

## **INDEPENDENT HEALTHCARE FORUM**

### **CRITICAL CARE TRANSFER FOR PATIENTS TREATED IN THE INDEPENDENT SECTOR**

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

It 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. 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, where possible..

It is the responsibility of the individual hospital or treatment centre general manager 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. 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.

## **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). This charge will apply irrespective of whether the patient chooses to be treated as an NHS patient or to continue to be treated as a private patient. 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 hours.
3. A separate charge may be made by the consultant intensivist (or consultant responsible for this service) for stabilisation and transfer. This charge will apply irrespective of whether the patient chooses to be treated as an NHS patient or to continue to be treated as a private patient. It will be the responsibility of the hospital or treatment centre to make provision for payment, which will be negotiated between the hospital or treatment centre manager and the consultant intensivist, to whom payment will be made directly.
4. Some NHS Trusts/Networks have developed their own arrangements to accept patients from the independent sector irrespective of whether they remain as a private patient or transfer to become an NHS patient and this paper will not negate any such local arrangements.

5. When practicable, it is important to ascertain the patient's preference for private or NHS status after transfer. Patients should be made aware that they may, if they so choose, retain their private status in the critical care facility. However the payment requirements must be clarified by the hospital provider. It should be made clear that their treatment will not be different if they choose to become an NHS patient, but they should understand that they will not necessarily be treated by a particular consultant. The responsibility for ascertaining the patient's views should lie with the admitting consultant (i.e. the consultant responsible for their care in the independent hospital), but if necessary this may be discussed by a medical or nursing colleague.
6. Patients who have not expressed a preference and who are too ill to do so at the time of transfer for critical care may pose a problem. Their next-of-kin may know the patient's wishes, but do not have the right to make a decision regarding change of status on behalf of an unconscious or otherwise incompetent patient.
7. Historically there have been problems with patients who have been referred and treated in a critical care facility as a private patient, then returned to an independent hospital, with them or their insurer claiming retrospectively that for the period of their critical illness they became an NHS patient. This will be unacceptable for patients transferred under this agreement.
8. Some insurers insist that authorisation for critical care as a private patient must be sought in advance of transfer. This may be unrealistic if the requirement for transfer for critical care occurs during unsocial hours. If the patient elects to be treated as a private patient and the insurer cannot be contacted for authorisation for critical care, the patient will be treated as a private patient until the patient's status is clarified by the hospital provider.. The responsibility for ascertaining access to critical care lies with the admitting consultant.
9. During the requirement for critical care there will be an appropriately trained consultant continuously available to supervise treatment and to manage any complications. Fees will be charged to private patients by the intensivist for daily attendance and for therapeutic interventions performed. This will be paid to the NHS unit if the intensivist is doing this in his/her NHS time. Where the insurer publishes a schedule of fees applicable to intensive care these will be used as a guide to charges.
10. If an insurer requires a medical statement in order to authorise continued critical care benefit, this will be provided by a consultant intensivist.

## **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.

3.4 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 in 3.4 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.*

3.5 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, 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.

3.6 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 the Modified Early Warning System is recommended.

#### **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 Transfer with Retrieval Teams**

4.3 On each ward nursing station and in the operating theatre a plastic laminated card will be placed. This card will contain the following wording:

#### **Urgent Critical Care Assistance:**

**Telephone xxxxxxxxx**

**Ask for Duty Doctor**

**Advise them of clinical details**

4.4 Where a Retrieval Service is in place, this single call will activate the local NHS Transfer Service protocol (*insert local name if appropriate*). The Level 3 critical care duty doctor 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).

4.5 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.

4.6 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.

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

#### **Arrangements for transfer without retrieval**

**Urgent Critical Care Assistance:**  
**Telephone xxxxxxxxx**

**or xxxxxxxx**  
**or xxxxxxxx**

**Ask for Senior ICU Nurse**  
**Advise them of clinical details**

4.8 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.

4.9 Once a bed has been identified, one of the responsible consultants or the RMO must discuss the case with the senior nurse in level 3 care.

4.10 The transfer team must be identified. There must be a consultant or SPR, either an anaesthetist or a physician, trained to appropriate local network standards. They must be accompanied by appropriately trained personnel for

example nurses or operating department practitioners (ODPs) skilled to care for ventilated patients.

4.11 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.

4.12 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.

4.13 All necessary equipment and drugs should be assembled and checked. All clinical documentation should be photocopied in preparation and relevant X-rays gathered.

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Independent Healthcare Forum,  
T: 020 7379 8598  
E: [info@ihf.org.uk](mailto:info@ihf.org.uk)  
W: [www.ihf.org.uk](http://www.ihf.org.uk)