South Thames Paediatric Network

CLINICAL PRINCIPLES

Inter-Hospital Referral & Transfer Principles:

For acutely unwell paediatric surgical patients

This document sets out principles to enable the safest and quickest transfer of children requiring surgery in the South Thames Paediatric Network (STPN) with clear communication at all levels.

To be read in conjunction with the STOPP Tool https://stpn.uk/stopp/ & https://stpn.beautifulinformation.org/LogOn?ReturnUrl=%2f

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South Thames Paediatric Network

Inter-Hospital Referral & Transfer Principles:

For acutely unwell paediatric surgical patients

SETTING South Thames Paediatric Network

FOR STAFF All tertiary specialist centre & District General Hospital (DGH) staff involved in the inter-hospital referral & transfer of:

- Acutely unwell paediatric surgical patients requiring specialist intervention
- Paediatric surgical patients with complex needs that require a specialist centre
- Paediatric surgical patients requiring repatriation to their local DGH paediatric surgical patients

PATIENTS Children (under 16)* requiring transfer from a DGH within the regional STPN network to a tertiary centre, for specialist emergency paediatric surgical care and back to the referring DGH.
* In certain circumstances this document can be used for complex children older than 16 years requiring admission to a specialist paediatric centre.

Overview

The transfer of all emergencies to the tertiary unit may result in missed opportunities for safe and quick care locally in the secondary care units. Anecdotally the need for transfer from one unit to another is one of the greatest risks in the management of emergency surgical patients. The fear, confusion and medical risk is only increased in the paediatric population with the combination of stress on the parents and the child.
The two key areas that cause excessive delays:

- Liaising with other specialist centres to obtain a second opinion and arranging transfer of the sick children
- Following surgery, repatriating the child back to the local hospital and securing a bed closer to home.

This document sets out principles to enable the safest and quickest transfer of children requiring surgery in the South Thames Paediatric Network (STPN) with clear communication at all levels. The guiding principle should be that children with emergency surgical conditions should be treated at their local secondary care unit where it is safe to do so, but with clear guidelines indicating when they should be transferred to a specialist unit. Any locally agreed policy should align with these principles. This document should be read in conjunction with the relevant local policies which should be followed at all times by local clinical teams.

Referring DGH's Responsibilities Prior to Transfer

1. A review by the local surgical/paediatric[1] team should occur before referral. Discussion at the appropriate decision making level[2] must occur to confirm whether the child requires tertiary input, and if so whether this must occur in the form of inter-hospital transfer (IHT) or as an outpatient referral.
2. Please refer to Appendix A for the list of procedures / conditions and the level of care and the urgency with which these are required.[3]
3. When IHT is required, the referring clinician will initially make a single call to its designated primary tertiary centre for transfer and then should wait for confirmation/guidance from the tertiary centre. The DGH will not contact multiple centres simultaneously in order to request a bed.
4. The primary tertiary centres for transfer for every DGH is showed in Appendix B. Useful contacts can be found in Appendix C.

[1] The decision to involve the surgical or paediatric is dependent on the DGH and the clinical case. The aim is to involve the right team that is best placed to review the patient.
[2] A surgical/paediatric consultant is preferable, if this is not possible then an appropriate decision making level surgical/paediatric registrar.
[3] Surgical input for non-urgent sub-specialist referrals can be greater than 24 hrs but less than 48hrs

5. The parents/carer of the child must be informed of the decision, reason and destination before the transfer takes place and their agreement to the transfer must be documented in the patient's notes (see section 1.1 & 1.2 of this document).
6. It is the responsibility of the referring clinician to request the most suitable method of transport which will determine the most appropriate escort during the transfer.
7. If the child is critically ill and requires Paediatric Intensive Care Unit (PICU) pre or post-surgery then South Thames Retrieval Service (STRS) will be contacted for advice and retrieval to an available PICU bed / and or theatre.
8. If there are any safeguarding concerns they should be acted upon in line with local safeguarding procedures (see section 1.2. of this document).
9. Prior to transfer of a suspected or confirmed infectious patient information/needs will be shared with the ward, receiving unit or hospital (see section 1.3. of this document).
10. For ALL transfers (except STRS) of children BETWEEN hospitals, a STOPP form should be completed by the referring hospital (https://stpn.uk/stopp/). Please refer to Annex D.

Receiving Tertiary Centre's Responsibilities Prior to Transfer

11. When the designated primary tertiary centre receives the request call they are responsible for reviewing internal bed capacity with the consultant in charge and with the bed management team.
12. The tertiary centre will contact the referring clinician within 30min of receiving the call to either confirm availability of a bed there or re-direct them to the other tertiary centres in the STPN. It is the DGH's responsibility to then call another tertiary centre.
13. Only when there is no capacity across the STPN attempts should be made across tertiary centres in the NTPN and Southampton. A daily snapshot of bed capacity across the STPN can be accessed on https://stpn.beautifulinformation.org/LogOn?ReturnUrl=%2f
14. If upon arrival accepted transfers are to be tended to by the Paediatric Emergency Department (PED), the receiving surgical team should inform their PED department of the incoming transfer.

Tertiary Centre's Responsibilities for Repatriation

15. As soon as the child has been assessed, it is the responsibility of the receiving tertiary centre to discuss the potential need for specialist follow up care and/or whether repatriation to the child's referring centre is appropriate.
16. If decision on the need for future repatriation of the child is made, it is the responsibility of the receiving tertiary centre to contact the referring hospital within 24 hours from the child been assessed and provide an approximate timeframe for repatriating the child back.

DGH's Responsibilities for Repatriation

17. It is the responsibility of the child's original referring centre to identify a suitable bed in a timely fashion for repatriating the child once the child no longer needs specialist paediatric input.
18. Once notified of the need for the child to return from a tertiary centre the DGH has 24 hours to repatriate the patient.

Timely transfer:

Time from referral call made to notification (confirm/re-direct) from tertiary centre:	**Within 30min**
Time from referral accepted to patient admitted for urgent tertiary input (Appendix B):	**Within 6 hours**
Time from referral accepted to patient admitted for non-urgent tertiary input (Appendix B):	**Within 24 hours**
Notification of clinical status of child / potential repatriation date (from tertiary centre to referring centre):	**Within 24 hours** from assessing the child.
Time from tertiary centre's request for repatriation:	**Within 24 hours**

Additional Information

1.1 Patient and family needs

The parents/carer of the child must be informed of the decision, reason and destination before the transfer takes place and their agreement to the transfer must be documented in the patient's notes.

It is also important to keep the family informed about transfer delays to manage their anxiety and expectations.

Children and parents need to understand that their care will be shared between the DGH and the tertiary centre. Thus they may need to spend time recovering in the DGH following surgery /intervention in order to maintain capacity in the tertiary centres.

1.2 Management of the patient before and while awaiting transfer

Agreed protocols relating to common conditions such as the pre-operative management of pyloric stenosis, intussusception, bilious vomiting, obstructed inguinal hernias and torsions will be in place.

1.3 Safeguarding assessment and process

If there are any safeguarding concerns they should be acted upon in line with local safeguarding procedures. Appropriate referrals should be made prior to transfer and it should be documented in the transfer notes who a referral has been made to and what has been said to parents.

A child or young person with altered behaviour due to mental health problems will require a full medical and CAMHS assessment[4] prior to any transfer to another inpatient facility. After a risk assessment the child or young person should be escorted by an appropriate healthcare professional using a secure ambulance if deemed necessary.

Delays in determining that there are mental health issues and informing the tertiary centre may delay the transfer. However, if the patient is critically unwell and needs urgent surgery the mental health assessment may need to carried out at a later stage. It is the responsibility of the referring centre to ensure that all the relevant physical, social and mental health concerns are notified properly to the receiving hospital. In situations where the information is not available or incorrect then the delay in transfer will sit with the referring centre.

1.4 Infection control assessment and process

Prior to transfer of a suspected or confirmed infectious patient information/needs will be shared with the ward, receiving unit or hospital. The failure to notify the receiving unit of infectious concerns will lead to delays with placing the child into the correct bed and potentially increase of transmission of infection to other in-patient children.

Coronavirus has detrimentally impacted the number of children undergoing elective surgery. In periods of recognised high prevalence early and repeated swabbing of patients is recommended. In these high risk periods all patients without a negative swab result should be treated as a potential covid case until proven otherwise. Appropriate PPE and isolation may be required. Please follow all national and local guidance.

[4] CAMHS provisions may vary, if the patient is critically unwell this assessment should not delay transfer.

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Appendix A

General Surgery and Urology

List of procedures / conditions and the level of care and the urgency with which input is required

Not for transfer – Manage at DGH or Review in Clinic	Non-emergency transfer - Referral accepted within 30 minutes Surgical input can be greater than 24 hrs but less than 48hrs	Emergency transfer - Referral accepted within 30 minutes Surgical input within 6 hrs
Acute scrotum > 5yrs age (ASA 1, 2)	Appendicitis < 5yrs age (without peritonitis)	Oesophageal Atresia
Appendicitis > 5yrs age (ASA 1, 2)	Abdominal pain, persisting diagnostic uncertainty (without peritonitis)	Gastroschisis / Exomphalos with ruptured sac
Superficial abscess, younger child	Intra-abdominal mass (without peritonitis)	Delayed passage of meconium
Superficial post-op wound infection	Post-appendicitis collection	Peritonitis/bowel perforation
Reducible inguinal hernia	Perianal abscess in infant/younger child	Bilious vomiting
Hydrocoele	Empyema (without respiratory compromise)	Bowel obstruction
Undescended testis	Pyloric stenosis	Intussusception
Phimosis / balanitis		Irreducible inguinal hernia
		Acute Scrotum < 5yrs age
		Spontaneous pneumothorax (without respiratory compromise)

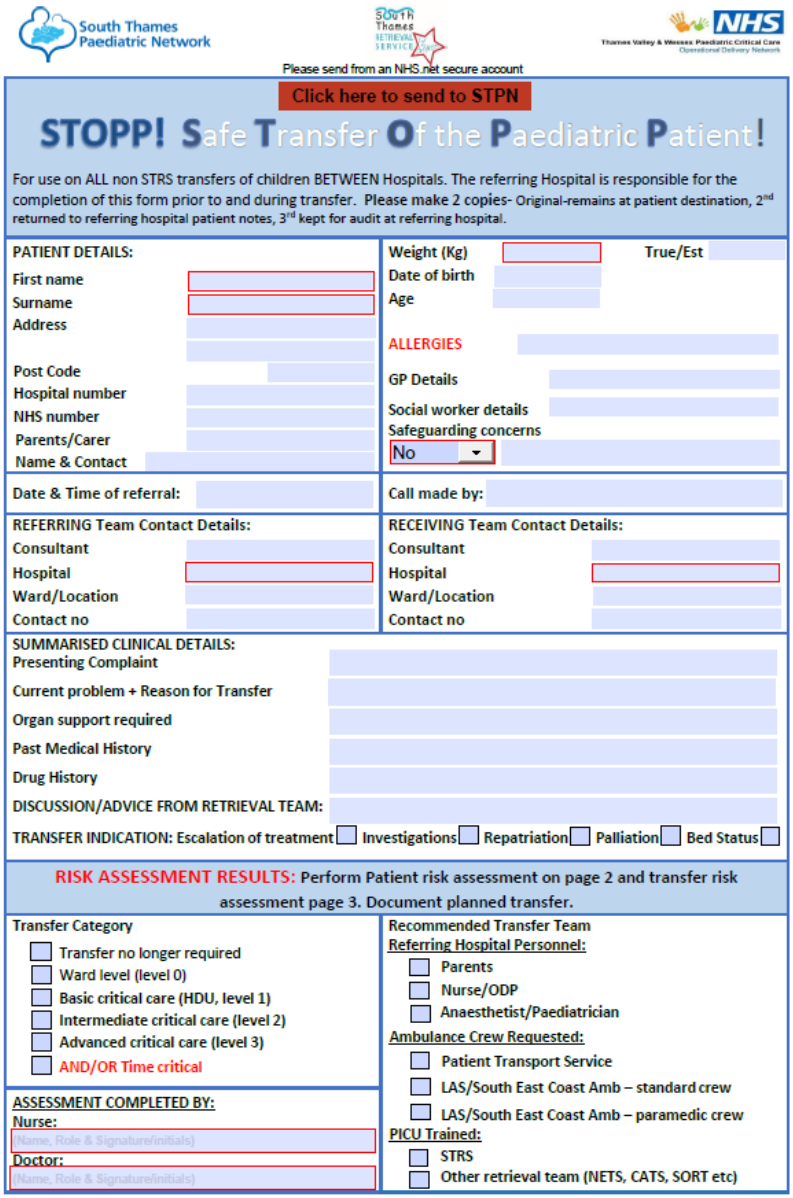
Appendix B – Designated primary tertiary centres for transfer for every DGH

REFERRAL GRID: PRIMARY TERTIARY CENTRES			
St George's Hospital	**King's College Hospital**	**Evelina Children's Hospital**	**Royal Alexandra's Hospital**
Ashford Hospital	Medway Maritime Hospital	Tunbridge Wells Hospital, Pembury	Worthing Hospital
St Peter's Hospital	Princess Royal University Hospital	Maidstone Hospital	East Surrey Hospital
Epsom Hospital		Kent & Canterbury Hospital	Eastbourne District General Hospital
St Helier Hospital		Queen Elizabeth, The Queen Mother Hospital, Margate	Conquest Hospital, Hastings
Croydon University Hospital		University Hospital Lewisham	
Royal Marsden Sutton		Queen Elizabeth Hospital, Greenwich	
Kingston Hospital		Darent Valley Hospital	
Royal Surrey County Hospital		Queen Mary's Hospital, Sidcup	
		William Harvey Hospital, Ashford	

Appendix C – Useful Contacts for Referrals

Useful Contacts: Tertiary Centres						
Name of Hospital	Switchboard	On Call Surgical Registrar		Surgical SHO	Bed Manager	
		In Hours	Out of Hours	In Hours	In Hours	Out of Hours
St George's Hospital	020 8672 1255	6763	0778 765 8739			
King's College Hospital	020 3299 9000	0203 299 6451	0752 897 7587		0203 299 7233 / bleep 295	Same as in hours
Evelina Children's Hospital	0207 1887 188	2505	0782 456 1635	1202	Bleep 0821	Bleep 0821
Royal Alexandra's Hospital	0127 369 6955	0777 580 0516				

Appendix D –STOPP form https://stpn.uk/wp-content/uploads/2020/10/STOPP-Tool-fillable-digital-version.pdf



South Thames Paediatric Network

Please send from an NHS.net secure account

Click here to send to STPN

STOPP! Safe Transfer Of the Paediatric Patient!

For use on ALL non STRS transfers of children BETWEEN Hospitals. The referring Hospital is responsible for the completion of this form prior to and during transfer. Please make 2 copies- Original-remains at patient destination, 2nd returned to referring hospital patient notes, 3rd kept for audit at referring hospital.

PATIENT DETAILS:
First name
Surname
Address
Post Code
Hospital number
NHS number
Parents/Carer
Name & Contact

Weight (Kg) True/Est
Date of birth
Age
ALLERGIES
GP Details
Social worker details
Safeguarding concerns
No

Date & Time of referral:
Call made by:

REFERRING Team Contact Details:
Consultant
Hospital
Ward/Location
Contact no

RECEIVING Team Contact Details:
Consultant
Hospital
Ward/Location
Contact no

SUMMARISED CLINICAL DETAILS:
Presenting Complaint
Current problem + Reason for Transfer
Organ support required
Past Medical History
Drug History
DISCUSSION/ADVICE FROM RETRIEVAL TEAM:
TRANSFER INDICATION: Escalation of treatment Investigations Repatriation Palliation Bed Status

RISK ASSESSMENT RESULTS: Perform Patient risk assessment on page 2 and transfer risk assessment page 3. Document planned transfer.

Transfer Category
- Transfer no longer required
- Ward level (level 0)
- Basic critical care (HDU, level 1)
- Intermediate critical care (level 2)
- Advanced critical care (level 3)
- AND/OR Time critical

ASSESSMENT COMPLETED BY:
Nurse:
(Name, Role & Signature/initials)
Doctor:
(Name, Role & Signature/initials)

Recommended Transfer Team
Referring Hospital Personnel:
- Parents
- Nurse/ODP
- Anaesthetist/Paediatrician

Ambulance Crew Requested:
- Patient Transport Service
- LAS/South East Coast Amb – standard crew
- LAS/South East Coast Amb – paramedic crew

PICU Trained:
- STRS
- Other retrieval team (NETS, CATS, SORT etc)