Midlands Major Trauma Operational Delivery Network - Repatriation/Reverse Transfer Principles & Escalation Policy
Description: This policy defines the principles to achieve safe and effective transfer of care/repatriation of trauma patients within 48 hours of notification.
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INTRODUCTION

Major trauma care is delivered through an inclusive Operational Delivery Network (ODN) model of care to facilitate the smooth operation of regional major trauma systems within defined geographical regions [1]. Timely repatriation of patients back to an appropriate healthcare provider is key to the availability of resources in the Major Trauma Centre (MTC) to allow for the immediate admission of patients requiring MTC level care when this is most needed and when it is likely to be of greatest benefit. On-going care and rehabilitation should reflect the patients' needs [2]. It is essential therefore to have systems in place to repatriate patients to an appropriate hospital setting to continue their treatment. This also includes the timely repatriation of a patient to an identified receiving unit out of our own network region.

This policy defines the principles of the network repatriation agreement to achieve transfer of care/repatriation within 48 hours of notification to an appropriate healthcare provider.

This policy has been written by utilising 2 National documents [3, 4] and the agreement of the principles contained within it will facilitate delivery of the best care for patients in line with the right care principles [5] and will improve the patient and family experience through the effective communication of all parties involved at this challenging time in the patient pathway.

This policy should be backed up by internal trust policies and procedures.

Principles

Patients will be transferred to an appropriate healthcare provider within 48 hours of notification (when fit to transfer) for their on-going treatment based on patient need, not hospital designation. The notification allows the healthcare provider time to plan for the repatriation.

Repatriations should not create delay; patients' GP postcode should be used and where feasible as close to the patient's home as possible. Patients with no home address will remain under the care of the admitting hospital until further information is obtained.

Patients should not be repatriated back to a TU/LEH if they can be discharged home from an MTC within a 48hour period.

All repatriations will be patient focused and as a result of a clinical decision and multidisciplinary discussions and will be supported by the Major Trauma Co-ordinators and other contacts identified by the hospitals involved.

Repatriation will be via a clinician-to-clinician referral and where initial contact is made between junior clinicians it should be escalated to a Consultant where both parties agree that the patient is clinically fit for transfer of care/repatriation.

The receiving team will confirm bed availability and both the receiving and referring team will identify and provide details of a lead contact/consultant to reduce delays in accepting patients within the 48hour period from notification.

Once the agreement for repatriation is confirmed the referring Trust/team will make a formal referral to the receiving Trust. Both parties will maintain regular and effective communication on the patient's condition and needs during the repatriation process.

Patients and/or relatives/carers will be informed of repatriation arrangements and will be informed of progress throughout.

When there is no clinical agreement between the healthcare providers about the repatriation, then the escalation process on page 4 should be followed.

All transfers should take place within normal working hours (8.00 am and 5.00 pm, or later by local agreement) except in exceptional circumstances (ie. major incident).

Patients will transfer with the appropriate documentation including a full clinical summary of injuries and treatment procedures, most up to date Rehabilitation Prescription and imaging. Rehabilitation Prescriptions/Care Plans must be followed to ensure the patient is not discharged home too quickly from a TU/LEH, putting them at risk of deterioration and/or re-admission.

It is recognised that not all clinical specialties are available at all the receiving Trusts and this needs to be considered when assessing a patient for onward care / repatriation, hence why clear and effective communication between healthcare providers is paramount from the start.

Specialist Beds

The process for specialist beds is as follows:

Level 1 rehab bed needs: These are complex rehab cases and should stay at the MTC. Funded by NHSE who look to balance access to this level of bed across the region. Only by exception should transfer to a TU be considered and only after the rehab team have confirmed that the TU have the skills to manage individual patient needs.

Level 1 SCIC needs: Should stay at the MTC until transfer to specialist unit for complex care needs. Only where the wait is significant should a transfer be considered to a TU and only after the MTC team has ensured the 14 core care needs are embedded in their daily management.

Level 2b specialist rehab bed needs: These are funded by local CCGs. Patients can be considered for care closer to a TU/LEH local to their GP when medically fit and Consultant in Rehabilitation and Rehab team agree is for 2b bed. Prescription of rehabilitation indicates the recommendation for TU/LEH to source locally as per their CCG commissioning processes.

Local Acute Brain Injury team referrals (where they exist) should be made for appropriate cases being discharged from MTC to home. If the patient is being transferred for inpatient care closer to their local GP this referral should be recommended on the Prescription for Rehabilitation, for the accepting hospital to make at the point they are discharge planning in case the patient's condition/ function/ circumstances differ compared to the time when they transferred from the MTC.

This policy should be applied 7 days a week.

Escalation Process - Trusts should enact escalation in line with local and Network policies

Delay Time	Situation	Communication
+1 Day (24 hours)	Transfer of care has not occurred within 24 hours after the planned transfer date	**Site Team** at referring hospital to communicate with receiving hospital team to expedite transfer of care
+2 Days (48 hours)	Transfer of care has not occurred within 48 hours after the planned transfer date	**Trauma Clinical and Managerial Leads** or equivalent will be informed and communicate with their equivalent at the receiving Trust **Site Team** at referring hospital to communicate with receiving hospital team to expedite transfer of care
Escalation	**Situation**	**Communication**
+3 Days Delay above 48 hours = 24 hours Divisional	Transfer of care has not occurred within 72 hours after the planned transfer date	**Divisional Manager/Head of Site Operations** for Trauma or equivalent will be informed at the receiving Trust **Site Team** at referring hospital to communicate with receiving hospital team to expedite transfer of care **Network Manager** all 48hr "breaches" are reported via TRID for network overview and monitoring via https://www.mcctn.org.uk/trid.html

+4 Days Delay above 48 hours = 48 hours	Still no plan of action or acceptance date/time set and agreed	**Chief Operating Officer/Chief Executive** to be informed at the receiving Trust **Site Team** at referring hospital to communicate with receiving hospital team to expedite transfer of care
+5 Days Delay above 48 hours = 72 hours	Still no plan of action or acceptance date/time set and agreed	**NHSE/CCG leads** to be informed of delay **Site Team** at referring hospital to communicate with receiving hospital team to expedite transfer of care
Other reasons		
Clinical Fitness	If there is a dispute regarding the patient's clinical fitness for transfer of care	**MTC Clinical Lead** to resolve this with the Trauma Lead at the receiving Unit/facility. This process will be supported by the Network Clinical Lead/Director and MTC Trauma Director as required
Refusing to accept the patient	Where an identified Consultant (or their team) refuses to accept a patient, they have been allocated to accept	**MTC Clinical Lead** will immediately escalate to the receiving Trust's single point of contact for prompt resolution and inform the Network Office.
Patient not fit for transfer/repatriation	If the receiving Trust ring the ward at the transferring MTC or TU/LEH and are told the patient is not fit or ready for transfer	**The accepting single point of contact** should immediately escalate this to the MTC Single point of contact for resolution so as not to lose the bed at the accepting hospital unnecessarily.
Unable to accept a patient	If the TU/LEH feels unable to take a patient for clinical reasons, then repatriation should be MTC to MTC with onward transfer to a TU/LEH or other facility when deemed appropriate	Cases should be escalated to the Network Office/Network Manager for resolution

Administration / Communication Process Requirements

- Each Trust is responsible for setting up a **Single Point of Contact (SPOC)** email address which includes all the relevant people involved in the escalation process which may include:
    - Site/Bed Management Team
    - Major Trauma Coordinator

  - Rehabilitation Coordinator
  - Major Trauma Clinical Lead

- Each Trust is responsible for ensuring their contact list is up to date and any changes communicated to the Network Administrator and the Trusts they regularly communicate with, at the earliest opportunity.

References

1 NHS Commissioning Board, 2013. NHS Standard Contract for Major Trauma (All Ages). D15/S/a (D02)

2 Regional Networks for Major Trauma. NHS Clinical Advisory Groups Report. September 2010

3 National Major Trauma Network to Network Repatriation Agreement June 2018

4 Major Trauma Repatriation Principles draft 1.4 April 2020

5 NHS England. What is NHS Right Care? Available at https://www.england.nhs.uk/rightcare/what-is-nhs-rightcare/ (accessed 6.4.18)