INDEPENDENT HEALTHCARE ADVISORY SERVICES

CRITICAL CARE TRANSFER FOR PATIENTS TREATED IN THE INDEPENDENT SECTOR – April 2009

1. Context setting:

Independent Healthcare providers completing the IHAS Hospital Profile carry out 631, 000 procedures each year of these a tiny proportion have unexpected complications that require specialised care including within NHS critical care facilities. The number of cases that need to be transferred to the NHS is less than 0.5% of the total cases.

2.Principles:

a) To facilitate escalation of care when appropriate for all patients in a timely fashion.
b) There is an underlying right to free NHS services under the NHS Act 1977.This right does not cease to exist simply because a person is receiving treatment within an independent facility.
c) There is a requirement for Independent hospitals and treatment centres to have in place written policies and procedures for the transfer of patients to another hospital where required.
d) When being treated within an NHS Critical Care facility there is no differentiation in the care received between an NHS or privately funded patient.

3. Objectives of the policy:

a) Enable people to exercise their right to free NHS services.
b) Embed informed choice for people in a vulnerable situation.
c) Ensure that all parties have clarity on terms of engagement.

4. Introduction

This paper has been prepared in conjunction with the Intensive Care Society, the Critical Care Network Managers, the Department of Health (England) and the National Critical Care Stakeholders Forum.

This agreement has been written to cover adult and paediatric transfers. For the purpose of this paper paediatric age range will cover birth to 16 years of age (i.e. up to the day before the 17th birthday).

A transfer agreement is a requirement for compliance with the Care Standards Act 2000 for all independent hospitals and treatment centres to have written policies and procedures for the transfer of patients to another hospital where required (Regulation 9 (1) A). This requirement is developed in the relevant National Minimum Standards A 29.10/11 for adults and A19 (1-5) for children's services. These require a documented agreement for the transfer of patients for level 2 or 3 critical care that includes the provision of an appropriate transfer team, which meets the ICS Standards.

It is the responsibility of the individual hospital or treatment centre general manager/hospital director to ensure that a written transfer agreement is developed with a specific NHS Trust or Trusts, including guidelines for the transfer team.

If a retrieval team is not provided by the NHS Trust(s) then the independent provider needs to identify the process for transferring the patient and ensure there is appropriate equipment and that staff are competent to undertake such a transfer.

All independent providers must ensure that an adequate risk assessment is carried out prior to admission as tabulated in *'Guidance on Comprehensive Critical Care for Adults in Independent Sector Acute Hospitals' – September 2002* (currently being updated). All independent hospitals and treatment centres will be responsible for undertaking monitoring of critical care transfer key performance indicators.

The Department of Health has clarified that private patients who meet UK eligibility criteria may opt to return to free NHS emergency and elective treatment at any time should they require it. Implicit is that the patient chooses to relinquish their status as a private patient and be treated as an NHS public patient, and accepts that their clinical priority will be judged by the same criteria as any other NHS patient.

'*The right to free NHS services under the NHS Act 1977 is an underlying one and does not cease to exist simply because the patient in question is receiving private treatment'*. NHS Executive Letter (95) 132.

When appropriate and with their approval the patient should be transferred back to the independent sector facility providing the appropriate level of care can be provided.

Independent sector providers will adhere to the following model transfer protocols.

5. Model Transfer Protocols

Transfer of Critically Ill Patients from an Independent Hospital or Treatment Centre into an NHS Critical Care Facility

1. The critical care transfer protocol should offer a simple and comprehensive solution to the problem of providing access to critical care facilities for private patients treated in the <   > Hospital. In order for this protocol to become operational, the registered hospital or treatment centre manager must accept certain conditions, and the Medical Advisory Committee (MAC) of the hospital or treatment centre must agree the protocol.

2. **In the case where a retrieval service is offered, a charge will be made to the hospital or treatment centre for the retrieval process by the < > NHS Trust(s). It will be the responsibility of the hospital or treatment centre to make provision for payment.** The amount may be based on a 'cost per case' basis, or by prior negotiation on a contract basis. The cost of transfer will take into account the cost of equipment, its maintenance and of staffing costs. **The recommended charge is between £1,000 - £1,500 depending on whether the retrieval needs to be organised out of usual working hours.**

3. **A separate charge may be made by the Consultant Intensivist or Consultant responsible for stabilisation and transfer. The intensivist will submit their charge to the relevant Insurer or for self pay patients directly to the patient via the<   > Hospital.**

4. Some NHS Trusts/Networks have developed their own arrangements to accept patients from the independent sector and this paper will not negate any such local arrangements. [May be removed once local written agreement obtained].

5. <   > Hospital must notify the patient's Insurer of their transfer out of the hospital stating the reasons for transfer and the transfer location immediately following transfer or the next working day.

6. Any patient transferred as an emergency from an independent sector provider, to an NHS organisation for critical care shall, on transfer, be deemed to revert to NHS status as long as they comply with the provisions of the NHS Act 1977. This situation applies where the required level of care, or specialist service is not provided by the independent sector provider and is provided by the NHS organisation. (See points 9 for other payer type)

7. If an Insurer requires a medical statement in order to authorise continued critical care benefit, this will be provided by a consultant intensivist.

8. The relevant points above may be applied for all patients who are resident in the UK or within the EU.

9. **Patients who reside outside the EU are not entitled to free NHS care. In such cases <   > Hospital will notify the relevant liaison person and instigate immediate contact with the NHS Trust to agree arrangements for treatment. This may be through private funding, the relevant Embassy or overseas Insurer.**

Operational protocol for transfer with or without a retrieval arrangement

1 Aim:

Provision of a comprehensive plan to deal with urgent and semi-urgent transfers to an NHS Trust critical care and theatre facilities.

2 Objective:

To ensure that patients who become critically ill, or whose condition is anticipated to deteriorate, can be transferred promptly, efficiently and safely to facilities where they will receive comprehensive treatment for their condition. This process should involve the minimum of disruption and inconvenience to the patient, staff and other patients in both the referring and receiving units.

3 Indications for Action:

3.1 The protocol should be considered whenever a patient’s condition deteriorates acutely and does not respond to simple therapeutic measures (e.g. reversal of opioid-induced respiratory depression, DC cardioversion) or when observation over a period of time suggests that level 3 critical care is likely to be required.

3.2 The decision to refer a patient for critical care should ideally be made by the admitting consultant or consultant providing cover in their absence. This decision should take into account the patient’s and family’s wishes, the patient’s chronic health status, and the likelihood of eventual recovery.

3.3 The protocol should normally be activated by the consultant responsible for the patient’s inpatient care, or this person in conjunction with an anaesthetic colleague. The covering consultant anaesthetist may also activate the protocol in the absence of the admitting consultant if the patient’s condition demands it. NB. If the Anaesthetist involved does not usually manage critical care patients they should refer to an Intensivist for a specialist opinion.

3.4 If the admitting Consultant responsible for the patient's care does not have a contract of employment with the NHS Trust, arrangements must be made for the patient to be transferred to the care of another appropriately skilled Consultant at the NHS Trust. This referral must be made and agreed prior to the patient's transfer by the Consultant responsible for the patient's care.

3.5 The resident medical officer, senior ward and theatre nursing staff should be authorised to activate the protocol in certain circumstances eg:

- Cardiac arrest
- Respiratory failure ($P_aO_2 < 8$ kPa, $P_aCO_2 > 6.5$ kPa)
- Reasonable concern that the patient's condition will deteriorate requiring level 3 care within four hours

The criteria above may ONLY be used when both the admitting consultant and supervising anaesthetist are for some reason out of immediate contact. Staff must also first seek the assistance of an alternative consultant from the same speciality or an alternative consultant anaesthetist before activating the protocol themselves.

3.6 Where the nursing staff are concerned that a patient may require transfer to level 3 care because of their deteriorating condition but the consultant disagrees, a process of review and arbitration may be required. In the first instance the nursing staff must discuss the matter at length with the patient's consultants and their managers, but if this does not resolve any impasse, the MAC anaesthetics representative should be contacted to review the situation and liaise between the nursing and consultant teams. In the event of neither being available within a reasonable timescale the receiving Consultant at the Trust will make the final decision.

3.7 It is important to emphasise that patients who require critical care treatment should be referred and transferred as early as possible after this requirement is identified. Early recognition of impending deterioration is essential to avoid late referral. Use of Modified Early Warning System is recommended and is normal practice at < > Hospital. The paediatric early warning system will be applied for children.

4 Modus Operandi:

4.1 The person who decides to activate the protocol should first of all ensure that the patient is receiving appropriate treatment and supervision. If they are the only person capable of dealing with the patient's immediate care they should delegate the process of critical care contact to a suitable colleague.

4.2 When possible, the critically ill patient should be transferred to a suitable area for stabilisation for example the theatre recovery area, as this area provides better lighting and space to allow interventions to be carried out.

Arrangements for Emergency Transfers

4.3 Arrangements for transfer without Retrieval Service

Every unit should have a laminated card containing the following wording:

Urgent Critical Care Assistance:
Telephone xxxxxxxxx
or xxxxxxxx
or xxxxxxxx
Ask for Senior ICU Nurse
Advise them of clinical details *(*N.B. Specify if patient is above 'average' weight / BMI)*

4.4 If no bed is available, the number of the Critical Care Network or the Emergency Bed Service should be requested. They should be contacted and asked for local/regional bed availability.

4.5 Once a bed has been identified, one of the responsible consultants must discuss the case with the Consultant in level 3 care.

4.6 The transfer team must be identified. There must be a consultant or SPR, either an anaesthetist or a physician, trained to appropriate national standards. They must be accompanied by appropriately trained personnel for example registered nurses, critical care technologists or operating department practitioners (ODPs) skilled to care for ventilated patients and the monitoring needs to comply with the ICS standards.

4.7 The hospital or treatment centre should have arrangements for access to an ambulance appropriately equipped for critical care transfer. If none is available, the < > Ambulance Service Control must be contacted and a request made for *"Urgent Blue Light Ambulance Transfer"* to the receiving critical care facility and an ETA ascertained. If this is likely to be in excess of 60 minutes, the call should be terminated and 999 called when the patient is ready for transfer.

4.8 The patient's next-of-kin should be contacted and advised of the patient's condition and the plan to transfer. They should be encouraged to attend the hospital in the first instance and offered all necessary

support including arranging transport to the receiving hospital as appropriate after the patient has left.

4.9 All clinical documentation should be photocopied in preparation and relevant X-rays gathered.

4.10 Clinical Dialogue should be maintained on a daily basis to ascertain the patient's clinical condition from the Senior Nurse of the referring hospital to the critical care unit in which the patient was received. The detail of this dialogue must be recorded within the patient's medical record. The frequency of communications to monitor progress may reduce in frequency only when critical care is no longer required.

4.11 The details will be reported through the adverse event reporting mechanism at the transferring hospital.

4.12 **Arrangements for transfer with Retrieval Service**

Every unit should have a laminated card containing the Following wording:

Urgent Critical Care Assistance:
Telephone xxxxxxxxx
Ask for Duty Doctor
Advise them of clinical details *(*N.B. Specify if patient is above 'average' weight / BMI)*

4.13 This single call will activate the local NHS Transfer Service protocol *(insert local name if appropriate)*. The admitting Consultant or Anaesthetist will contact the duty consultant intensivist, who will offer telephone advice or guidance. If appropriate, the retrieval nurse will arrange for the despatch of a rapid response vehicle. This vehicle will collect the critical care transfer team and the mobile critical care stretcher and transport them to the independent hospital or treatment centre as rapidly as possible. The team is fully equipped to deal with critically ill patients of all ages, including children. (These are usually different teams and different hospitals).

4.12 Once the intensivist has accepted the patient for transfer they will take responsibility for organising their further care. This will include the stabilisation of the patient prior to transfer, the provision of monitoring and care during transfer and of communication with next-of-kin (in conjunction with the admitting consultant). If a critical care bed is not available at the NHS Trust they will assume responsibility for finding a

bed elsewhere within the critical care network or moving an existing patient in order to create a bed.

4.13 This system should ensure that expert assistance and comprehensive advanced life support equipment reaches the patient promptly and efficiently, and in doing so relieves ward or theatre staff of the responsibility for a seriously ill patient as quickly as possible. However, until the arrival of the team the most experienced personnel available must ensure that the patient receives the best care that can be achieved. The transfer team may require assistance from trained staff during the process of stabilisation. This may include liaison with members of family and other senior medical staff.

4.14 All clinical documentation should be photocopied in preparation and relevant X-rays gathered

Signed:

General Manager MAC Chairperson

Medical Director

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