South East Coast Ambulance Service NHS
NHS Foundation Trust

Referral Discharge and Conveyance Policy

Contents

1 Introduction

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) has recognised that patient choice, safety, and outcomes are paramount. The Trust continues to strive to ensure that patients are cared for in the right place at the right time. This ranges from transport to a specialist centre to discharging the patient on scene for self-care.

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. National policy drivers support the need to provide the correct care in the correct place as part of regional, system, and place-based Urgent & Emergency Care (UEC).

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

1.10. 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.

1.11. 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.

1.11.1. 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.

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

1.12.1. 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.

1.12.2. 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.

1.12.3. 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**

1.13. 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.

1.13.1. 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.

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

1.13.3. Staff are responsible for acquainting themselves with the documents which inform safe practice, professional/registration standards and capability.

2 Statement of Aims and Objectives

2.1. Aims

2.1.1. To provide a consistent approach to the care of patients who call 999 or are passed to the 999 service from another function or system (i.e., 111).

2.1.2. To be an overarching policy from where staff can 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 as a system partner.

2.1.5. To empower staff to make the correct decision for the ongoing care and safety of their 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 (pPCI) centres or stroke units appropriately and rapidly.

2.2.3. To refer and/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 contractual and regulatory (CQC) 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 with clinical decisions devolved closer to patients.
- To improve clinical outcomes and safety through effective governance
- To demonstrate interventions that support an individual's well-being.
- To reduce health inequalities across our populations

- To ensure that services are delivered in the most efficient way possible.
- To deliver a timely, convenient and responsive access to care including interventions and diagnostics.
- To make every contact count by delivering proportionate and appropriate health promotion messages according to our contractual, regulatory, and ethical obligations.

2.2.7. **Support to clinical decision makers**

2.2.7.1. The Trust engenders a culture of supporting staff to make the correct pathway decisions, and ensuring that staff feel supported, and have access to support, to make these decisions.

2.2.7.2. The Trust has 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.

2.3.2.3. A patient may be discharged from care following a referral being made (see next section).

2.3.2.4. Referrals may be made directly with the referee, or via a system that allows referrals to be made. The latter must be an approved pathway available via the Directory or Service, Service Finder, or another specifically governed and approved source.

2.3.2.5. Referrals can be arranged during a face-to-face encounter or via a remote consultation where this is part of a defined role.

2.3.2.6. Patients advised to organise their own follow-up have not been referred (instead they have been discharged with advice).

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 the most potential risk depending on the nature of their illness and if any referral, follow-up, or self-care advice has been arranged.

2.3.3.3. Patients may be discharged from our care with no referral or follow-up planned. In these cases, 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.

2.3.3.4. Discharge may occur at the end of a face-to-face encounter or via a remote consultation, with or without an associated referral.

2.3.3.5. Patients may be discharged on scene (or remotely) after a referral has been made to another approved party. Advise to seek follow up does not constitute a referral. Referrals may be undertaken on the basis of a phone call to an approved referee (i.e., via Service Finder or Directory of Service) or using an approved electronic referral system (where applicable/available).

2.3.3.6. 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.**

2.3.3.7. 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).

2.3.3.8. The Trust may develop and deploy systems to improve the safety of discharge by monitoring unsupported discharge decisions using suitably qualified and authorised senior clinicians.

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 should consider the suitability for ED 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).

2.3.4.3. ED conveyance should not be used to abdicate responsibility for the patient's ongoing care, or to avoid the need to manage clinical risk. Systems exist regionally, at "system" level, and at "place*" to help ensure patients care is delivered in the most appropriate setting.
(***"place" refers to the delivery of a care within an Integrated Care "System" [ICS] local to the patient***)

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.

2.5.4.2. Please refer to trust policy and procedure relating to Worsening Care Advice, Safety Netting, and arrangement for leaving patients in the care of a family member, friend, or other suitable person (where possible).

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

2.5.6.2. Registrants must also adhere to the standards published by their professional regulator such as the Health & Care Professions Council.

2.6. Emergency Operations Centre (EOC) actions

2.6.1. EOC staff will keep all care and logistic 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, and for the purposes of reporting. Where crews need specific information adding to notes, this should be done via the dispatcher (or clinician in EOC or Hub if trained to do so).

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 or Directory of Service 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)

2.9.2.11. Urgent Community Response (UCR)

2.9.2.12. Mental Health Crisis

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 patients, 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. This can be done in person (over the telephone) or via approved electronic referral methods.

3.2. **Discharge**: The Trust definition of discharge is the termination of care or the end of the episode with an ongoing referral made, or with no follow up arranged for the patient. (Patients who refuse care/transport and have capacity to do so are deemed to have “self-discharged”). Follow-up may be part of the worsening care advice and safety netting provided, for instance but advising the patient to contact their GP within the next 48 hours.

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 to 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