NHS Improvement

NHS England

NHS England-South East Hampshire & the Thames Valley (HTV)

Onward Care Procedure

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Revision History

Version	Amendment	Date
0.2	Local Authority references updated; Terminology made more definitive; Documentation process defined; Consideration of fines added; Role of SRGs added Escalation process included;	25.04.16
0.3	Comments from Berkshire East included Sections on infection control and black status updated Two way process of sending and receiving reiterated	13.06.16
1.0 Final Version		16.06.16
1.1 Second Draft	Changes to terminology i.e. SRG to A&E Delivery Board/STP Update on Escalation status in include OPEL scoring **Section 5 - Roles & Responsibilities:** "Red Bag" initiative added; Use of voluntary sector added **Section 7 Escalation** – bullet 3 updated	27.03.17
2.0 Final Version		10.05.17
2.1	Refresh for 2018- Removal of 'South Central' from NHSE and changed to NHS England-South East HTV Addition of NHSI logo Emphasis on chronology for	20.08.2018

	patient transfer Clarification on NHSE/I responsibilities Time limits included in Escalation section Update of section on PTS	

The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Contents

1 Introduction/Executive Summary

This procedure describes the process for achieving a smoother process for accessing onward healthcare for patients i.e**. getting the right care at the right time, in the right place.**

It outlines the operational pathway for the cohesive management of those patients who need further care when they have been admitted for various reasons to a hospital that is either not their local acute trust or when they need further interventions/specific care at another tertiary site (at a site following primary or secondary care). This may also be known as “repatriation”.

To achieve person-centred coordinated care for patients moving between care settings may need changes in culture and local practice. Both sending and receiving organisations must adopt the overarching principles of effective collaboration, co-ordination and communication to ensure that our patients receive the best experience possible.

Managers need to assess the factors affecting integrated working in their areas, motivating and supporting practitioners to adopt attitudes and behaviours that focus on person centred approaches. (NICE December 2015 “Transition between inpatient hospital settings and community or care home settings for adults with social care needs”).

2 Scope/Purpose

This procedure applies to patients who have been admitted to secondary care through the emergency route or for tertiary care at a specialist centre but who now need returning to their local hospital/care home for the remainder of their definitive care.

The required input from local authorities for patients to be managed at home or in local authority establishments will be locally determined and implementation of these core responsibilities will led by the appropriate A&E Delivery Board and its partners.

Each acute trust is required to have a clear set of principles and guidelines to enable patients to be returned to their local hospital, another appropriate NHS or private facility or home in a timely way when it is clinically appropriate in order that it can, working with its NHS partner organisations, provide the best possible experience and outcome for all its patients.

Effective onward care will also maximise bed availability and thereby augment accessibility of specialist tertiary services. Waiting times, cancellations and diversions of potential tertiary admissions will be minimised.

Onward care of patients requires NHS trusts, community hospitals and social care commissioners to work in partnership and to act in the best interests of patients. This is not only for transferring of patients but equally the accepting of patients as an equitable process.

3 General Responsibilities

This procedure should be read and understood by all NHS funded organisations. This also includes any other organisations that may at some time have to repatriate or receive a repatriated patient for onward care.

Each organisation will agree a single point of contact/contacts for the management of patients requiring onward care. This is normally the bed manager. Liaison thereafter should be via these nominated individuals.

Each hospital, nursing/residential/intermediate care facility or a community care team for continued care at home will have the on-going responsibility for their patients who have been admitted elsewhere, with specific time-limited obligations and understand that they may return if appropriate for onward care.

There will be benefits for all concerned by identifying and referring these patients fit for onward care efficiently and effectively in order to consistently manage patient flow.

Hospitals should ensure that the constraints imposed by methicillin-resistant staphylococcus aureus (MRSA) screening do not prevent them from meeting their obligations under this procedure by delaying an otherwise clinically appropriate and desirable transfer. The transferring hospital will make full disclosure of the infection status of patients and any relevant infection control procedures in place to the receiving hospital/care home and to the ambulance service or patient transport service.
These general responsibilities relate to:

- Acute Hospitals;
- Local Authorities (Social Care);
- Nursing Homes;
- Residential Care Homes;
- Intermediate Care Facilities;
- Community Care Teams (for home care packages);
- Community Hospitals;
- Private Care/Independent Care Sector

4 Operational Arrangements

Patients that require onward care will adhere to the following physical and operational arrangements and may use the impact assessment detailed in **Appendix 1** to assist them in this process:

Any patient requiring onward care must be stable, medically safe and clinically fit for transfer. This will be decided by the transferring clinician;

The receiving hospital, nursing/residential/ intermediate care facility or domiciliary care provider must be able to provide the level of onward care required for the patient referred;

It will be the responsibility of the lead specialty or clinical lead within the receiving hospital, nursing/residential/intermediate care facility or domiciliary care provider to accept the patient on behalf of their provider organisation;

It will be the receiving hospital's responsibility to identify the consultant, who will take primary ownership of the patient's onward care and acceptance of their transfer.

It will be the responsibility of the receiving hospital/nursing/residential or intermediate care facility to identify an appropriate bed via the bed management team if appropriate and to liaise with other relevant specialist teams if required;

Each transferring and receiving hospital will have an agreed single point of contact/contacts for all referrals. It is recommended by the National Institute for Clinical Excellence (NICE) that this is the role of a discharge co-ordinator who maintains the central point of contact for health and social practitioners;

Liaison thereafter will be between the transferring hospital's bed manager and the designated single point of contact for the receiving facility or domiciliary care team.

The transferring hospital will be responsible for providing adequate notification of impending patients requiring onward care;

Patients will be repatriated to their local hospital for onward care within these defined time periods after referral has been accepted by the receiving hospital:

- Critical care patients within 48 hours of the request;
- Ward patients within 24 hours of the request;
- Patients for nursing/residential or intermediate care facility within 24/48 hours of the request.

The time limit for repatriation will also be observed at weekends with the responsibility lying with the duty consultants as well as during the week. **The only exception would be in the instance where a receiving hospital has cancelled all elective treatment and is at organisational OPEL 4 (this has to be in agreement with their CCG). At this point negotiation for return would take place between sending and receiving hospitals to agree a suitable time frame.**

In the event that no critical care bed is likely to be available, within 48 hours, the receiving hospital will be responsible for staffing an additional critical care bed when physical space is available.
The transferring hospital will be responsible for providing all relevant clinical and social information. A personalised rehabilitation prescription will also be issued.

The transferring hospital will ensure that the patient and their family/carers are fully informed of the tertiary care, the repatriation process or the transfer of the patient for onward care and that this process is carried out in partnership with them. Planning for discharging at admission with the patient and their families at the earliest opportunity will maximise the patient choice protocol.

All transferring discussions will be documented in the nursing notes and an action log maintained by the bed management team.

5 Key Roles and Responsibilities

Role	Responsibilities
Transferring Consultant (This may not always be a clinical decision, for example if the patient is declared fit for transfer it may be a decision of Social Services or Community Matron as to where the right onward care is provided (e.g. step down bed, care home, residential home or at home)	Will identify and authorise patient transfer for onward care; Outline type of onward care required; Confirm and document in medical notes that the patient is fit for transfer; Complete relevant documentation; Refer patient to onward care facility; Advise patient and patient's relatives/carers; Handover to transfer arrangements to bed management team via senior nurse
Receiving Consultant/GP/ Matron/ Local Authority/Community Care Team	Will accept patient for transfer and onward care; Will ensure an empty bed/beds are retained for readmission for onward care purposes
Nurse in Charge/Ward Staff/Discharge Co-ordinator – transferring hospital	Will confirm transfer plan with patient and relatives/carers and document in the notes; Arrange transfer of patient via PTS or other means which could include use of the voluntary sector (i.e. Red Cross) in liaison with the bed management team; Provide a clinical escort for the transfer journey, if required. Complete any documentation ready for transfer including any handover clinical details to ensure continuity and inform onward care; Ensure all clinical and social information using the "red bag" initiative is transferred with the patient which may or may not include the medical notes but will include a discharge summary; Notify the receiving hospital/care home that the patient is ready for transfer Liaise with the patient and patient's relatives/carers;
Bed Management Team – transferring hospital	Will facilitate all onward care transfers Liaise with the nurse in charge to ensure that any patients requiring transfer for onward care are maintained on a daily

	list and are part of any capacity teleconferences to ensure an efficient process is maintained; Liaise with the receiving hospital/care home to ensure that an appropriate bed is made available as a matter of urgency;
On call teams	Will ensure any patients requiring onward care have been transferred during reasonable working hours (07.00-21.00); If onward care has not occurred as planned advise the appropriate director on call, bed management team and clinical teams involved to ensure a timely transfer still occurs. This discussion will take place through existing system conference calls as appropriate.
PTS	Will ensure timely transfer of patients to onwards care **as per local contracting arrangements;** If unable to fulfil this contract alternative transport will be sought; Transfers must occur during reasonable working hours (07.00-21.00)
A&E Delivery Boards	Will ensure that each CCG: Has the list of patients requiring onward care made available for each daily teleconference; Will implement use of the Alamac/Shrewd or similar tool kit where appropriate to monitor and oversee the management and coordination of all patients for onward care; Promote the urgency of this patient pathway on a daily basis 7/7; alongside review of stranded and super-stranded patients Are in continual liaison with Social Care Teams and the Independent Care Sector.
NHSE and NHSI	Advice and guidance

6 Onward Care Process

The transferring hospital will be responsible for providing adequate notification of patients requiring onward care and will be in continual liaison with the receiving facility to ensure a seamless patient transfer.

For definitive repatriation, patients will be returned to their local hospital within the time periods documented in this procedure. The time limit for repatriation should be observed at weekends as well as during the week. The only exception would be in the instance where a receiving hospital has cancelled all elective treatment and externally declared OPEL 4 status. At this point negotiation for return would take place between sending and receiving hospitals to agree a suitable time frame.

In the event that no critical care bed is likely to be available, within 48 hours, the receiving hospital will be responsible for staffing an additional critical care bed when physical space is available.

In the event that no onward care bed is available at a nursing/residential or intermediate care facility the receiving facility will make provision for an additional bed to be made available.

It will always remain the responsibility of both the transferring and receiving facility to put patients' welfare first, to ensure they are being cared for in the right facility. It is the responsibility of each organisation involved to:

- Implement this procedure for the management of patients requiring onward care;
- Ensure patients are accepted by receiving organisations in chronological order , in all circumstances
- Ensure each relevant member of staff is aware of their own roles and responsibilities;
- Ensure that all details of patients requiring transfer to onward care are clearly and distinctly recorded so that standards can be monitored and actioned if outliers persist;
- Ensure this procedure is cascaded and made available to each relevant member of staff;
- Ensure the process is sooth and seamless for the patient;

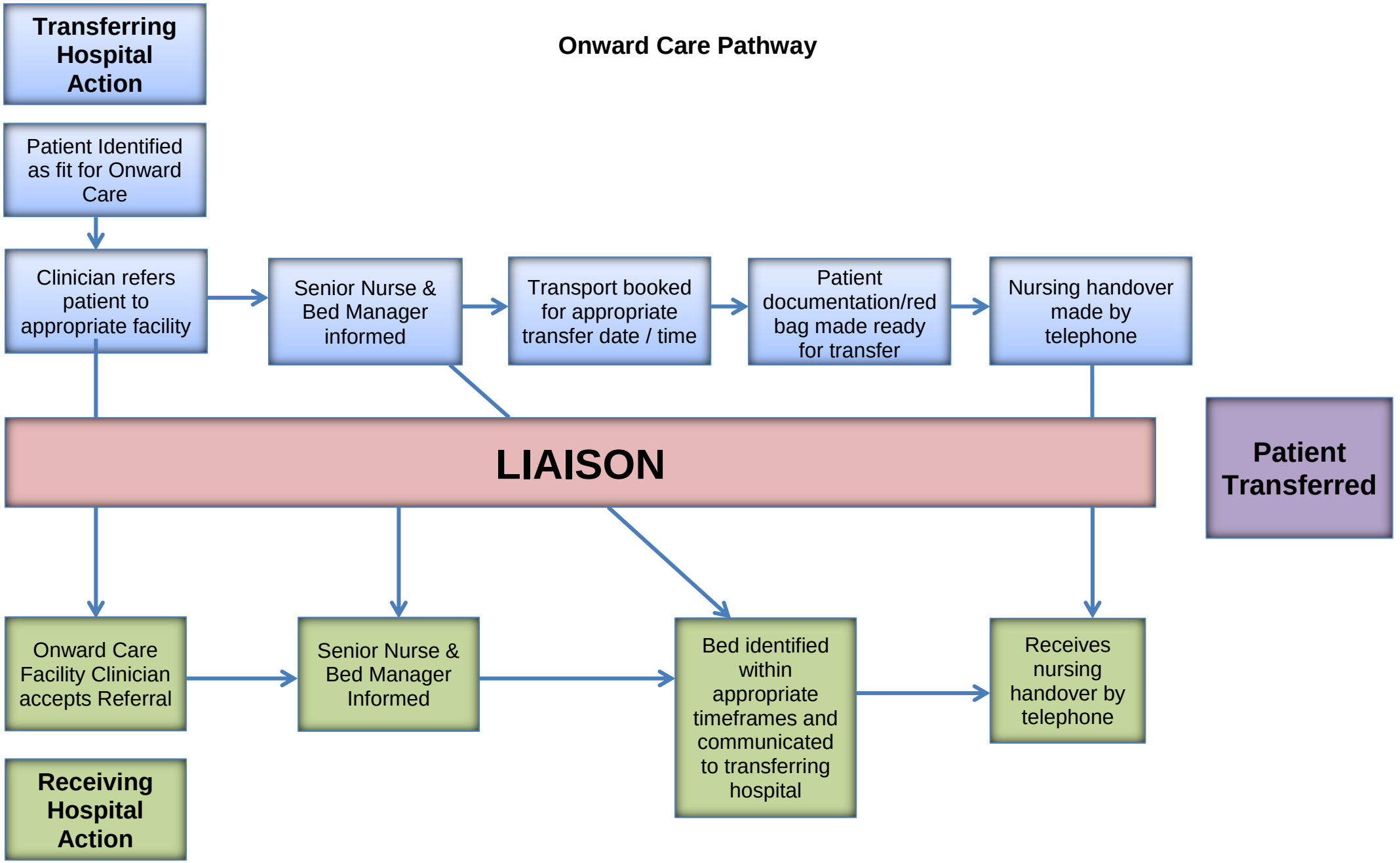
7 Escalation

Failure to facilitate this onward care procedure by any named organisation within the timescales described will take the following escalation pathway:

1. A Chief Executive Officer (or designate) to Chief Executive Officer (or designate) conversation in the first instance to discuss the present issue and agree an immediate resolution; if, within 48 hours an estimated discharge date has not been secured, the following steps will be taken:
2. Escalation to relevant A&E Delivery Board for formal rectification.
3. If no immediate solution is found and the patient is not transferred to the nominated onward care facility then any further tertiary referrals may not be accepted by the host acute trust.

NHS England and NHS Improvement are available to provide advice to systems.

Onward Care Pathway



8 Patient Transport Services

South Central Ambulance Service (HTV)

The Thames Valley PTS Contract includes repatriations for eligible patients registered with a GP practice within the Oxfordshire, Berkshire or Buckinghamshire Clinical Commissioning Group footprints being treated in a healthcare facility outside of contracted mileage (100 miles) that require repatriation to an Oxfordshire, Berkshire or Buckinghamshire bedded care facility or their home address. Journeys for an Oxfordshire, Berkshire or Buckinghamshire patient (whose distance of travel falls outside the contracted mileage) to be repatriated from a healthcare facility will be funded by the Oxfordshire, Berkshire or Buckinghamshire CCGs. The NEPTS Contractor will coordinate directly with the relevant Hospital Trust to arrange the patient's journey. All patients must meet the eligibility criteria.

Contract timings:

- Outpatient appointments, Inpatient and admissions to Acute, Community, Mental Health and Diagnostic Contractors between the hours of 0600 and 2200hrs, seven (7) days a week, including bank holidays;
- Discharges and transfers from Acute, Community, Mental Health and Diagnostic Contractors between the hours of 0600 – 2300hrs, seven (7) days a week, including bank holidays.
- Renal patients attending any dialysis unit (including satellite) between the hours 0500 – 0100hrs, seven (7) days a week, including bank holidays;
- Rapid Assessment Services to any named rapid assessment unit between the hours of 0800 to 2200, seven days a week, including bank holidays.
- Repatriations of patients registered with a GP in the commissioning area from elsewhere in the England, Wales and Scotland 0800 - 1800hrs (pick up time), seven (7) days a week, including bank holidays.
- NSIC patients attending the Stoke Mandeville Spinal between the hours of 0600 and 2200hrs, seven (7) days a week, including bank holidays;

9 Summary

The NHS is committed to provide the highest quality care for its patients. This entitles them to have the right care in the right facility at the right time. Effective onward care affects a vast range of patients including those patients waiting for beds whilst in the emergency department and those in acute beds that would be better cared for in an alternative and more appropriate setting.

A person centred approach treats individuals with dignity and respect and meets their diverse or unique needs to secure the best outcomes possible.

All partners will be involved in ensuring that this onward care procedure is implemented and initiated in a seamless and collaborative way so that the requirements of the onward care processes are fulfilled. The involvement of the patient and their carers to make informed decisions and choices will deliver a personalised patient pathway which will in turn maximise the correct, appropriate and timely onward care.

Appendix 1
Impact Assessments for Local Determination/Implementation

Consider:

- What is the impact on partner organisations and any aspect of shared risk?
- Will this impact on the organisation's duty to protect children, young people and adults?
- Impact on patient safety?
- Impact on preventable harm?
- Will it affect the reliability of safety systems?
- How will it impact on systems and a process for ensuring that the risk of healthcare acquired infections to patients is reduced?
- What is the impact on clinical workforce capability care and skills?

Risks to patient safety						
Risk Ref	Risk owner	Risk description	Risk score			Mitigating actions
			L	I	RAG	

Consider:

- How does it impact on implementation of evidence based practice?
- How will it impact on clinical leadership?
- Does it reduce/impact on variation in care provision?
- Does it affect supporting people to stay well?
- Does it promote self-care for people with long term conditions?
- Does it impact on ensuring that care is delivered in most clinically and cost effective setting?
- Does it eliminate inefficiency and waste by design?
- Does it lead to improvements in care pathway?

Risks associated with clinical effectiveness						
Risk Ref	Risk owner	Risk description	Risk score			Mitigating actions
			L	I	RAG	

Consider:

- What is the impact on race, gender, age, disability, sexual orientation, religion and belief for individual and community health, access to services and experience?
- What impact is it likely to have on self-reported experience of patients and service uses? (Response to national/local surveys/complaints/PALS/incidents)
- How will it impact on the choice agenda?
- How will it impact on the compassionate and personalised care agenda?

Risks linked to patient experience						
Risk Ref	Risk owner	Risk description	Risk score			Mitigating actions
			L	I	RAG	