South East Coast Ambulance Service NHS
NHS Foundation Trust

Referral Discharge and Conveyance Policy

Version:	V5.00
Name of originator/ author:	Andy Collen Consultant Paramedic (Urgent & Emergency Care)
Responsible management group:	Professional Practice Group
Directorate/team accountable:	Medical/Urgent & Emergency Care

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Review/comments:

Person/ Committee	Comments	Version	Date
Andy Collen	Minor revisions	V4.01 – 4.02	Feb 2022
Andy Collen	Final updated and corrections prior to publication	V3.02	August 2018
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Andy Collen	Updated template Preparation for re-ratification by CQWG and RMCGC	V2.01	Oct 15
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Equality Analysis Reference Group	Comments and revisions	V2.00	20/08/2013
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CGWG	Tele conference recommended for approval at RMCGC subject to minor changes	V1.05	22/10/12
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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
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Jo Byers	First Draft	V0.01	18/9/11
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Internal Stakeholders	
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Review Due by responsible Management Group:

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

Record Information:

Security Access/ Sensitivity	[select either **Official (Public Domain)** or **Official – Sensitive** for document(s) which should not be made available to the public routinely]
Where Held	Corporate Records Register
Disposal Method and Date	In line with national guidelines

Contents

1 Introduction

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) has recognised that for many patients default conveyance to an Emergency Department (ED) is not an appropriate model for a modern ambulance trust.

1.2. Nationally, ambulance services have seen activity shift to seeing more patients with urgent, unscheduled undifferentiated care needs, and this has led the Trust to develop systems to manage this more effectively.

1.3. 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.

1.4. The main principles underpinning the document are:

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

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

1.4.3. To define the systems that safeguard patients when they are not conveyed or are conveyed to non-ED destinations (including where conveyance is planned/delayed).

1.5. **Policy Statement**

1.6. 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.

1.7. The Trust strives to meet and exceed national and international best practice. The ambulance performance standards (ARP – Ambulance Response Programme) introduced in April 2017 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.

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

1.9. 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.

1.10. 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.

1.10.1. 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.

1.11. The Trust bases its clinical practice on evidence-based and commissioned pathways of care. Some care pathways are, developed as bespoke local or regional pathways to support service delivery and timely patient care.

1.11.1. Where care pathways are not commissioned directly or are created outside established practice compared to other providers, approvals are made in accordance with the Trust's governance arrangements

1.11.2. 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.

1.11.3. The following procedures sit beneath this policy and provide further specific guidance related to each relevant domain.

- **Clinical Handover and Transfer of Care Procedure**
- **Discharge Procedure**
- **Referrals Procedure**

1.12. 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.

1.12.1. Staff must always follow guidelines and local policies and procedures in order to minimise the risk to patients. Where an adverse event occurs, the principles associated with just and learning cultures will be observed by the trust.

1.12.2. This policy does not, and will not, support wilfully negligent practice.

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

2 Statement of Aims and Objectives

2.1. Aims

2.1.1. To provide a consistent approach to the disposition of patients who call 999.

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 healthcare 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 refer or discharge patients where appropriate, promoting care closer to home and the use of community/primary care services.

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

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

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

- To deliver high-quality and appropriate care based on transparent and fair rules with decisions devolved closer to patients;
- To improve clinical outcomes, safety and governance;
- To demonstrate intervention that supports an individual's well-being;
- To reduce health inequalities across the dependent population;
- To ensure that services are delivered in the most efficient way possible;
- To deliver a timely, convenient and responsive access to care including preventative interventions and diagnostics.

2.2.7. **Support to clinical decision makers**

2.2.7.1. 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.

2.2.7.2. 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. Please refer to the specific procedure which sit under this policy

2.3.2. **Referrals Procedure:**

2.3.2.1. 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.

2.3.2.2. Staff can seek advice and guidance from a senior colleague (such as via the PP Hub or CCD) when making referrals.

2.3.3. **Discharge Procedure (including self-discharge):**

2.3.3.1. 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**.

2.3.3.2. 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, may place patients are risk of harm.

2.3.3.3. 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.**

2.3.3.4. In a patient with capacity and where they have sufficient information to make an informed decision to refuse care, staff not otherwise authorised to discharge are not required to seek joint decision making (although are encouraged to).

2.3.4. **Conveyance Clinical Handover and Transfer of Care Procedure**

2.3.4.1. With the exception of Community First Responders, or Solo or Double Crewed ECSWs attending an emergency call as a first responder (as opposed to a planned/delayed conveyance), all clinical staff are authorised to convey any patient as required.

2.3.4.2. 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 undertaking conveyance (including associated decision-making).

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).

2.5.5.2. Please refer to the Clinical Handover and Transfer of Care Procedure

2.5.6. Record Keeping

2.5.6.1. Staff must make accurate and detailed clinical records for all patients in their care. Please refer to the relevant Health Records policy and procedures

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 (manually or automatically in the CAD) 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. Staff should use tools such as Service Finder to identify the most appropriate pathway of care for their patient

2.9.2. Below is a (non-exhaustive) list of the care pathways available to Trust clinicians. Some may not be directly available and will need approval or further assessment by a Specialist or Advanced Paramedic to support access.

2.9.2.1. Emergency Departments

2.9.2.2. End of life care

2.9.2.3. Primary Percutaneous Coronary Intervention (pPCI)

2.9.2.4. Stroke

2.9.2.5. Major Trauma

2.9.2.6. Primary Care

2.9.2.7. Secondary Care specialists

2.9.2.8. Tertiary Care

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

2.9.2.10. Ambulatory care pathways/Same Day Emergency Care (SDEC)

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

2.9.4. 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 patient care is passed from one clinician or provider to another. In the context of 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. This includes interfacility transfers and home to hospice, or similar, type incidents.

4 Responsibilities

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

4.2. The **Executive Medical Director** has executive responsibility for referral, discharge and conveyance.

4.3. The **Consultant Paramedic(s)** are responsible for overseeing the policy on a day-to-day basis.

4.4. The **Executive Director of Operations** is responsible for ensuring that staff 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 documents through the performance appraisal process.

5 Education and training

5.1. All staff in clinical roles have 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 compliance

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

6.2. The **Consultant Paramedic(s)** 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.** Staff involved in adverse events relating to this policy may require support from the **Professional Standards Department**. This will be ensure fairness and the principles of a just culture are upheld

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 Advice and Liaison Service (PALS)

6.3.2.2. DATIX/Dif1 report forms

6.4. Serious Incidents investigation report

7 Audit and Review (evaluating effectiveness)

7.1. The **Consultant Paramedic(s)** 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 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 Equality Analysis (extract from the Policy on Policies)

8.1. 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.

8.2. Compliance with the Public Sector Equality Duty: 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.

Name of author and role	Andy Collen, Consultant Paramedic		
Directorate	Medical	**Date of analysis:**	28th Feb 2022
Name of policy being analysed	Referral, Discharge and Conveyance Policy		
Names of those involved in this EA	Andy Collen		

1. Trust policies and procedures should support the requirements of the Equality Duty within the Equality Act:	• Eliminate discrimination, harassment and victimisation; • Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; • Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.	In submitting this form, you are confirming that you have taken all reasonable steps to ensure that the requirements of the Equality Duty are properly considered.

2. When considering whether the processes outlined in your document may adversely impact on anyone, is there any existing research or information that you have taken into account?	For example: • Local or national research • National health data • Local demographics • SECAmb race equality data • Work undertaken for previous EAs	The Referral, Discharge and Conveyance Policy describes the actions relating to each of the areas in its title and reflects local and national drivers for provider care in the right place at the right time, and with the patient at the heart of what we do

3. Do the processes described have an impact on anyone's human rights?	No. The policy supports the correct disposition for our patients

4. What are the outcomes of the EA in relation to people with protected characteristics?			
Protected characteristic	**Impact** Positive/Neutral/Negative	**Protected characteristic**	**Impact** Positive/Neutral/ Negative

Age	Neutral	Race	Neutral
Disability	Neutral	Religion or belief	Neutral
Gender reassignment	Neutral	Sex	Neutral
Marriage and civil partnership	Neutral	Sexual orientation	Neutral
Pregnancy and maternity	Neutral		

5. Mitigating negative impacts:
If any negative impacts have been identified, an Equality Analysis Action Plan must be completed and attached to the EA Record. A template for the action plan is available in the Equality Analysis Guidance on the Trust's website. Please contact inclusion@secamb.nhs.uk for support and guidance.

Protected characteristic:	N/A	Issue identified:		
Action required:				
Action lead:				
How will impact/outcome be measured?		Timescale:		
Resolution of actions:				

Protected characteristic:	N/A	Issue identified:		
Action required:				
Action lead:				
How will impact/outcome be measured?		Timescale:		
Resolution of actions:				

EA Sign off	
EA checkpoint (Inclusion Working Group member, preferably from your Directorate)	Richard Quirk (Deputy Medical Director)
By signing this, I confirm that I am satisfied the EA process detailed on this form and the work it refers to are non-discriminatory and support the aims of the Equality Act 2010 as outlined in section 1 above.	
Signed: Richard Quirk	Date: 24th March 2022

9 Associated Trust Documentation

9.1. Scope of Practice & Clinical Standards Policy

9.2. Response & Incident Resourcing Policy

9.3. Clinical Handover and Transfer of Care Procedure

9.4. Procedure

9.5. Referral Procedure

9.6. Discharge Procedure

9.7. Mental Capacity Act and Informed Consent Guidelines

9.8. Information Governance Policy

9.9. Health Records Management Policy

9.10. Safeguarding Policy

9.11. Infection Prevention and Control Policy

9.12. Manual Handing Policy

9.13. Patient Clinical Record