South East Coast Ambulance Service NHS
NHS Foundation Trust

Referrals Procedure

Contents

1 Scope

1.1. This document describes the requirements and processes which underpin the safe transfer of care for patients who are not conveyed to hospital immediately by South East Coast Ambulance Service NHS Foundation Trust (the Trust) staff, or where care by community teams may be more appropriate.

1.2. This procedure applies to all staff attending any incident relating to patient care, with the exception of clinical staff working in the “Hear and Treat” setting in the Emergency Operations Centres (EOC), as this has its own governance and procedural arrangements.

1.3. Specifically, this procedure describes referrals to:

1.3.1. Paramedic Practitioners (PP)

1.3.2. Urgent Care Hubs

1.3.3. Primary care

1.3.4. Community specialist services

1.3.5. Hospital specialist service

1.3.6. Consultant Paramedics

1.3.7. Practice Development Leads

1.4. This document sits under the **Referral, Discharge and Conveyance Policy** which describes referrals as follows:

1.4.1. 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.

1.5. A referral is the act of referring a patient for consultation, review, or further action.

1.6. Specifically, a referral is defined as an episode of care which is passed onto another professional for onward management, and there is a defined point at which responsibility for the patients care transfers to the referee.

1.7. This document refers to “clinicians” throughout, and this refers to any member of staff with a patient facing role and/or qualification. On occasion, this will be prefixed with the word “registered” to denote specific additional responsibilities in line with the **Scope of Practice and Clinical Standards Policy.**

2 Procedure

2.1. Overarching principles

2.1.1. Prior to making a referral, clinicians must be satisfied that the patient is clinically suitable and safe to be referred and has no requirement for immediate conveyance to hospital.

2.1.2. **Electronic Patient Clinical Record (ePCR)**

2.1.2.1. Electronic Patient Clinical Records (ePCR) must be managed in line with the **Health Records Management Policy. If the ePCR is down and staff are using paper PCRs, records must also be managed in line with the Health and health records policy.**

2.1.3. When making a referral, the ePCR and any associated documentation must be sufficiently detailed and accurate, observing the minimum data set and required clinical observations.

2.1.4. Discharged and referred patients should have an 'Ambulance service advice sheet' left with them which records basic details of their assessment, diagnosis and plan as well as any advice given to them by the attending clinicians. The reverse of the advice sheet must be photographed and saved in the ePCR to evidence any written advice given. For all non-conveyed patients, also document any advice given in the advice given field.

2.1.4.1. The details about the referral must be documented and include any intermediate instructions passed by the referee.

2.1.4.1.1. Where the patient is to be conveyed as a delayed conveyance, the referring clinician completes the ePCR on the Trust iPad. Advice given must be documented in the advice given field and an advice sheet left with the patient. The clinician should close the case on their device so that it is removed from their iPad but kept on the cloud so that it can be accessed later.

2.1.4.1.2. Where the referral is to a Paramedic Practitioner (PP), the referring clinician completes the ePCR on the Trust iPad. Advice given must be documented in the advice given field and an advice sheet left with the patient. The clinician should close the case on their device so that it is removed from their iPad but kept on the cloud so that it can be accessed later by the PP.

2.1.4.1.3. If the patient has been referred to another health care professional such as a GP in primary care, the referring clinician must complete the ePCR. Advice given must be documented in the advice given field and an advice sheet left with the patient. The clinician should complete the discharge/referral sub-tab and record under disposition/outcome who the

patient was left in the care of and who they were referred to before closing and submitting the case.

2.1.5. **Clinical Decision Making**

2.1.5.1. Staff must not make assumptions about the progression of any illness or injury encountered. The level of diagnosis made for the patient must be in line with the scope of practice of the clinician, as defined in the **Scope of Practice and Clinical Standards Policy**.

2.1.5.2. All staff are encouraged to seek assistance with clinical decision making, and this can be sought from the Urgent Care Hub PP, a Clinical Supervisor, the patient's GP or an Out of Hours provider (subject to any restrictions in the **Scope of Practice and Clinical Standards Policy** appendix relevant to each clinical grade).

2.1.5.3. Where there is doubt about the certainty of any formal or working diagnosis the patient must be conveyed.

2.1.6. **Collaborative care planning with the patient**

2.1.6.1. The wishes of the patient (who is deemed to have capacity) must form the basis of any decision to refer.

2.1.6.2. Please refer to section 2.2.5 for guidance on patients who lack capacity.

2.1.6.3. Patients must not be coerced into any decision regarding referral (be cautious in the use of leading questions, supposition or directive questions). This is especially relevant for vulnerable patients.

2.1.7. **Special conditions**

2.1.7.1. **Children**

2.1.7.1.1. Only staff with specific competencies in paediatric assessment and treatment should consider referring children, particularly where this creates an interrupted period of care.

2.1.7.1.2. Where a child is not immediately conveyed or referred, consideration must be given and recorded in relation to safeguarding considerations (child protection). Any concerns must be raised in accordance with Trust Safeguarding Policy and Procedures.

2.1.7.1.3. Care must be delivered in line with the Paediatric Care Policy and the Obstetric Care Policy.

2.1.7.2. **Mental Capacity**

2.1.7.2.1. Registered Clinicians must be fully aware of the Trust's Informed Consent and Mental Capacity Act Guidelines and the requirement to be assured

that a patient being considered for discharge has capacity to, or is left in the care of someone with capacity to, understand instruction and advice pertaining to that discharge, regardless of circumstances (i.e. agreed care plan or refusal of care).

2.1.7.2.2. Clinicians are encouraged to seek assistance with clinical decision making from a Paramedic Practitioner, a clinical supervisor, the patient's GP or an Out of Hours provider (subject to any restrictions in the **Scope of Practice and Clinical Standards Policy** appendix relevant to each clinical grade).

2.1.7.2.3. 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. Mental Capacity assessment can be documented in the ePCR.

2.1.7.3. **Delayed conveyance**

2.1.7.3.1. Reference should be made to the **Interrupted Care/Delayed Conveyance Protocol** for specific information about delayed conveyance

2.2. **General arrangements**

2.2.1. Referrals can only be made according to the referral rights described in the **Scope of Practice and Clinical Standards Policy**.

2.2.2. Referrals must only be made within the established clinical pathways.

2.2.3. Referrers are responsible for ensuring that the information upon which a referral is accepted is accurate and appropriate.

2.2.4. Referrals must be fully documented in the ePCR and any worsening care advice must be given to the patient where there will be a delay between the referrer leaving and the referee arriving.

2.2.5. Patients must give consent to be referred to another clinician or service. Where patients lack mental capacity, a best interest decision can be made to make a referral for your patient, but the decision and the referral must be made according to the guidance in the **MCA and informed consent guidelines**.

2.3. **Specific Referral Pathways**

2.3.1. **Paramedic Practitioners**

2.3.1.1. All clinical staff can refer to and seek advice from Paramedic Practitioners (PP) in the urgent care hubs.

2.3.1.2. Referrals to PPs are managed through a single point of access in the Emergency Operations Centre (EOC), via the Emergency Crew Advice Line (ECAL). Clinicians wishing to make referrals to PPs must use this route not make ad-hoc or informal requests to operational PPs or Urgent Care Hub PPs as these conversations are not recorded and can make the PP un-contactable for urgent calls.

2.3.1.3. When making referral calls to the Urgent Care Hub PP, make sure you have completed all documentation and be prepared to answer questions about the patient/incident.

2.3.1.3.1. Do not make an instinctive decision to refer until you have completed a thorough assessment first.

2.3.1.4. In the context of requests for referrals, it is normally best practice to accept the decision of the Paramedic Practitioner. There will be occasions where referral is not clinically appropriate and conveyance will be advised.

2.3.2. **General Practice/Out of Hours and Community specialist services (Primary Care)**

2.3.2.1. When referring a patient back to a GP, it is preferable to do this directly to that patient's own practice.

2.3.2.2. During Out of Hours (OOH) periods, you can refer to the Out of Hours Service for patients who would benefit from care at home, but clinicians should bear in mind that OOH provision for home visits is limited and therefore requests for visits should only be for urgent requests (subject to any restrictions in the **Scope of Practice and Clinical Standards Policy** appendix relevant to each clinical grade).

2.3.2.3. Information can be passed to the patient's own GP by completing a GP summary.

2.3.2.4. Where available, discussions with other agencies about patient care should take place on a recorded telephone line. Where this is not available, clinicians are advised to accurately document discussions and instructions.

2.3.3. **Hospital specialist service**

2.3.3.1. Referrals for admission to secondary or tertiary hospitals are usually only available to PPs.

2.3.3.2. Emergency pathways to specialist hospital care are not in the scope of this document (for instance major trauma, pPCI, Stroke).

3 Responsibilities

3.1. The **Chief Executive Officer** has ultimate responsibility for patient care.

3.2. The **Consultant Paramedics (Urgent & Emergency Care)** are responsible for managing the procedure

3.3. The **Operating Unit Managers** and **Operations Managers** are responsible for implementing the procedure.

3.4. All clinicians are responsible for following this procedure.

3.5. The **Consultant Paramedics** are responsible for monitoring and audit of the procedure.

4 Audit and Review

4.1. Referrals will be monitored using data collected on non-conveyed incidents. This will be collated into an annual report by the **Consultant Paramedics or Practice Development leads** and presented to the Clinical Governance Group via the Professional Practice, Guidelines and Pathways Sub Group.

4.2. Any Serious Incident Requiring Investigation related to referrals will, where applicable, be investigated using this document and the **Scope of Practice and Clinical Standards Policy**.

4.3. All procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

4.4. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

4.5. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

4.6. All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.