Nottingham University Hospitals NHS
NHS Trust

Response to HM Coroner following Regulation 28 Report (PFD) dated 18 January 2017

[redacted] Deputy Medical Director

29 March 2017

The key concern of the Coroner was that "There should be a clear written protocol for patients requiring lifesaving surgery that **allows immediate transfer of a patient to a place where an appropriate intervention can be undertaken."**

The following actions have been taken.

A new protocol has been written after consultation with the following groups:

- NUH Critical Care Consultants
- NUH Theatres and Anaesthetic teams
- NUH Surgical Divisional and specialty teams (including Neurosurgery and Gastroenterology)
- NUH Interventional Radiology
- NUH Medical Division and specialty teams (including Stroke team)
- Mid Trent Critical Care Network and Clinical Leads.
- Medical Directors and Critical care service leads at NUH, Lincoln, Derby and Kings Mill Hospitals.
- Sheffield Teaching Hospitals neurosurgery team and Medical Director

The new protocol is attached as a flow-chart in Appendix 1.

Although primarily directed at requests for transfer of patients to NUH or Sheffield Teaching Hospitals for emergency neurosurgical intervention, this arrangement will apply at NUH to requests to consider other life-saving specialist procedures. The protocol will not override extant policies for transfers to NUH for Major Trauma or Coronary Interventions.

The protocol can be summarised as:

1. If the local hospital consultant considers that a life-saving emergency intervention (that cannot be provided in the local hospital) should be considered for a patient they will contact the relevant on-call specialty consultant at NUH.

2. The NUH specialty consultant will discuss the patient's management with the referring consultant. If the NUH consultant agrees with the clinical judgement (taking account of relevant national guidance where applicable) that life-saving intervention in less than 6 hours is indicated, the patient will be accepted for transfer to NUH irrespective of the critical care (or other) bed state. It is expected that wherever possible this will be a consultant to consultant conversation.

3. The accepting NUH consultant will confirm details of the case with the NUH theatre manager who will ensure that all relevant teams are informed.

4. The only exceptions to the patient being accepted for immediate transfer as in 2 will be if there is major infrastructure failure in NUH theatres or a major incident that is overwhelming theatre capacity. In these exceptional circumstances the NUH consultant will discuss the patient with a consultant in an alternate specialist centre.

5. The referring hospital will arrange safe transfer of the patient to the NUH theatre recovery area, where the patient and transfer team will be met by the on-call anaesthetic, theatre, surgical and critical care team. The transfer team will maintain responsibility for the patient until the patient has been handed over and accepted by the NUH team.

6. The NUH multidisciplinary team will agree the next course of action and the likely post-operative care requirements.

7. In circumstances where it is likely that the patient will require post-operative critical care and there is no capacity (or prospect of imminent capacity) in critical care at NUH (ensuring appropriate utilisation of both QMC and City campus intensive care units), the consultant responsible for critical care will consider the following options:

    - Patients who are considered suitable for repatriation to the referring hospital ICU will be identified and discussed with the referring hospital critical care team for urgent transfer. [a 'non-clinical' transfer]
    - Patients who are considered suitable for transfer to the referring hospital ICU will be identified and discussed with the referring hospital critical care team for transfer. [a 'non-clinical' transfer]
    - If the referring hospital has no ICU capacity the critical care consultant will identify the next nearest ICU for repatriation or non-clinical transfer
    - If it is not possible to identify suitable patients for repatriation or non-clinical transfer, the NUH ICU consultant will consider with NUH surgical colleagues referral of the index patient to another specialist centre (e.g. Sheffield neurosurgical unit) as is consistent with national guidance (e.g. SBNS Quality Statement for neurosurgical provision).

- If ICU capacity cannot be generated at NUH or a suitable alternate specialist centre to accommodate the index patient using one of the above manoeuvres the consultant will consider the use of surge capacity at NUH or will discuss with the referring hospital critical care about extending to surge in that institution.

8. The Transfer team from the referring hospital will remain at NUH until discussion has taken place with the NUH critical care consultant regarding critical care capacity. Whenever possible, the same transfer team will conduct any transfer from NUH necessary to make capacity available for the index patient.

Patients whose transfer to NUH is agreed for urgent, but not lifesaving treatment, will continue to be accommodated at NUH after discussion between relevant clinical teams (including ICU if necessary) to ensure timely transfer and specialist intervention.

Additional notes

A non-clinical transfer may carry risk to the patient transferred and the critical care consultant will use their clinical judgement to determine the optimal course of action. The decision-making and communication processes described offer partial mitigation. There has been extensive discussion with clinical teams and referring hospitals about their responsibilities in accepting patients for repatriation or transfer.

An electronic log of all patients referred under this protocol will be maintained using 'Medway' patient administration system and 'Nervecentre' software. This additional software programming has been approved but is not yet fully developed or functional. Medway recording will be available within 2 months. It is expected initial 'Nervecentre' updates will be complete in 3 months, however this will only log internal referrals and the external referrals will be included in a more extensive upgrade as part of a bed management project. In addition to recording the use of this protocol, these electronic logs will allow regular review of the care and outcomes of any patients transferred to accommodate the incoming patient.

The significant national interest generated by this PFD have resulted in NUH adopting this policy of accepting patients for lifesaving intervention irrespective of critical care capacity from the time the PFD was issued. There have been no significant adverse events from this protocol to date but the performance will continue to be monitored.

The next steps for this protocol are:

1. Formal Ratification by the Mid Trent Critical Care Network by the Network Clinical Group in May 2017
2. Formal Ratification by NUH in May 2017

Communications

This protocol has been shared with the Mid Trent Critical Care Network Clinical Leads, Sheffield Teaching Hospitals and the local Medical Directors.

In addition to the local work on this PFD, the Faculty of Intensive Care Medicine and Intensive Care Society have been contacted.

A redacted version of the PFD has been published at:

https://www.ficm.ac.uk/sites/default/files/ficm-pathway-for-urgent-neurosurgical-procedures.pdf

All critical care units in the country have been contacted to make them aware of the expectations around care for patients requiring life-saving neurosurgical interventions.

Other concern 1 - Radiology access

NUH hosts the EMRAD consortium of 7 trusts that allows all radiological imaging to be viewed in all participating organisations which include NUH, Sherwood Forest Hospitals, Leicester, Northampton, Kettering, Lincoln and Chesterfield. Currently Derby hospitals have a separate electronic image system which can be viewed by NUH clinical teams and the images can then be transferred between Trust systems.

Other concern 2 - Input from Stroke Consultants

NUH and SFH currently contribute to a shared consultant on-call rota for stroke services.

Previously the on-call stroke consultant has been available for decisions related to possible thrombolysis (clot-busting therapy) and discussion of thrombolysis-related complications in stroke patients. From now the service will describe that the on-call consultant is available to discuss any atypical course or acute complication of stroke, including those where urgent neurosurgical or neuroradiological intervention may be indicated where the referral is made by a registrar or above.

Summary

I believe that the steps outlined above will reduce to the lowest risk achievable the possibility of a similar occurrence in the future.

Signed: 

[redacted] (Consultant/Deputy Medical Director)

Date: 29.03.17