Principles of capacity transfers

1. Definition:

Capacity transfers are the transfer of a critically ill patient from one critical care unit to the same level of care in another intensive care unit, where there is no clinical indication for the move (such as access to specialised care or opinion).

2. Background:

Capacity transfers remain a specific measure of system failure as they represent inadequate resource in the referring hospital to manage the demand.

There are significant ethical and legal challenges as there is limited or no benefit to the patient being moved and the patient is subject to increased risk (even with specialist transfer services). Furthermore, in most cases, a capacity transfer results in the patient being further from their place of residence, their usual discharge pathway, the clinical teams which may be managing any long-term condition, and their friends and family.

Further information is available in the two national documents published on this matter[1, 2].

The South-West Region has particular considerations due to its geography, the associated travel times, and relative isolation of each of the major trusts, especially in the Peninsula.

3. Key Principles:

i. A capacity transfer is an option of last resort for decompressing a critical care unit and maintaining the unit's ability to care for and admit patients likely to benefit from critical care, as per GPICs v2.

ii. All commissioned local capacity must have been used:
   a. In most centres this will be all physical capacity (which may require sub-optimal staffing for some patients. It should be noted that sub optimal staffing, while occasionally necessary, should not be sustained for any longer than 48hours).
   b. In some cases, *catastrophic* staff shortages may intervene before all commissioned physical capacity is used. A catastrophic shortage of staff is one where care is deemed unsafe for all patients due to a lack of staff.

iii. All options for additional staffing must have been used, and should include:
   a. Bank / agency / NHSP.
   b. Cancellation of meetings, teaching or training days if that results in liberation of staff.
   c. Ex-critical care staff elsewhere in the hospital.
   d. A balanced assessment of risk should be made when considering drawing in outreach staff into the critical care unit. This must encompass the risk to patients in the wider organisation as well as the risk to the critical care patients.
   e. Theatre and anaesthetic staff.

f. A balanced assessment of risk should be made when considering the use of reserve ICU staff or bed buddies to enable nursing care outside of established ratios. The lead consultant and lead nurse must weigh the relative risks against those involved in undertaking a capacity transfer, for the individual patient, the whole patient cohort and the safety and wellbeing of the staff.

iv. Alternative options should be considered such as the use of theatre recovery / early step down or outlie of suitable patients. This will be a complex clinical decision, weighing relative risks, and as it is entirely situation dependent. It will rely on the judgement of the duty critical care consultant and critical care senior nurse/matron in liaison with the wider hospital executive team.

v. All critical care patients must have been reviewed to consider if anyone is suitable for step down to the ward or repatriation. Patients' likely trajectory over the next 24-48 hours should be considered and any likely fall in dependency over this time frame should factor into the decision to transfer.

vi. There should be sufficient disparity in unit pressure (as measured by capacity, CRITCON[1] score or nursing ratios) between the referring and accepting units to ensure that a capacity transfer is unlikely to render the accepting unit themselves in need of decompression in the subsequent 48 hours.

4. Capacity transfers of critical care patients to facilitate surgery:

i. This section refers to category P1 and P2 surgical patients who require post-operative critical care support. It does **not** refer to category P1 and P2 surgical patients who do not require critical care support. It is intended to provide a regional framework which supports the National guidance already available[2, 3].

ii. Capacity transfers of one critically ill patient to facilitate P1 or P2 surgery for another patient, should only be considered in exceptional circumstances. It is unlikely that there will be any direct benefit to the patient being transferred, and they will likely be exposed to risk. The following criteria should be met before a capacity transfer of this nature is considered:

a. The overarching expectation is that critical care should be provided within organisations to meet the needs of their patients. The process of capacity transfer must not be relied upon to deliver critical care capacity; it should be seen as an exceptional process in exceptional circumstances.

b. Referring organisations must exhaust all the steps outlined in section 3 (above), to accommodate their own critical care patients and the patient who requires P1 or P2 surgery in their own unit.

c. Both referring and accepting units must be confident that the greatest overall potential risk lies with the surgical patient for whom an operation is dependent on a capacity move. This assessment must encompass any potential risk not only to the patient being transferred, but also to the patients in the accepting unit as the dependency increases on that site. At a patient level, the assessment of risk must include not only physical and psychological risk, but also the risks of handing over the care of complex patients. At an organisational level, the assessment of risk must be guided by the GPICS staffing ratio, CRITCON score and ability to deliver P1 and P2 surgery in the referring and accepting organisations[1,4].

d. Consideration of capacity transfers of this nature must be discussed and ultimately agreed by the consultants *and* charge nurses/matrons *and* Trust executives in the referring *and* receiving organisations. A third critical care consultant, ideally from within the referring organisation, but, if required from the accepting organisation or from the Network, should also be consulted in accordance with the national guidance[2]. Where uncertainty over the risks and benefits remain, an urgently convened ethics committee may be consulted.
e. A full and honest conversation must occur with the patient, next of kin or IMCA and agreement to transfer be obtained.
f. The senior individuals involved in patient selection for transfer, the decision making surrounding the choice of patient, and the conversation with the family must be clearly documented in the medical notes. The appendix of this document is designed to support that process.
g. Critical care capacity transfers must not occur to create critical care capacity for surgical patients of priority P3 or lower.

5. Patient selection:

i. Patient Condition
   a. The receiving hospital must have appropriate services to manage the needs of the patient. Consider whether the accepting hospital may be able to provide a higher standard of care for some patients given their pathology and availability of services in the accepting Trust.
   b. The patient should be stable and deemed fit for transfer (this may be relative to other potential patients).
   c. Usually the patient will require level 3 care as this creates more capacity, and ensures a more controlled situation for transfer.
   d. The patient should be predicted to require at least 2 more days of level 3 care, but ideally not more than 1 week.
   e. Do not send highly complex patients with the requirement for multiple specialist service input.
   f. Do not send patients with unresolved family conflict, be that between the family and the organisation (for example over issues of visiting or treatment escalation) or within members of the family.
ii. Patient Residency
   a. If possible, transfer patients where the impact of the transfer on their discharge pathway or family visiting is minimised (e.g. where patients or family may reside equidistant between the two organisations).

6. Ethical and legal:

i. The ethical and legal issues around capacity transfers are complex and there remains a lack of legal precedent over their conduct.
ii. In the majority of cases discussion with the family and gaining their understanding and approval is sufficient, however there are increasing reports of families raising forceful objection, raising the possibility of legal challenge. A legal challenge of a transfer which brought no benefit to the patient, with or without the agreement of the family, remains a possibility and is currently untested in law.
iii. Pragmatically in an urgent situation a clinician has little alternative but to select a different patient or over-rule the family. In most instances, over-ruling the family will be deemed undesirable. As doing so would represent a breach of national guidance, an urgent ethics committee review and seeking legal advice is encouraged where this option is being considered.
iv. Whilst capacity transfers are best planned, by the nature of them being a last resort this is often not possible.

7. Repatriation:

i. This principles document was first created during the COVID-19 pandemic of 2020/2021. At that time, it was deemed preferable for patients, once transferred, to complete their critical care stay at the receiving hospital and be discharged home or repatriated once receiving ward level care. At that time, visitors were excluded from critical care units and the desire was to avoid anything but the most essential transfers of critically ill patients.
ii. Outside of a pandemic scenario, the decision on whether to repatriate a patient initially transferred for reasons of capacity whilst critically ill is nuanced and should be based on multiple factors. These should include, but are not limited to: the clinical complexity of the patient, the care required by that patient and the ability of each unit to deliver it, the risk to the patient of information loss during an additional handover of care, the risk to the patient of critical care transfer which may not be essential, the distance of each unit from the residence of the patient's most valued visitors, the likely duration of critical care and hospital stay, access to hospital teams for management of long-term conditions, access to an appropriate discharge pathway, and the CRTICON score (strain) in the sending and receiving units.
iii. The decision on whether or not to repatriate a patient should be made by the duty consultant and nurse in charge of each unit, having considered the issues above, and any other issues which may be pertinent to the patient, their relatives/friends and the wider critical care landscape within the Network.
iv. The decision need not be fixed and can be reviewed sequentially- the most appropriate decision may alter with the passage of time.
v. The original critical care unit should only receive a returned capacity transfer if there is no likelihood of them exceeding capacity for the remainder of that patients' predicted stay.
vi. Patients should never be subjected to multiple capacity transfers, and a Root Cause Analysis (RCA) should be undertaken if they are.

Appendix 1 (Added 16th January 2025)

This page should be completed for any patient undergoing capacity transfer. It should contain the details of the patient (name, date of birth, NHS number) but not that of any other patients. It should be entered into their notes and a copy emailed to SWCCN@uhbw.nhs.uk .

Name	
Date of Birth	
NHS Number	

Checklist prior to transfer

Date		Time	
Referring unit		Referring unit CRITCON score	
Receiving unit		Receiving unit CRITCON score	

Sitrep/governance process:

1	All commissioned local capacity must have been used	Y/N
2	Illustrate the reasons behind the referring unit CRITCON score. Indicate all that apply: **CRITCON 2:** Critical care patient numbers mandating expansion beyond funded or physical bed base into escalation areas (theatre recovery, other acute areas) for more than 24 hours. **OR** Unable to meet nurse OR medical rota expected GPICS staffing ratios for up to 48 hours, despite undertaking the measures listed in section 3iii. **OR** Cancelled planned surgery because of a lack of staffed critical care beds for 2 or more consecutive days, despite undertaking the measures listed in section 3. **OR** Resources becoming limited because of high demand e.g. renal replacement therapy equipment, despite reasonable attempts to mitigate. **CRITCON 3:** Sustained (more than 48h) use of GPICS non-compliant nurse and medical staffing ratios AND use of redeployed non-critical care staff necessary to support critical care, despite undertaking the measures listed in section 3iii. **OR** Critical care and escalation areas (theatre recovery, other acute care areas) saturated at full physical OR technological/equipment capacity at any point, with	 Y/N Y/N Y/N Y/N Y/N Y/N

	no ability to admit more critically ill patients, despite undertaking the measures listed in section 3. **CRITCON 4 or 5** If the NETWORK has been declared CRITCON 4 or 5 indicate this here. In addition, indicate which of the factors under CRITCON 2 or 3 have prompted a transfer in this specific case.	Y/N
3	The key principles described in section 3 have **ALL** been exhausted.	Y/N
4	Where a transfer of one critically ill patient is considered to facilitate P1 or P2 surgery in another patient, the principles outlined in section 4 are **ALL** met.	Y/N/ NA
5	In the unfortunate event that a capacity transfer is required, it is always difficult deciding which patient should be transferred. Have the principles in section 5 been met? Please provide narrative about the selection of this particular patient. Do not include names or identifiers for other patients.	Y/N
6	Please summarise the discussion that has been had with the patient/family/next of kin:	

7	Please record the names of decision-makers involved in this decision:	
	Executive in referring Trust:	
	Critical care consultant in referring Trust:	
	Most senior critical care nurse in referring Trust:	
	Executive in receiving Trust:	
	Critical care consultant in receiving Trust:	
	Most senior critical care nurse in receiving Trust:	
	Indicate here the names/role of anyone else who has been consulted over the transfer and their stance on the conduct of it:	
8	Please provide any further important information here:	

Name and designation of person(s) completing this form:

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Appendix 2: Version control and ratification details

Version	Ratification date and details
1.0	December 2021. Initial version. Ratified at SWCCN Board meeting
1.1	February 2022. Ratified at SWCCN Network meeting.
1.2 (current version)	March 2025. Ratified at SWCCN Board meeting. Update includes- appendix for decision support, documentation, and governance trail. Modification to repatriation position.

References

[1] The Intensive Care Society. CRITCON levels. 2023. https://ics.ac.uk/resource/critcon-levels.html (Accessed 16/01/2025).

[2] FICM and ICS joint position statement. Capacity transfer of adult critical care patients: position statement. 12/11/2021. https://www.ficm.ac.uk/capacity-transfer-of-adult-critical-care-patients-position-statement (accessed 22/12/2021)

[3] NHSE guidance. Framework to support inter-hospital transfer of critical care patients. Version 1. 09/12/2021. https://www.england.nhs.uk/publication/framework-to-support-inter-hospital-transfer-of-critical-care-patients/. (Accessed 22/01/2021)

[4] Guidelines for the Provision of Intensive Care Services version 2.1. Faculty of Intensive Care Medicine July; 2022. https://www.ficm.ac.uk/standardssafetyguidelinesstandards/guidelines-for-the-provision-of-intensive-care-services. (Accessed 27/07/2021)