South East Coast Ambulance Service NHS
NHS Foundation Trust

Referral, Discharge and Conveyance Policy

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Contents

1 Introduction

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) has recognised that for many patients the traditional default of conveyance to A&E is not an appropriate model for a modern ambulance trust. Nationally, ambulance services have seen activity shift to seeing more patients with urgent, unscheduled or undifferentiated care needs, and this has led the Trust to develop systems to manage this more effectively.

1.2. The Trust still manages large numbers of patients with life-threatening and life-changing conditions and strives to support modern healthcare networks and take these patients to centres of excellence – often regionally.

1.3. The main principles underpinning the document are:

1.3.1. To define what the Trust means by referral, discharge and conveyance

1.3.2. To define the systems and processes that inform our clinicians to make the correct decision to refer, discharge or convey.

1.3.3. The systems that safeguard patients when they are not conveyed.

1.4. **Policy Statement**

1.5. The intention of this policy is to evidence the Trust's commitment to ensuring that it delivers high quality patient care whilst minimising waste and promoting efficiency.

1.6. The Trust strives to meet and exceed national and international best practice. The ambulance performance standards introduced in April 2011 mean that the Trust must ensure that it not only responds quickly, but arrives with a clinician that is able to promote good patient outcomes. This may mean treating the patient at home or conveying to a hospital.

1.7. This policy will direct staff and a team within the Trust to ensure that the patients care disposition is correct and that the management of care is done safely, focussing on a high-quality patient experience.

1.8. The management of risk and evidencing of a governance-led approach to how the Trust plans and delivers care is vital. The Trust is committed to ensuring that this is always paramount.

1.9. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

1.9.1. If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

1.10. The Trust bases its clinical practice on evidence-based standard pathways of care, developed into bespoke local or regional pathways where appropriate.

1.10.1. Where this differs from practice adopted by other providers, approval is made in accordance with the Trusts governance arrangements

1.10.2. The Scope of Practice and Clinical Standard Policy (SoPCS) states the responsibilities of each clinical grade of staff. Full implementation of pathways by staff is dependent on their scope of practice, staff should implement pathways as permitted under their scope of practice where clinically appropriate.

1.10.3. Within the Conveyance, Handover and Transfers of Care Procedure, Discharge Procedure and Referrals Procedure, there is further specific guidance related to each relevant domain.

1.11. The Trust will support staff to make the correct clinical decision, where there is evidence that the decision was based upon appropriate scope of practice, commensurate to education, training, qualification and experience, and where applicable national or local guidelines have been followed.

1.11.1. Staff must always follow guidelines and local policies and procedures in order to minimise the risk to patients, but also risk to themselves should there be an unanticipated event lead to a diminished outcome for the patient.

1.11.2. This policy does not, and will not, support negligent practice.

1.11.3. Staff are responsible for acquainting themselves with the documents which inform safe practice, profession standards and capability.

2 Aims and Objectives

2.1. Aims

2.1.1. To provide a consistent approach to the conveyance of patients.

2.1.2. To be an overarching policy for staff to be directed to more detailed policies/procedures.

2.1.3. To maximise our resources by ensuring the Trust operates efficiently.

2.1.4. To promote the Trust as a provider, capable of managing emergency and urgent care.

2.1.5. To empower staff to make the correct disposition decision for the patient

2.2. Objectives

2.2.1. To convey patients who need to go to hospital in safety and comfort; promoting recovery and rehabilitation, whilst preventing deterioration.

2.2.2. To convey patients to specialist centres, such as major trauma centres, primary percutaneous coronary intervention centres or stroke units appropriately and rapidly.

2.2.3. To ensure that the Trust meets its legal obligations.

2.2.4. To ensure staff follow the appropriate scope of practice and maintain high standards of clinical care.

2.2.5. To ensure that the Trust achieves its strategic objectives, specifically:

2.2.5.1. To deliver high-quality and appropriate care based on transparent and fair rules with decisions devolved closer to patients;

2.2.5.2. To provide care in the right setting;

2.2.5.3. To improve clinical outcomes, safety and governance;

2.2.5.4. To demonstrate intervention that supports an individual's well-being;

2.2.5.5. To reduce health inequalities across the dependent population;

2.2.5.6. To ensure that services are delivered in the most efficient way possible;

2.2.5.7. To deliver a timely, convenient and responsive access to care including preventative interventions and diagnostics.

2.2.6. **Support to clinical decision makers**

2.2.6.1. To engender a culture within the Trust of supporting staff to make the correct disposition decision, and ensuring that staff feel supported, and have access to support, to make these decisions.

2.2.6.2. To have systems in place to ensure that where scope of practice and guidelines have been followed, staff feel secure in making decisions (with and/or without support), and which are defensible in the event of an unanticipated outcome.

2.3. **Arrangements - Core requirements and instructions**

2.3.1. **Referrals:**

2.3.1.1. Referrals can only be made where authorisation is given in the Scope of Practice and Clinical Standards Policy for each grade of staff. Referrals made out of scope of practice place the patient at risk and will leave the clinician at risk of disciplinary action.

2.3.1.2. Staff can seek advice and guidance from an authorised supervisor on making referrals.

2.3.2. **Discharge (including self-discharge):**

2.3.2.1. Patients can only be discharged (as per the definition in 3.2) where the clinician is authorised to do so in the Scope of Practice and Clinical Standards Policy.

2.3.2.2. Discharge is the clinical decision that carries most risk .Discharging a patient means that their condition has been resolved or will be self limiting. Staff not authorised to discharge patients, or where a discharge has been deemed to have taken place, outside his/her scope, the clinician (unless authorised) may be at risk of disciplinary action.

2.3.2.3. Where a patient wishes to self-discharge, staff must assess the capacity of the patient to make this decision in accordance with the Trust's Mental Capacity Act and Informed Consent Guidelines

2.3.2.4. Staff not authorised to discharge are required to refer patients or provide adequate follow up.

2.3.3. **Conveyance:**

2.3.3.1. With the exception of Community First Responders and Solo or Double Crewed ECSWs, all clinical staff are authorised to convey any patient as required.

2.3.3.2. Staff must however consider the suitability for conveyance in context to the needs of the patient and the opportunities to safely manage care in the community (by referring to a PP or community service, for example).

2.4. **Procedures**

2.4.1. There is a separate procedure for making referrals, discharging patients and conveyance decisions.

2.4.2. Whether a patient is being referred, discharged or conveyed, the following key actions must be considered and/or complied with in order to validate the decision.

2.5. **Consent and Capacity**

2.5.1. Patients receiving care from Trust staff must be informed about the treatment they require in a way that is acceptable to the patient in an easily understandable manner. However, if they have capacity, patients have the right to refuse to allow treatment to take place based on their own beliefs and/or values, even if the decision seems unwise, irrational or may cause them harm. Patients can only consent to treatment, or refuse treatment if they have capacity to do this

2.5.2. If a refusal of treatment may potentially result in serious harm to the patient's health, staff must undertake a capacity assessment. A person lacks capacity if they are unable to make a particular decision because of an impairment or disturbance of the mind or brain at the time the decision needs to be made**.**

2.5.3. Clinicians must acquaint themselves with Trust documentation on consent and capacity – see section 11.

2.5.4. **Patient safety**

2.5.4.1. Patient safety is paramount and where staff have arranged for follow up care, they must ensure that the patient understands what to do if they deteriorate.

2.5.5. **Handover**

2.5.5.1. When transferring care of a patient over to another clinician or department, a detailed and accurate handover is vital to ensure the transfer of care is safe. Staff must present accurate information on the patient's condition and document fully their findings on the patient clinical record (and associated documentation).

2.5.6. **Record Keeping**

2.5.6.1. Staff must make accurate and detailed clinical records for all patients in their care.

2.6. **Emergency Operations Centre (EOC) actions**

2.6.1. EOC staff will keep all care records up to date in all the systems in use in the control room.

2.6.2. Where patients are not conveyed, EOC will update incidents logs to reflect this where appropriate.

2.7. **Manual Handling**

2.7.1. Staff must comply with the requirements stated in the manual handling policy and procedure at all times.

2.8. **Infection Control**

2.8.1. Staff must comply with the requirements stated in the Infection Control Policy and Procedure at all times.

2.9. **Care pathways**

2.9.1. Below is a list of the care pathways available to Trust clinicians. Some may not be directly available and will need approval or further assessment by a senior paramedic or Clinical Advisor.

2.9.1.1. Accident & Emergency

2.9.1.2. End of life care

2.9.1.3. Primary Percutaneous Coronary Intervention (pPCI)

2.9.1.4. Stroke

2.9.1.5. Major Trauma

2.9.1.6. Primary Care

2.9.1.7. Secondary Care specialists

2.9.1.8. Tertiary Care

2.9.1.9. Minor Injury/Urgent Treatment Centres/Walk in Centres

2.9.1.10. Ambulatory care pathways

2.9.2. Where a patient is being conveyed, staff must ensure that the receiving unit has the required levels of service to meet patient need (i.e. vascular surgery).

2.9.3. Where bypass arrangements are in place for certain types of patient, conveyance to those units must be considered in the first instance even if journey times are longer than a local unit. Evidence exists to support regional centres of excellence and the Trust supports these pathways.

3 Definitions

3.1. **Referral**: This is where a patient care is passed from one clinician or provider to another. In context to the Trust, this may be a referral between a crew and Paramedic Practitioner (PP). Externally, it may be a PP referring a patient to a hospital specialist or a crew referring a patient back to primary care.

3.2. **Discharge**: The Trust definition of discharge is the termination of care or the end of the episode with no follow up for the patient. (Patients who refuse care/transport and have capacity to do so are deemed to have "self-discharged").

3.3. **Conveyance**: The movement or transport of patients from the scene of an incident to a care facility or other place of safety..

3.4. **Managed conveyance**: This is the conveyance rate which reflects the incidents over which we influence the decision to convey. The managed conveyance rate excludes transport requests such as GP Urgent Journeys and Inter-hospital Transfers.

4 Responsibilities

4.1. The **Chief Executive** has ultimate responsibility for referral, discharge and conveyance.

4.2. The **Chief Clinical Officer** has executive responsibility for referral, discharge and conveyance.

4.3. The **Consultant Paramedic/ Head of Clinical Development** are responsible for overseeing the policy on a day-to-day basis.

4.4. The **Chief Operating Officer** is responsible for ensuring that staffs work in accordance with this policy.

4.4.1. Managers must make documentation available to staff using the systems available (such as team briefing folders) and review staff understanding of key document through the PADR process.

5 Competence

5.1. All staff in clinical roles has defined levels of training and education in order to practice at grades with a variety of abilities and rights to use alternative pathways.

5.2. The Scope of Practice & Clinical Standards Policy defines the competency and referral rights for all staff employed by the Trust in clinical roles.

6 Monitoring

6.1. This policy will be monitored by the **Clinical Governance Working Group** or **appropriately delegated committee**. This will be achieved by quarterly reports from the **Consultant Paramedic/Head of Clinical Development** containing incidence of practice outside the definitions laid out in this document.

6.2. The **Consultant Paramedic/Head of Clinical Development** will be responsible for ensuring adherence to the policy by reviewing internal reporting systems (i.e. risk registers).

6.3. Any non-compliance or deviation from this policy that results in an adverse outcome for a patient will be dealt with in accordance with the Incident Reporting Procedure and referred to the Professional Standards Department.

6.3.1. All staff and managers are responsible for reporting incidences of practice operating outside the definitions laid out in this document.

6.3.2. Reporting will be done through the usual Trust systems of incident reporting, such as:

6.3.2.1. Patient Advise and Liaison Service (PALS)

6.3.2.2. IWR1 report forms

6.3.2.3. Serious Incidents Requiring Investigation report

7 Audit and Review

7.1. The **Consultant Paramedic/Head of Clinical Development** will review the implementation of this policy on a yearly basis and/or in response to incidents of non-compliance. A report will be sent to the Clinical Governance Working Group.

7.2. This document will be reviewed every three years or sooner if new legislation, codes of practice or national standards is introduced.

8 Associated Documentation

8.1. Scope of Practice & Clinical Standards Policy

8.2. Response & Incident Resourcing Policy

8.3. Conveyance, Handover and Transfers of Care Procedure

8.4. Referral Procedure

8.5. Discharge Procedure

8.6. Mental Capacity Act and Informed Consent Guidelines

8.7. Information Governance Policy

8.8. Health Records Management Policy

8.9. Safeguarding Policy

8.10. Infection Prevention and Control Policy

8.11. Manual Handing Policy

8.12. Patient Clinical Record

9 Document Control

Manager Responsible

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Directorate:	Clinical

Committee to approve	Risk Management and Clinical Governance Committee	
Version No. V2.01	Final / Draft	Date: 27/10/15

Approval

Person/ Committee	Comments	Version	Date
Andy Collen	Updated template Preparation for re-ratification by CQWG and RMCGC	V2.01	Oct 15
Andy Collen	Minor revisions to text to ensure EA compliance.	V2.00	5/09/2013
Equality Analysis Reference Group	Comments and revisions	V2.00	20/08/2013
Andy Collen	Amendments to final version	V2.0	15/11/12
RMCGC	Approved pending minor revision relating to deviation from standard care pathways	V1.06	06/11/12
CGWG	Tele conference recommended for approval at RMCGC subject to minor changes	V1.05	22/10/12
Andy Collen	Final version for submission (as per v1.03 but without tracked changes)	V1.04	13/10/12
Andy Collen	Updated following comments	V1.03	13/10/12
Barbara Tree	Comments and update	V0.01	11/10/12
John Griffiths	Comments	V1.02	11/10/12
Andy Collen	Addition of revised monitoring table Clarification on decisions to refer, discharge or convey	V1.02	5/10/12
Temporary withdrawal April 2012	No changes made to this document prior to republication	V1.01	20/6/12
RMCGC	For Approval	V0.02	10/11/11
Clinical Governance Working Group	Approved with minor changes (included in this version)	V0.01	25/10/11
Jo Byers	First Draft	V0.01	18/9/11
Andy Collen	First Draft	V0.01	14/9/11

Circulation

Records Management Database	Date:
Internal Stakeholders	
External Stakeholders	

Review Due

Manager		
Period	Every three years or sooner if new legislation, codes of practice or national standards are introduced	Date:

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Disposal Method and Date	

Supports Standard(s)/KLOE

	Care Quality Commission (CQC)	**IG Toolkit**	**Other**
Criteria/KLOE:	Name core service area and CREWS elements		