute GPICS staffing ratio than the referring unit.
- Does not have a CRITCON level higher than the referring unit.
- Is still able to maintain priority 1 and 2 surgery.

Other considerations include:

- A review of any extra-contractual rates and agency or bank rate caps should be undertaken if there is significant variation with regional or national standards.
- There must be benefit from moving a critically ill patient over and above the movement of staff (surgical teams or ICU) or patients pre-operatively.

Guidance for planned surgery capacity transfers

Regions should have a policy statement and Standard Operating Procedures (SOPs) in place which are agreed by the Regional Medical Director(s) or Devolved Nation Chief Medical Officer and relevant Critical Care Networks.

The decision to transfer any individual patient to enable planned surgery should be ratified at a Trust Executive level.

A 'three wise person' approach to decide on the most suitable person to transfer is encouraged. This could consist of the duty Critical Care consultant, senior Critical Care nurse and Critical Care Clinical Director (or nominated delegate). The shared-care clinical team consultant and receiving unit consultant should be involved in this process. The panel decision and named participants, including the Medical Director (or nominated executive level representative) authorising the transfer, should be documented in the patient's notes.

Process once a planned surgery capacity transfer is approved

- Confirmation of the capacity transfer should be made with the receiving unit consultant and nurse in charge.
- The teams should agree that care requirements for the individual patient being transferred are able to be met in full at the destination hospital, including appropriate staffing levels. The transfer must be able to be effected safely and with minimal risk to the patient.
- Clinical autonomy must be maintained, and if no suitable patient is identified then the transfer cannot happen.
- A risk assessment (see appendix 1) must be undertaken and documented by a senior clinician.
- The reason for transfer should be explained clearly and with honesty to the patient and family/next of kin.
- The transfer process should be fully compliant with existing national and regional standards and operating procedures (staffing, skill mix, and logistic arrangements); and with the additional safeguard of daytime-only transfer, reflecting the planned nature of these transfers). On occasions, out of hours transfers may be necessary, but this should only happen when a dedicated regional transfer service is available and earlier decisions and discussions have already happened.
- Any complaints or family concerns should be dealt with pre-emptively with senior Trust/Health Board support, not solely by the intensive care team. There should be a clear process in place for the circumstance in which a patient or their next of kin disagree with such a transfer, and that process should be made known to the patient and their close family or advocate.

Appendix 1: Risk Assessment for planned surgery capacity transfer to be documented in patient records

Name of accountable Medical Director, deputy or duty Executive, and responsible clinician(s) involved in decision to transfer.
Updated CRITCON status of sending and receiving Trust/Health Board (transferring organisation must declare CRITCON 2 by definition)
Current Critical Care (level 2 and 3) dependency.
Staffing ratio for level 2 and 3 patients.
Review of patient's current clinical condition and anticipated physiological trajectory, and the potential for setbacks from transfer e.g. to their recovery & rehabilitation progress. Any Infection Prevention & Control (IPC) risks e.g. COVID-19, MRO. Consider possible medicines management risks e.g. with complex ongoing therapy.
Risks related to transfer including length of transfer, monitoring and interventions required. See Intensive Care Society and Faculty of Intensive Care Medicine Transfer of the Critically Ill Guidance .
Consideration of any potential delay in specialist treatment for any patient transferred to another unit.
The rationale for the move, at patient-by-patient level (i.e. exactly which planned operation is being facilitated and who for, to enable subsequent clarification of reasoning).
Infection Prevention & Control issues in this transfer (COVID-19, MRO, or other).
Documented patient and/or next of kin discussion including any details of any resource or information leaflet provided.

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References

The Federation of Surgical Specialty Associations. COVID-19 https://fssa.org.uk/covid-19_documents.aspx

Guidelines for the Provision of Intensive Care Services. Faculty of Intensive Care Medicine and Intensive Care Society
<https://www.ficm.ac.uk/standardssafetyguidelinesstandards/guidelines-for-the-provision-of-intensive-care-services>

Levels of Care https://www.ics.ac.uk/Society/Guidance/PDFs/Levels_of_Care_25_3_21

Enhanced Care <https://www.ficm.ac.uk/standardssafetyguidelinescriticalfutures/enhanced-care>

CRITCON Levels
https://www.ics.ac.uk/Society/Policy_and_Communications/Articles/CRITCON_levels

Intensive Care Society and Faculty of Intensive Care Medicine Transfer of the Critically Ill Adult https://www.ics.ac.uk/Society/Guidance/PDFs/Patient_Transfer_Guidance

