	Date: Update 11th June 2021 **Author WP Stuart, CoM South Sector, NHS GG&C**

Purpose: Proposal for safe transfer of patients between Acute sites.

Title:	**Transfer of care between specialties, hospital and Health Boards for specialist treatment and invasive intervention (Not including Major Trauma referrals.)**

Situation

Patients are frequently transferred between hospitals to access specific specialist services. The majority are unscheduled and transfer often occurs outside office hours. The patients are often extremely unwell. It is important to define clinical responsibility. (**Note**: there is a separate process for major trauma referrals.)

Background

Several services are only available on a single site in the West of Scotland region. Some are National Services.

As an example, the Interventional Radiology (IR) team work across GG&C but most work is done on the QEUH site; many IR procedures are only available on the QEUH site. Work includes elective and emergency procedures. Some conditions are time-critical, and transfer is arranged quickly and at all times of the day. Other service examples include the pancreatic unit at the GRI, or renal services at QEUH.

Problems arise when patients are transferred with incomplete or inadequate arrangements for care and clinical responsibility. Patients have arrived in ED or critical care without clear indication of who will provide overall responsibility for care and, on occasion, there has been no notification and no indication of destination ward. (Radiology are a non-bed holding specialty.) Critical care are not responsible for the specialist needs of the patient and the underlying condition is very likely to require specialist care. Particular issues arise if an IR procedure fails (or is deemed inappropriate at the time a patient arrives), if there are complications of the procedure, if the patient condition on arrival alters plans or if end of life decisions are required.

Assessment

Good care and governance require clearly-defined clinical responsibility, either an individual or a team. This team should host the patient and provide the designated consultant for the patient. Handover and discussion with the host team prior to transfer is good practice to explore treatment options, determine best care and define treatment escalation plans. Consultants from non-bed holding specialties cannot take overall patient responsibility and critical care teams also require a specialty consultant to carry responsibility for care out with the scope of an intensive care consultant.

Recommendations

A standardised approach to referral and handover is required for all transfers between hospitals, including those coming from other health boards.

1. **Establish the need** for specific treatments or procedures with the service provider eg IR consultant on-call.
2. **Liaise** directly with the **specialist team** or service that will **host** the patient eg GI medicine, general surgery. (This is not critical care or interventional radiology.)
3. **Confirm the indication** for treatment, **expectations** of all concerned, including the patient and family, and **treatment escalation plans**, ideally before transfer.
4. Discuss **arrangements for return** to referring service.
5. **Continue to asse**s and respond to **patient** condition prior to transfer. This includes deferring transfer.

Standard Operating Procedure for inter-hospital patient transfer for specialist care

Date: 11th May 2021

WP Stuart, CoM South Sector

Background
Transfer for specialist intervention is common.

Good care requires clear delineation and communication of responsibilities. This is crucially important when care involves transfer of patients between hospitals. Care is easily compromised by poor planning, failure to make responsibilities clear and failure to communicate.

(**Referrals to the Major Trauma Centre are by a separate process**.)

Define the required treatment
-Contact the primary provider of treatment eg specialist clinician or radiologist. Many procedures are image-driven. However, it is important to maintain and overview of the patient's chronic health and acute physiological status.
-Agree indications and appropriate treatment, including discussion on outcomes and other possible or subsequent, treatments and which other services might become involved.
-Agree urgency of treatment.

Establish Responsibilities
-If the care provider of treatment is non-bed-holding, decide which service will provide continuing specialist care eg GI medicine, general surgery, vascular surgery, renal medicine.
-Contact team(s) that will provide continuing specialty care and discuss the following:
-The **need for the treatment**
-The **limits of the treatment** and potential decisions and treatments that may ensue
-Treatments escalation plans
-**Expectations** (patient, family, referring clinician)
-**Destination and routes of transfer** eg ED, critical care, ward level care
-Plans for discharge or return to referring service and obligations to make repatriation beds available in a timely fashion.
-**The patient may deteriorate** while waiting for transfer. While the responsibility for care still lies with the referring team, it may also be necessary to discuss the clinical changes with the recipient service and reassess needs and priorities.

Communicate with
-Patient and family/next of kin
-Team who will deliver intervention
-Clinical teams involved in wider patient care
-Teams involved in transfer process eg ED, Critical care, acute specialty ward

Define later management
-Describe likely process to discharge if successful
-Describe preferred options if treatment is unsuccessful eg return to referring, hospital discharge, end of life care

Acute Services
Patient Transfer Checklist

ADDRESSOGRAPH LABEL **Patient Name:** **DOB:** **CHI:** **Address:**

Date of Transfer:
(This does not apply to referrals to the Major Trauma Centre.) Transfer discussed with Specialty **Team delivering** care or intervention: ☐ Eg IR, Renal medicine Transfer discussed with **Host Team** (if different): ☐ Eg GI medicine, General Surgery Transfer discussed with site/specialty **Bed Manager** ☐ **Next of Kin** informed: ☐ **Plan and expectations** discussed: Patient☐ NoK ☐ Receiving team ☐ **Transfer letter completed** (this should contain the information below) ☐ • Diagnosis • Reason for transfer and indications for treatment • Important Past Medical History • Expectations of treatment (patient, family, referring team) • Current medications (photocopy of Kardex or copy of HEPMA paperwork) • Copy of relevant Medical/Nursing/AHP notes • **DNACPR status** or any discussions regarding ceiling of care ☐ • **Plans for repatriation or discharge**, and subsequent follow-up ☐ • **Infection Control** issues (incl C-19) ☐

Transfer Arrangements: • Where will the patient be received (eg acute ward, crit care, ED)? • Has the appropriate reception team been notified of transfer? ☐
Patient **belonging's** checklist ☐
Has there been any **change in the patient's condition** while waiting for transfer**?** If so, **are the receiving team aware** and **is the transfer still appropriate?**