Critical Care Networks of England, Wales and Northern Ireland.

Memorandum of Understanding

National Critical Care Networks coordinated response to recent Regulation 28 publications from UK Coroners relating to critical care capacity and immediate life preserving interventions

January 2019

The Adult Critical Care Networks of England, Wales and Northern Ireland have produced a coordinated response in acknowledgment of the findings of two Regulation 28 coroner reports published in January 2017 regarding specialist care and implications relating to immediate availability of Intensive Care level 3 provision. This response references the letter on the subject from Sir Bruce Keogh of 27 February 2017 (see below), which highlights the key features and concerns raised by the Regulation 28 reports. We would like to thank the North of England Critical Care Network for writing the original Memorandum of Understanding upon which this is based and for allowing its further development into this national memorandum by the collaborative working structure of our Networks.

In summary, there have been two cases in the UK when at coroner's inquest it was stated there were delays in transferring patients to specialist neurosurgical units for immediate lifesaving neurosurgery. These delays were judged to have adversely affected outcome. One of the contributing factors cited was a lack of available intensive care beds at the receiving specialist centre.

In the open letter from Sir Bruce Keogh he reaffirms that "professional guidance includes recommendations that, admission to a regional neurosurgical unit for life-saving, emergency surgery should never be delayed and that neurosurgical units should not refuse admission to patients requiring emergency surgery from their catchment population. The lack of critical care beds must not be a reason for refusing admission for patients requiring urgent surgery."

This comes with the caveat that this should not exclude co-operation between neighbouring units if this can expedite patient care.

Furthermore, Prof Keogh states that "There should be a designated consultant in the referring hospital with responsibility for establishing arrangements for the transfer of patients with head injuries to a neuroscience unit and another consultant at the neuroscience unit with responsibility for establishing arrangements for communication with referring hospitals and for receipt of patients transferred."

These cases and the Regulation 28 letters from the Coroner and their implications for critical care were discussed at the National Critical Care Networks Medical Leads meeting in London in March 2017. In addition to this, further cases were discussed at

the meeting in October 2017 arising from documented incidents where there was lack of access to specialist centre beds for ongoing care in patients requiring a tertiary centre for services other than neurosurgery. There was general acceptance of the necessity to comply with the process outlined above whereby, even in the immediate absence of critical care capacity in the receiving specialist centre, the patient should still be admitted to that hospital to undergo the emergency intervention. Capacity would then need to be created on site if possible (following site-specific discharge policies) to admit the patient to that centre's critical care unit, or if necessary transfer out either the same patient or an alternative patient to another critical care unit.

It was subsequently agreed that the same principle should apply to any immediately life- threatening event where an emergency procedure might improve outcome. This would therefore encompass procedures such as unstable ruptured aortic aneurysm, either for open repair or emergency endovascular repair, a defined group of acute coronary events mandating immediate primary percutaneous coronary intervention (PPCI), major burns and multiple trauma, amongst others. Other areas such as recipients for implantation of time critical cadaveric donor organ transplant (i.e. heart, lung, liver), where the procedure is time critical though the recipient is not in immediate danger, may also come under the same consideration.

Furthermore, in cases where transfer to a specialist centre is clinically indicated for ongoing specialist treatment on an urgent timescale without the requirement for an immediate life preserving intervention, that transfer should occur as soon as possible in accordance with the pre-existing care pathway. If there are inadequate critical care resources to provide the required ongoing management within this specialist centre, then in accordance with the principle of care already agreed to, the consultant at the specialist centre should be responsible for ensuring an appropriate bed is found in another specialist centre to enable the patient to receive necessary care without delay.

The Medical Leads for the Adult Critical Care Networks of England, Wales and Northern Ireland agree with these principles, accept them and seek to ensure all units within our individual Networks understand their nature and ensure they work to provide them, in the best interests of the patients receiving their care:

- We, as Medical Leads of the Networks, agree to work to the principle that if a patient is identified as having an immediately life threatening clinical event, that can be effectively treated by an immediate time critical specialist intervention, limitation in critical care resources should not delay the access for the patient to the immediate intervention. This only applies in the circumstance where the intervention can be performed immediately and that any delays (i.e. of more than 2 hours) in the procedure will have a significant adverse effect on outcome.

- Where these principles are met, the patient should be transferred to the specialist centre according to the existing care pathway as soon as possible to undergo the necessary procedure. Plans to accommodate the patient, either

within the critical care at the specialist site or another unit, should be made simultaneously. Responsibility for identifying appropriate critical care facilities for the patient and if necessary the arrangement of this with another specialist centre followed by coordination of the transfer of the patient to that specialist centre rests with the consultant accepting the patient. Clear communication between all medical and nursing teams is mandatory.

Furthermore, even when a lifesaving intervention is not immediately required, patients with a need for specialist intensive care unit treatment as a matter of urgency should not have their treatment delayed because of a lack of critical care capacity in specialist centres as defined by the pre-existing care pathway. The specialist consultant accepting the initial patient referral should take responsibility for guiding the care of the patient and ensuring a bed becomes available as soon as possible to accept that patient for specialist critical care. If the specialist centre on the care pathway is unable to receive transfer of the patient within the necessary time frame for ongoing treatment, it is the responsibility of the consultant at that specialist centre to arrange for the management of the patient at an alternative specialist centre (not the referring clinician seeking transfer of their patient). The urgency of this time frame will be determined by the consultant clinician in the specialist centre.

Once a patient's specialist intervention has been completed and they are stable and ready for repatriation to their original hospital then it is the responsibility of that local hospital to ensure the patient's return is completed within a timely manner (48 hours maximum from the time a transfer back is requested) in line with regional transfer policies. In some circumstances the return post-procedure may be within a very short time frame. A fundamental aspect of this process of immediate transfer is the cooperative working between the Network's Critical Care Units to ensure optimal use of regional critical care capacity. When unavoidable, acceptance of exchange transfers may have to be considered.

Signed on behalf of the Medical Leads of the National Critical Care Networks of England, Wales and Northern Ireland and endorsed by the Intensive Care Society.

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