

NHS England South Central Onward Care Procedure

Version 0.2



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Prepared by: Gail King, Head of Emergency Preparedness, NHS England- South Central

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0.2	Remove references to Local Authority responsibilities	23.03.16

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.

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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.

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..

Each acute trust requires clear principles and guidelines to enable patients to be returned to their local hospital or another appropriate NHS or private facility 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 and social care commissioners to work in partnership and to act in the best interests of patients.

3 General Responsibilities

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

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

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Each hospital, nursing/residential/intermediate care facility has the continuing 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 meticillin-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 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 Hospitals;
- Private care.

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 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 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,

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;

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Each transferring and receiving hospital will have an agreed single point of contact 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 maintain the central point of contact for health and social practitioners; (add Reference).

Liaison thereafter should be between the transferring hospital's bed manager and the designated single point of contact for the receiving facility.

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

Patients **must** be repatriated to their local hospital for onward care within these defined time periods:

- 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 should 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 internally/externally declared black 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.

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 must 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. **Planning for discharging at admission with the patient and their families at the earliest opportunity will maximise the patient choice protocol.**

All transferring discussions should be documented in the nursing notes

5 Key Roles and Responsibilities

Role	Responsibilities
<p>Transferring Consultant</p> <p>(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))</p>	<p>Must identify and authorise patient transfer for onward care;</p> <p>Outline type of onward care required;</p> <p>Confirm and document in medical notes that the patient is fit for transfer;</p> <p>Complete relevant documentation;</p> <p>Refer patient to onward care facility;</p> <p>Advise patient and patient's relatives/carers;</p> <p>Handover to transfer arrangements to bed management team via senior nurse</p>
<p>Receiving Consultant/GP/ Matron/</p>	<p>Accept patient for transfer and onward care;</p> <p>Ensure an empty bed/beds are retained for readmission for onward care purposes</p>
<p>Nurse in Charge/Ward Staff/Discharge Co-ordinator</p>	<p>Confirm transfer plan with patient and relatives/carers and document in the notes;</p> <p>Arrange transfer of patient via PTS or other means in liaison with the bed management team;</p> <p>Complete any documentation ready for transfer including any handover clinical details to ensure continuity and inform onward care;</p> <p>Ensure all clinical and social information is transferred with the patient which may or may not include the medical notes but will include a discharge summary;</p> <p>Notify the receiving hospital/care home that the patient is ready for transfer</p> <p>Liaise with the patient and patient's relatives/carers;</p>
<p>Bed Management Team</p>	<p>Facilitate all onward care transfers</p> <p>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;</p> <p>Liaise with the receiving hospital/care home to ensure that an appropriate bed is made available as a matter of urgency;</p>

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On call teams	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
PTS	Ensure timely transfer of patients to onwards care as per local contracting arrangements; If unable to fulfil this contract alternative transport must be sought; Transfers must occur during reasonable working hours (07.00-21.00)
TVEA (Thames Valley Only)	Have the list of patients requiring onward care made available for each daily teleconference. Implement use of the Alamac tool kit 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.

6 Onward Care Process

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

For definitive repatriation, patients **must** 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 black 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.

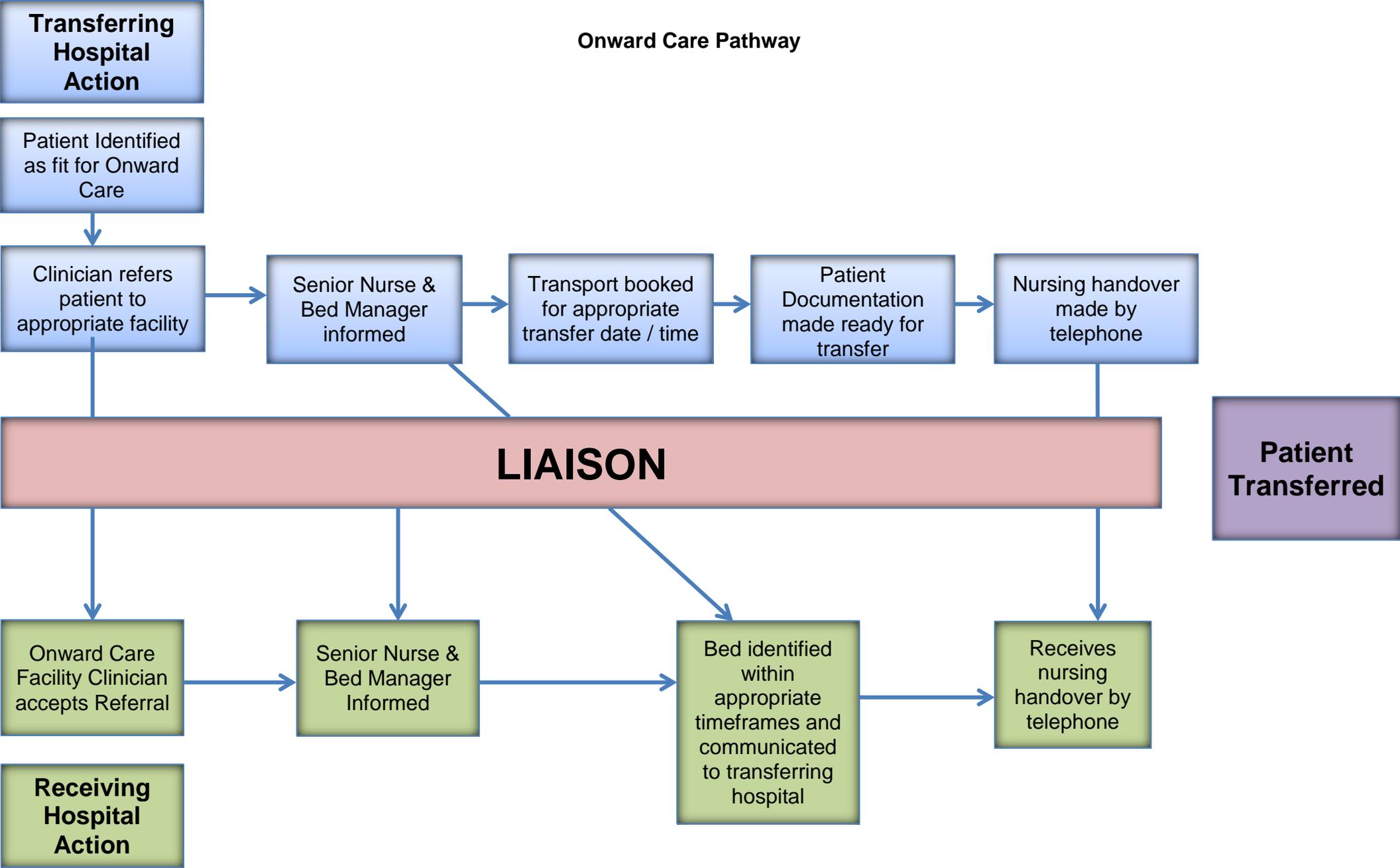
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It must always remain the transferring and receiving facility to putting the patients first to ensure they are being cared for in the right facility. It should be the responsibility of each organisation involved to:

- Implement this procedure for the management of patients requiring onward care;
- Ensure each relevant member of staff is aware of their own roles and responsibilities;
- Ensure this procedure is cascaded and made available to each relevant member of staff;
- Ensure the process is sooth and seamless for the patient;
- Ensure that the patient is cared for in the right facility at the right time.

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Onward Care Pathway



7 Patient Transport Services

Arriva Transport Solutions Ltd (ATSL)

The Department of Health defines non-emergency Patient Transport Services (NEPTS) as the non-urgent, planned transportation of patients with a medical need for transport to and from a premises providing NHS healthcare and between NHS healthcare providers. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients' medical needs.

The PTS service is for NHS non-emergency patients and their escorts who meet the eligibility criteria as defined by the Department of Health on 19 September 2007. These are journeys between their place of residence and healthcare facilities, and between healthcare facilities/hospitals.

The place of residence is defined as any address specified at the time of booking, e.g. home, nursing home, hospice, hospital or treatment centre.

There may be a requirement for patients to be taken to non NHS establishments e.g. Private Hospitals; however this will only be the case when they are going to receive NHS funded treatment at that establishment.

This service specification is underpinned by the following documents:

- Department of Health – Finance Arrangements for ambulance services
- Department of Health – Guidance for the commissioning of Ambulance Services
- Department of Health – Eligibility Criteria for non-emergency patient transport

The service is primarily for patients (and their escorts) who are registered with a GP in Wiltshire/BaNES/Gloucestershire/Swindon and who meet the agreed eligibility criteria for PTS, but will also include patients from other health communities where discharge or transfers are required. The service will also cover temporary residents in the geographical area covered. The eligibility criteria have been determined using national and local guidance.

The current national guidance states that the CCG in which a patient is registered is responsible for funding their PTS needs, provided they meet the eligibility criteria set out in the 2007 guidance and any supplementary local criteria. The national guidance states eligible patients for PTS are those where:

- The medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means
- The patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.
- Recognised as a parent or guardian where children or vulnerable adults are being conveyed.

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The journeys will mainly be in or around the area covered by Wiltshire/BaNES/Gloucestershire/Swindon but there will be a requirement for transport to anywhere within England, Scotland or Wales and will include journeys to specialist centres e.g. Birmingham, London etc.

There will also be a requirement to transport some patients who are not GP registered in the geographical area covered – this will primarily be for returning patients who are being discharged from an inpatient stay. It will not generally be for outpatient or day hospital appointments.

Patients outside the commissioned area would typically be subject to separate PTS arrangements commissioned by the respective host CCGs.

South Central Ambulance Service

Similarly the current contracts for Thames Valley do not include the repatriation for patients **outside of the commissioned area, these journeys are arranged and costed on an individual basis with the relevant CCG be that CCG within the commissioned area or outside.**

The new Thames Valley contract from April 2016 will include repatriations for all patients registered with a GP within the commissioned area for any journey up to 100 miles from that patient's place of residence.

All patients must meet the eligibility criteria as detailed below with additional local arrangements to the standard criteria.

Any deviation from these procedures will be assessed and dealt with on case by case basis to determine whether the journey fits within existing contracts.

8 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

Consider:

- What is the impact on partner organisations and any aspect of shared risk?
- Will this impact on the organisations 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	

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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	