CSOP 006- **Inter-facility Transfer**
- Incorporating TU/LEH to MTC transfers

Version No: 3.4 Effective date: 21/06/2023

APPROVALS

Original Document Author:	Dr Neil Thomson	Date	Signature
Revised Document Prepared by:	Dr Naveed Kordmahalleh	30/05/2023	
Reviewed by:	Dr Stuart Maitland Knibb Adam Nash, Clinical Quality Manager Phil Bridle, Head of Operations		
Approval:	Dr Justin Squires, Deputy Clinical Lead		
Next Review Date:	June 2025		

HISTORY

Effective Date	Version No.	Summary of Amendment
Feb 2010	1.0	Creation of document
Oct 2012	2.0	Review and update to TAAS
13/02/15	3.0	Review of document
16/05/2015	3.1	Addition to title for Trauma network clarity.
Feb 2017	3.2	Review
April 2020	3.3	Review with alterations, addition of section regards carriage of infectious patients.
Feb 2023	3.4	Role of commissioned critical care transfer services. Clarification of role with hyperacute trauma transfers. De-emphasis of TAAS role in routine critical care transfers. Clarification of process to deal with escalation of care transfer requests. Removal of transfer request form and addition of MCCTN TU/LEH to MTC policy to Annex A.

NOT DOCUMENT CONTROLLED ONCE PRINTED/COPIED

CSOP 006- **Inter-facility Transfer**
- Incorporating TU/LEH to MTC transfers

Version No: 3.4 Effective date: 21/06/2023

REFERENCES

Document Reference Number	Document Title
Annex A	Midlands Critical Care & Trauma Networks - Trauma Unit / Local Emergency Hospital to Major Trauma Centre Life ± Limb Threatening Transfer Policy

NOT DOCUMENT CONTROLLED ONCE PRINTED/COPIED

1. Scope

TAAS may be asked to carry out transfer work during operational duties.

This document serves as a guide to ensure a uniform and safe approach is taken to transfer requests and an appropriate means of transfer is identified, whilst minimising patient risks and disruption to HEMS cover.

2. Definitions/acronyms:

Abbreviations/Acronym	Definitions
ECMO	Extra Corporeal Membrane Oxygenation
TU	Trauma Unit
HEMS	Helicopter Emergency Medical Service
LEH	Local Emergency Hospital
NHS	National Health Service
TAAS	The Air Ambulance Service
ICU	Intensive Care Unit
MTC	Major Trauma Centre
ED	Emergency Department
STEMI	ST Elevation Myocardial Infarction
PPCI	Primary Percutaneous Coronary Intervention
EOC	Emergency Operations Centre
ACCOTS	Adult Critical Care Coordination & Transfer Service
KIDS/NTS	Kids Intensive Care and Decision Support & Neonatal Transfer Service

3. Background / principles

Since the introduction of the Midlands Critical Care & Trauma Network the majority of the patients requiring tertiary centre treatment are taken directly to the appropriate centre, however a small number of these patients will be taken to (or will self-present to) a TU/LEH, and will then require an inter-facility transfer for ongoing treatment.

In 2020, the Adult Critical Care Coordination & Transfer Service (ACCOTS) was commissioned to provide inter-facility transfer for critical care level patients, and now performs almost all routine inter-facility critical care transfers, including time-critical transfers. KIDS/NTS (Kids Intensive Care and Decision Support & Neonatal Transfer Service) provides the equivalent service for paediatric patients. Since ACCOTS was commissioned, TAAS less frequently performs routine inter-facility transfers.

4. Major trauma patients

With regards to major trauma patients, ACCOTS will transfer patients who have been stabilised and are unlikely to require acute interventions, however ACCOTS and KIDS/NTS are not commissioned or equipped to deal with time-critical hyperacute trauma patient transfers from TU/LEH emergency departments to MTCs, and these patients remain within the remit of HEMS services.

In the Birmingham area the MERIT service is commissioned to facilitate these transfers. The Midlands Trauma Network policy specifically includes a pathway of transfer to UHCW, from both Northampton General Hospital and Kettering General hospital, with the assistance of TAAS.

TAAS may be requested by EOC to facilitate the transfer of patients from other TU/LEHs to an MTC. The decision of who transfers these patients will be shared between TAAS, EOC and the referring hospital, however the final agreement to undertake the transfer rests with the duty team and not with either the ambulance service or the referring/receiving hospitals.

In cases where the team has decided to make a pit-stop to a TU for blood products/stabilisation, TAAS are likely to be better equipped to provide this onwards transfer than the team in the referring hospital, however the joint decision-making principles still apply.

NOT DOCUMENT CONTROLLED ONCE PRINTED/COPIED

5. Routine Critical Care transfers

TAAS may occasionally be requested by the ambulance service or referring hospital to facilitate the routine inter-facility transfer of other critical care patients. In the majority of these cases the referrer will need sign-posting to the ACCOTS or KIDS/NTS service.

In periods of heavy ice/snowfall, ACCOTS will often pause non-urgent (bed capacity/repatriation) transfers and will only consider requests for the escalation of patient care. TAAS is unlikely to be asked to perform non-urgent transfers in their place, and should not routinely accept a request to do so. In the exceptional circumstance TAAS is requested by a transfer service co-ordinator to perform a non-urgent transfer, please request them to speak directly with the base manager/head of operations.

6. Escalation of Care Transfers

If an urgent request which is not a hyper-acute trauma patient, comes directly to TAAS, in the first instance please direct the referring centre to ACCOTS or KIDS/NTS (if they have not already done so). See section 4 for transfer of trauma patients from an TU/LEH to MTC.

In the rare event that the commissioned transfer service cannot facilitate the transfer (e.g. lack of team availability, weather conditions that effect road but not air transfers), the transfer service co-ordinator should advise the referring centre of the best course of action. This may involve referral back to TAAS, however this request should come from the transfer co-ordinator to TAAS directly.

It may be reasonable for TAAS to consider facilitating these transfers, however in order to consider accepting such a request, the clinical urgency of the transfer should be on par with a HEMS tasking (e.g. urgent transfer for neurosurgical intervention, STEMI transfer for PPCI, leaking aortic aneurysm, stroke transfer for mechanical thrombectomy).

In order to facilitate a transfer, the crew must be allocated to an ambulance service task, therefore a three-way conference call is advised between TAAS, EOC and the transfer service co-ordinator. Taking a referral via EOC (without direct discussion with the ACCOTS or KIDS/NTS co-ordinator) is not advised. Requests should be discussed with either the base manager/head of operations and CS top-cover consultant prior to accepting the referral.

NOT DOCUMENT CONTROLLED ONCE PRINTED/COPIED

7. Crew experience

When receiving Escalation of Care requests, consider the expertise of the duty team, and whether any duty team member has recent hospital critical care experience (and familiarity with the infusions/treatments the patient is receiving). The HEMS crew must only accept a patient transfer for a patient that they have the knowledge, skills and experience to support.

If the crew members are not confident that they can look after the patient, then the transfer must be declined. HEMS/critical care paramedics are not allowed to transfer patients unaccompanied on medications/infusions which are not on the JRCALC / POMS Exemptions list, or for which they do not hold a patient group direction.

If there is a need for personnel from the referring hospital to travel with the patient due to a level of care being required (which cannot be undertaken by the TAAS duty crew) an alternative means of transfer should be used.

8. Appropriateness of transfer

Other considerations of suitability for transfer include the number of infusions, flight time, fuel requirements, oxygen requirements, weight limitations, flight weather, clinical implications of altitude, flight/duty hours limitations and impact on next shift. If any of the reasons above preclude transfer by TAAS, decline the request and email the base manager to inform them of the discussion (and insert a 'declined tasking' case record on TAASbase if there is already an ambulance service incident number).

Other than with the express permission of the pilot, equipment that does not belong to TAAS is not to be used in flight. Patients on ECMO or with aortic balloon pumps are not to be flown. There is not enough space for the equipment and the risks of failure / dislodgment are very high.

Requests to transfer patients in incubators/baby capsules should be forwarded to or discussed with the receiving facility. Requests to facilitate the transfer of a neonate made by a dedicated retrieval team should be passed to The Children's Air Ambulance.

9. Transfer by air

There are risks associated with the movement of all critical care patients. These risks may be amplified when the patient is transferred in a helicopter. For each request, the patient's clinical condition and potential for deterioration needs to be assessed against the benefits of rapid transport. This assessment needs to take into account the impact of secondary landing sites and how the patient will be transferred to / from the aircraft.

Air ambulances are not NHS resources and should not be used as an alternative mode of transport due to non-availability of land ambulances or for the purposes of achieving targets.

10. Carriage of patients with potential infectious diseases.

Following recent global events (Covid-19 pandemic) TAAS may be tasked in the transfer of critically ill patients with either a contagious illness as their primary presentation or patients who are coincidentally infected on top of other critical health issues.
If such a transfer is authorised, the operational team tasked with completing the transfer **must** confirm prior to departure:

- Most recent PHE updates regarding PPE requirements.
- Compliance to TAAS' own Infection, Prevention and Control SOP regarding infectious diseases
- The availability of the required Level 2/3 PPE for all crew members involved in the transfer.
- That the receiving hospital is aware of the patient's infection status as they may need a bed in a pre-specified side room / ward

11. Patient Handover

The HEMS crew must only take handover and receipt of the patient at the referring hospital - under no circumstances should the patient be brought to the helicopter by referring hospital staff.

It is vital that the HEMS crew make a final assessment at handover that the patient is suitable to fly including:

NOT DOCUMENT CONTROLLED ONCE PRINTED/COPIED

- Clinically safe
- No risks to aircrew
- All lines, tubes and monitoring secured.
- No need for additional equipment.
- All documentation, images and if necessary, blood products ready and labelled to go with patient.
- There is adequate oxygen available on the aircraft for the duration of transfer and handover process.

Handover of the patient should only take place in the receiving unit with a member of the receiving team present. It is not acceptable to handover to another ambulance crew. Documentation should be completed including an appropriate transfer form or paper PRF (or on taasBase 2 when live), a copy of which must be left with the patient's notes, along with a copy of the observations summary.

End of Document

NOT DOCUMENT CONTROLLED ONCE PRINTED/COPIED