South East Coast Ambulance Service
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.

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) or Urgent Care Hubs, providing a virtual response as these have their own governance and procedural arrangements.

1.3. Specifically, this procedure describes referrals to:

1.3.1. Advanced Paramedic Practitioners (APP)

1.3.2. Urgent Care Hubs

1.3.3. Primary care

1.3.4. Community specialist services

1.3.5. Hospital specialist services

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.

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. 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**. Where there is doubt about the certainty of any formal or working diagnosis the patient must be conveyed or a joint decision taken with the support of a senior clinican.

2.2. Clinical Decision Making

2.2.1. All clinicians are encouraged to seek assistance with clinical decision making and this should be sought from the Urgent Care Hub in the first instance, r an Out of Hours provider (subject to any restrictions in the **Scope of Practice and Clinical Standards Policy** appendix relevant to each clinical grade).

2.3. Mental Capacity

2.3.1. Where a patient wishes to self-discharge or refuse a referral, clinicians must assess the capacity of the patient to make this decision in accordance with the Mental Capacity Act 2005 and the Trust Mental Capacity Act and Informed Consent Guidelines. Clinicians must use the mental capacity assessment tool on ePCR when capacity is in doubt.

2.3.2. 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, or is left in the care of someone with capacity to understand instruction and advice pertaining to that discharge or referral.

2.4. Consent

2.4.1. In order for patients to give consent to treatment or refusal of treatment they must be given all of the information upon which to make their decision. This is the principle of 'informed consent'. They must have ALL material information, not just the information that the clinician feels is relevant. [Montogomery vs Lanarkshire HB 2015].

2.4.2. If there is doubt about the patient's capacity, a capacity assessment should be documented. The decision making around the decision to refuse should be documented on the ePCR. Support should be sought from an APP where there are concerns around a patient's capacity.

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

2.5.1. 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.**

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

2.5.3. Discharged and referred patients should be given advice on how to manage their condition (self-care), what to do if it does not improve (safety net) and what to do if it gets worse (worsening care). This must be recorded on the ePCR. Patients should have access to written advice as it been shown that patients will only recall small amounts of discharge information.

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

2.5.5. Where the referral is to an APP, the referring clinician completes the ePCR on the Trust iPad. Advice given must be documented in the advice given field. 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 APP.

2.5.6. 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. 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.

2.6. **Special conditions**

2.6.1. **Children**

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

2.6.1.2. 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.

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

2.7. **Delayed conveyance**

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

2.8. **General arrangements**

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

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

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

2.8.4. 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.

2.9. **Specific Referral Pathways**

2.9.1. **Advanced Paramedic Practitioners**

2.9.1.1. All clinical staff can refer to and seek advice from the Urgent Care Hubs.

2.9.1.2. Referrals to APPs 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 APPs must use this route and not make ad-hoc or informal requests to operational APPs or Urgent Care Hub APPs as these conversations are not recorded and can make the APP un-contactable for urgent calls.

2.9.1.3. When making referral calls to the Urgent Care Hub APP, make sure you have completed all relevant documentation prior to the call.

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

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

2.9.2. **General Practice/Out of Hours and Community specialist services**

2.9.2.1. It is not always possible to refer directly to the patient's GP and where this responsibility has been delegated to the patient, this is a discharge. Where you require a GP to follow up the patient or carry out further tests or evaluation, send a GP summary to the practice and call reception to inform them that we have assessed their patient and sent a summary.

2.9.2.2. If referring to a GP via the reception team for a call back, this is a referral if the practice have booked an appointment for contacting/assessing the patient.

2.9.2.3. 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).

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

2.9.2.5. 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 the name of the person and role, any discussions and instructions.

2.9.3. **Hospital specialist service**

2.9.3.1. Referrals for admission to secondary or tertiary hospitals can be made by registered clinicians via local pathways i.e SDEC or single point of access. Urgent care hubs can also support referral to specialist/secondary services.

2.9.3.2. 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.

5 Equality Analysis

5.1 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.

5.2 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.

6 Financial Checkpoint

This document has been confirmed by Finance to have no unbudgeted financial implications.

7 Associated Trust Documentation

- MCA and Informed Consent guidelines
- Incident Reporting Policy
- Scope of Practice and Clinical Standards Policy
- Referral, Discharge and Conveyance Policy
- Discharge Procedure
- Conveyance, Handover and Transfers of Care Procedure
- Interrupted care/delayed conveyance protocol
- Referral to a Paramedic (or Nurse) Practitioner Procedure
- Safeguarding Policy
- Safeguarding Referrals Procedures
- Resuscitation Policy
- Patient Clinical Record document set
- Implementing New Clinical Guidelines Policy and Procedure
- Health Records Management Policy