Saving lives, Improving lives

NHS
Bury & Rochdale Care Organisation
Northern Care Alliance NHS Group

Title of Report	Surgical Specialty Transfer Flowchart

Submitted to	Care Organisations Clinical Effectiveness Committee
Date	November/December 2018

Executive Summary	Following a Coroner's Inquest in September 2018, a Task and Finish Group was established to review the transfer of patients between hub and spoke sites and to develop a pathway to ensure the safe and timely transfer of patients requiring specialist opinion.
Actions requested	The Committee is asked to consider and support the implementation of the pathway

Corporate Priorities supported by this paper:

1.Pursue Quality Improvement to assure safe, reliable and compassionate care
2.Deliver mandatory standards
3.Support our staff to deliver high performance and improvement
4.Improve care and services through integration and collaboration
5.Deliver financial plan to assure sustainability
6.Implement enabling strategies

Risks:

If safe effective transfer of patients between sites does not occur, patients will come to harm.

Development and Assurance

The Clinical Directors of each Accident and Emergency Department, Orthopaedics, General Surgery and Critical Care Service were invited to attend a Task and Finish Group chaired by the Bury and Rochdale Medical Director

Public and/or patient involvement:

N/A

Resource implications:

No change anticipated

Communication:

Explain any internal and external communication plans

Have all implications been considered?	**YES**	**NO**	**N/A**

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Alignment to Trust Vision, Values and Priorities	**x**		
Assurance through the Committee structure	**x**		
Consultation (internal or external)	**x**		
Contract Implications	**x**		
Equality and Diversity	**x**		
Financial / Efficiency Implications	**x**		
Information Governance Assurance	**x**		
IM&T Requirements	**x**		
National policy / legislation	**x**		
Patient Experience	**x**		
Partnerships	**x**		
Sustainability and Carbon Reduction	**x**		
Workforce Implications	**x**		

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Date	14 November 2018

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Surgical Specialty Transfer Flowchart
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Introduction

Following an Inquest in September the following feedback was received from the coroner:

'We heard evidence of a convoluted system of communication which involved a significant number of people with little effect or positive outcome. The bottom line is that he should have been transferred sooner, should have been escalated sooner, should have been monitored more closely and his transfer should not have been refused due to his high INR. I accept that was not because the doctors were not trying to progress matters, but rather that the system within they worked let them down'

NCA recognises there is a risk that if the transfer of patients between sites is not rectified then the Northern Care Alliance will receive a Prevention of Future Deaths (Section 28) notice.

A referral flowchart has been put in place and the key narrative supporting the referral process is outlined below

Main context of report

A referral protocol was implemented in October 2016 to support the Extended Waits Policy. This was discussed at the Senior medical leaders meetings. Subsequently a speciality referral flow chart has been developed to support this process. (appendix 1)

The key points of the referral process are summarised below:

1. The default response to a referral should be 'Yes, I will see the patient…'
2. It is not appropriate or permitted for Junior or Speciality, Staff Grade or Associate Specialists (SAS) staff to refuse a referral.
3. If the specialty doctor does not attend ED within 1 hour of referral the referrer should escalate to the specialty consultant to agree where the patient is to be admitted or for patient transfer directly to the assessment unit.
4. Referrals cannot be 'handed back'.
5. Should the specialty team feel admission is not warranted, they are responsible for arranging discharge, not ED.
6. Referrals cannot be made conditional.
7. ED are not obliged to perform any tests which do not affect the patient's ED management
8. Patients attending the ED should have their care completed within four hours. The responsibility for meeting this standard is shared by everyone involved in the patient's care.
9. In the event of disagreement between specialty teams the senior ED doctor (Consultant) will make the decision regarding where the patient should be admitted.
10. Patients who have been referred directly to an inpatient team, but who present via the ED due to lack of beds, are not under the care of the ED doctors.
11. The lack of availability of a specialist or Critical care bed should not delay the ttransfer of the patient.

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Recommendation

The Committee is asked to consider and support the implementation of the pathway

Dr Shona McCallum
Medical Director
14 November 2018

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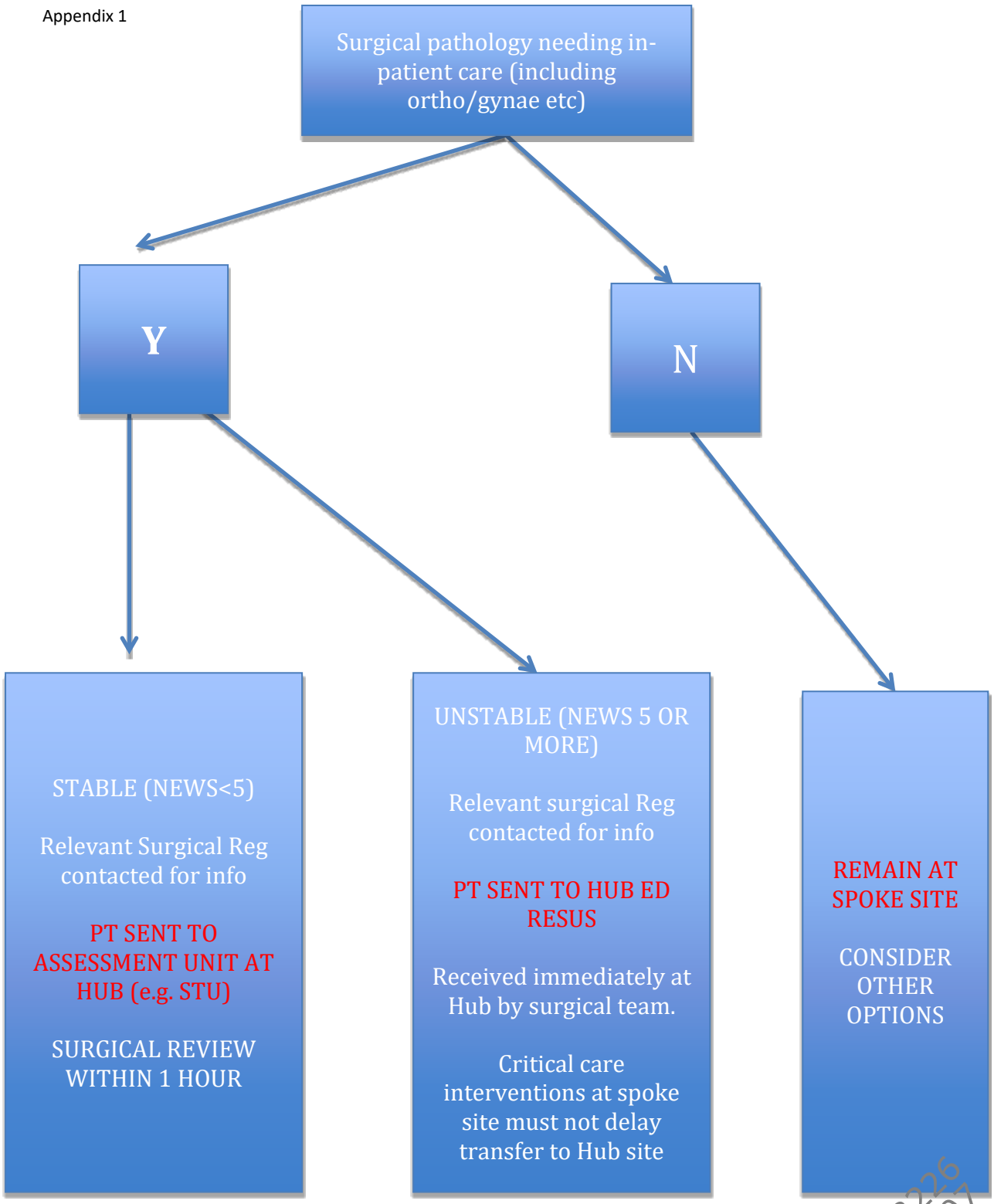
Appendix 1



PENNINE HUB/SPOKE ACUTE SURGICAL TRANSFER PATHWAY
November 2018

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