Standard Operating Procedure (SOP) – Management of Skin Cancer Referrals during COVID-19

1 Purpose of the Document

Following the COVID-19 outbreak Queen Victoria Hospital NHS Foundation Trust (QVH) has been assigned to act as a surgical cancer centre for head and neck, breast and skin cancers in agreement with the South East (SE) NHSI/E, commissioners, the Kent and Medway Cancer Alliance and the Surrey and Sussex Cancer Alliance.

This Standard Operating Procedure (SOP) is designed to explain the actions, roles and responsibilities of referring Trusts and QVH in the Management of Skin cancer cases during COVID-19.

This document should be read in conjunction with the following documents:

Regional guidance:

- Appendix 1 - Skin Cancer Management Guidance in Response to COVID-19
- Appendix 2 - Advice on maintaining cancer treatment during the COVID-19 response

QVH SOPS and information:

- Appendix 3 - Adult transfer and discharge policy
- Appendix 4 - Skin Inpatient PCR/ swab process

The purpose of this document is to outline the key principles and to detail the tertiary referral processes between referring Trusts and QVH, to ensure the robust transfer and management of patients.

2 General Principles

The aim is to ensure the provision of skin cancer surgery for patients in Kent, Surrey and Sussex (KSS) during COVID-19.

QVH will be working in line with and following the Skin Cancer Management Guidance (please see appendix 1) developed by COVID-19 cancer cell and SOPs set out above.

The SOP relates to day case (e.g. LA excisions - including grafts/flaps) and admitted surgical procedures under general anaesthetic (e.g. large WLE, SLNB (strict criteria), axillary dissections, groin dissections and excision of in-transit disease), in line with agreed clinical requirements. The SOP excludes the management of non-QVH 2ww and diagnostic requirements, which are not within scope.

The QVH will be designated as a COVID-19 free site.

This document will be shared with referring MDT's in advance of QVH accepting referrals.

3 Referral Procedure

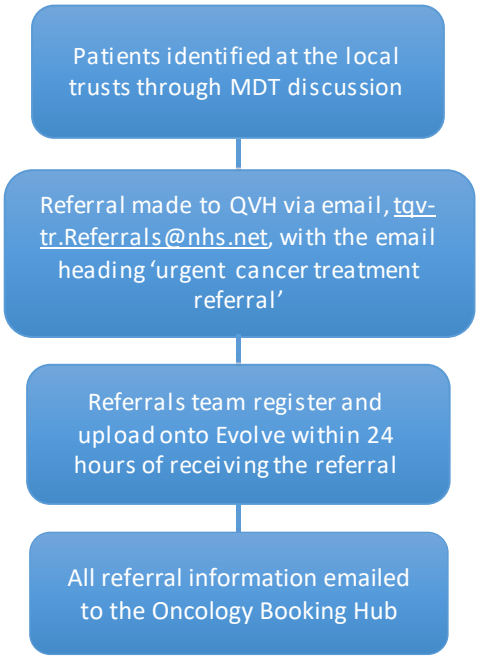
3.1 Clinical decision making

Patients will be referred to QVH for skin cancer surgery, at the point where a referral has been triaged, a suspicion of cancer identified and an excision is required.

Referring Trusts will determine patients appropriate for surgery at QVH in line with current guidance set out in the Skin Cancer Management Guidance in response to COVID-19.

3.2 Referral process

The referral to QVH should be made via usual referral letter.



4 Scheduling, pre assessment and screening

4.1 Scheduling

On receipt of the referral (from the referrals team), the Oncology Booking Hub will contact the patient by telephone to ascertain if the patient has the appropriate equipment for a virtual appointment. The appointments officer will send via email (if the patient has the appropriate IT access), the QVH photograph link, for the patient to return a photograph of the lesion/s.

The Oncology Booking Hub will print each referral and record if the patient has the appropriate IT access for a virtual appointment and photograph link.

The designated virtual clinical team (QVH Consultant and Registrar) will triage each referral (including the photograph if available), either for a virtual clinic appointment, a telephone clinic appointment or a See and Treat appointment.

The Oncology Booking Hub will contact the patient and book as per the triage outcome.

Following the virtual or telephone appointment, all outcomes will be managed by the skin schedulers, who will either book a follow-up appointment, a See or Treat appointment or an elective To Come In (TCI) date.

For patients requiring elective admission, the skin schedulers will contact the patient by telephone to arrange a To Come In (TCI) date for surgery and pre assessment date (face to face or telephone as per 4.2).

The skin scheduler will inform the patient of requirements for pre assessment and screening prior to admission.

The scheduler will send a confirmation letter and information booklet to the patient.

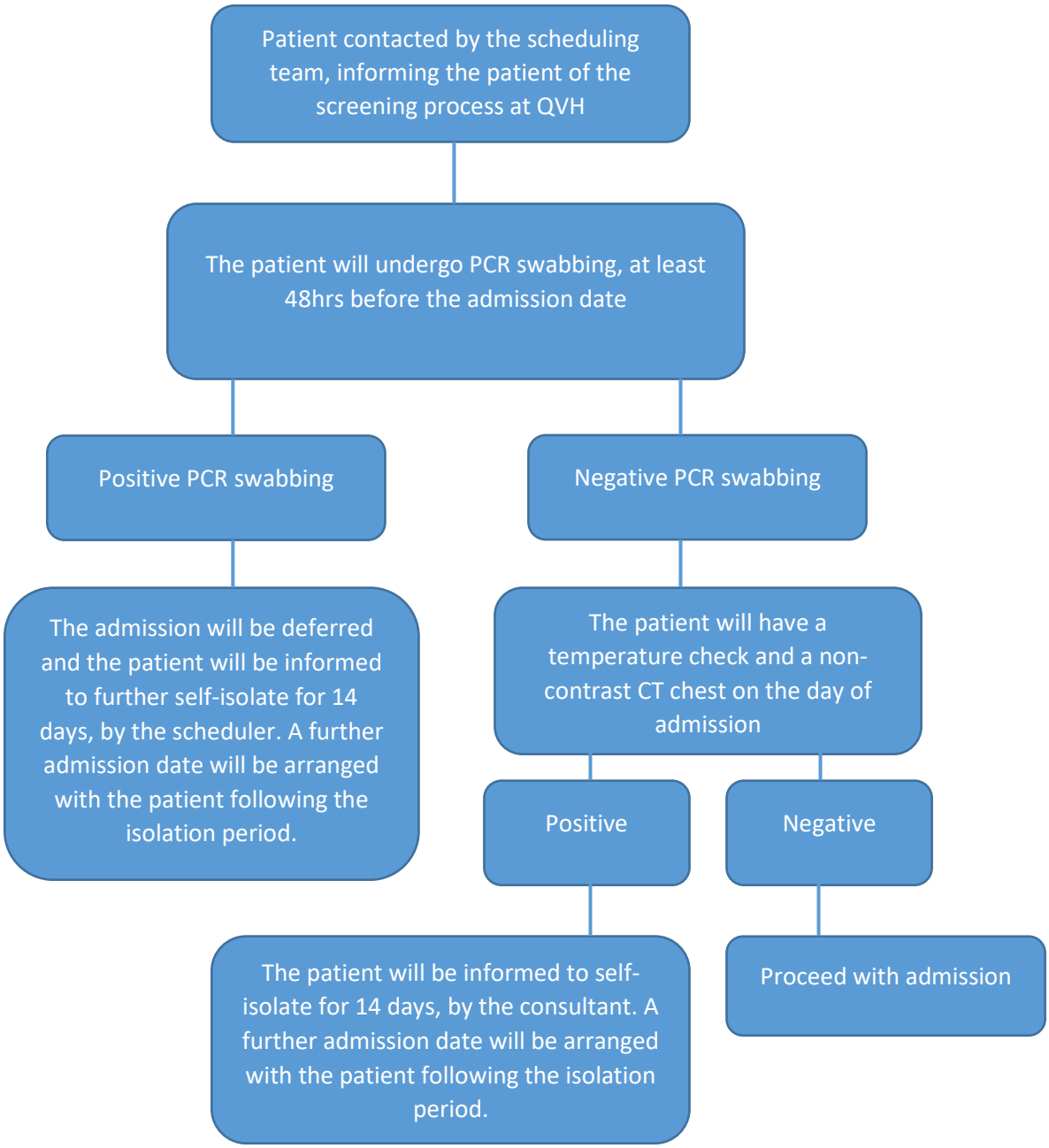
4.2 Pre Assessment

Patients requiring a day case procedure will be contacted by the pre assessment staff for a telephone assessment. If further investigations are required, these will be arranged either at QVH if available or at the referring Trust if appropriate.

4.3 Screening

In order to maintain a COVID-19 free site all patients will require screening ahead of admission including PCR test, temperature check and non-contrast CT chest as follows:

COVID-19 Elective Screening Process



5 Admission

On arrival, patients will report to Radiology and receive a temperature check, clinical assessment (to check the patient is asymptomatic) and non-contrast CT of chest.

If the CT of chest and temperature are normal, patients will be advised to proceed to the admitting ward areas.

If results are of concern, patients will be advised by the Consultant / Registrar that the surgery will be deferred to an alternative date. The patient will be advised to self-isolate for a further 14 days. The Consultant will inform the skin scheduler to rearrange the TCI date,

During the inpatient stay the patient will be under the care of the QVH admitting Consultant.

The QVH Skin Clinical Nurse Specialist (CNS) team will provide support to patients.

In the event of patients requiring an emergency transfer, the QVH Adult Transfer and Discharge Policy should be followed (please see appendix 3).

6 Patient follow up arrangements

After the procedure, the patient will either be sent a follow up letter (for benign and BCC) or booked into a virtual / telephone clinic for the results. Following this appointment, it will be ascertained if the patient needs a face to face follow-up at QVH or with the local Trust. If at the local Trust, a letter will be sent to the referring Trust to advise.

The patient will be advised regarding dressings and where necessary the patient will be booked into a QVH dressing clinic face-to-face appointment.

7 MDT follow up

All malignant histology reports are sent to the QVH MDT Coordinators.

Following MDT guidelines, patients will be discussed at either the local MDT or the Specialist MDT, depending on patient postcode either Kent or Sussex specialist MDT. This will be organised by the QVH MDT team.

If a patient requires further oncology treatment, QVH will complete and send a referral letter to the referring Trust Oncologist.

8 Transport

Patients should make their own travel arrangements to QVH where possible.

If patients require hospital transport for admission to QVH this must be arranged by the local Trust or Skin Care Nurse.

Further transport options are being explored via volunteers.

9 QVH Contacts

- Cancer, Access and Performance Manager:
  Victoria Worrell victoria.worrell2@nhs.net

- General Manager:
  Kathy Brasier k.brasier@nhs.net

Skin Cancer Management Guidance in Response to COVID-19

The following guidance has been produced by the COVID-19 South East Cancer Cell, 30th March 2020

1 Key Points

- For use to determine access to services when capacity is limited
- Higher priority chemotherapy will have protected access to available capacity
- Priority is determined by the absolute benefit a therapy provides to patients receiving that therapy

2 Purpose of document

These recommendations have been drawn up to guide local services to manage their new and review skin cancer patients. These are not evidence based, but are a peer reviewed practical policy, to cope with the expected drastically reduced clinical and surgical facilities.

3 PPE

PERSONAL PROTECTIVE EQUIPMENT (From BAD Covid advice, see link http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=6658)

• PPE may be in short supply, so the use of this should be discussed with local hospital infection teams, who may need to prioritise between different clinical areas when there are limited stocks.
• FFP3 masks, eye screens, aprons and gloves are essential for all close, face-to-face contacts with patients for examination and treatment.
• This will remain the case until the current trajectory of COVID-19 has flattened. To do otherwise is to be playing a very high-risk health lottery.
• For high-risk or known COVID-19 patients or invasive procedures, NHS England guidelines should be followed.
• The limited supplies of PPE mean that any patient who does not need to come to hospital should not.

4 GP referral to clinic

The emphasis is on the triage of the referral once received rather than putting off the referral. This is so that patients are logged in the system even if the decision is to defer treatment for now. Cancer cell are working on deferral codes and there will be central guidance on this to follow:
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/cancer-alliance-information-on-managing-cancer-referrals-19-march-2020.pdf

DRAFT

Letter to go out with skin clinic appointment, stating

- New model of appointment and guidance regarding actions should they have symptoms of COVID-19 or live with someone who is self-isolating.
- Continue to take two week wait referrals.
- Requirement for a minimum dataset from referrer with accurate description of lesion and where possible a photograph attached. Patient could also take photo and send in if secure mechanism available.

4.1 Triage of Referrals

As of 24 March 2020, to support the government's in enforcing enforce a lock-down, all effort should be made to negate footfall into hospital or community dermatology units.

Patients at high risk of severe illness from Coronovirus:
Frail elderly patient (>70 years) and/or those at risk with significant comorbidities represent a significant risk of death from complication of Covid-19. Strict consideration should be given as to whether these patients should be seen in the clinic setting or their management deferred until the pandemic is over.

(*For latest PHE guidance on social distancing and vulnerable people see link below -* https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults)

Triage of patient referrals will take the following mechanism:

- Electronic referrals received by trust reviewed by a senior clinician involved in skin cancer care. Minimum dataset required from referrer. A photograph **should be** attached to this referral. If photograph **not attached** there should be a secure mechanism is which patients can be contacted and can send in a photograph of the lesion.

- By default, all direct patient interaction should be by a virtual clinic and NOT face-face.
- Screening of referrals WITH photographs and minimum can be put into 4 streams:

1) **Discharge if Clinically Benign** - write letter to patient with reassurance and attach information leaflet explaining benign nature of diagnosis. Information should contain information to seek further medical help if lesions were to change in the future. Copy letter to referral unit (e.g. GP).

2) **Treat with topical agents (eg: Premalignant lesion such as Actinic keratosis)-** consider treating topically (e.g Efudix). Either screening clinician to send prescription or to advise GP to send prescription with clear instructions on how to use and follow-up.

3) **Defer treatment until pandemic is over:** This should apply to all all clinical BCC's in anatomically non-critical areas**.** Letter to go to patient explaining diagnosis and future treatment plan. Referral logged to ensure they are followed up for treatment in future. Can consider topical agents as above (eg; in superficial BCC)

4) **Suspicious lesion requiring surgery** – If surgery is deemed best course action, booked directly (ie See and Treat) to a minor ops / theatre list for day case local anaesthetic procedure (ie: see and treat). Information leaflet to be attached to letter to go to patient explaining the surgery. Protocols for anti-coagulation and pacemakers to be assessed as per trust / unit guidelines.

- Screening of referrals **WITHOUT** photographs or minimum dataset:

- Attempt to visualize the skin lesion through a virtual clinic. f the lesion can be diagnosed accurately then follow the procedure above.
- If patient has no access to a virtual clinic, consider bringing patient to a see and treat minor operating session. Ensure information sent to patient that treatment will be delivered on same day. Protocols for anti-coagulation and pacemakers need to assessed as per trust guidelines and information is sent accordingly to patient.

5 Diagnostics

Diagnostics will take place in the following stepwise fashion:

1. Referral letter with minimum dataset and photograph
2. Virtual clinic
3. Excision biopsy of lesion and specimen sent for histological analysis

Communicate all results via telephone / virtual clinics / letter where possible

5.1 Management of the Primary Lesion

Where surgery is deemed absolutely necessary for diagnosis, the following rules must apply;

- Patients prescreened for symptoms of Covid –19 and advised to self-isolate if symptomatic
- Patients to be advised NOT to bring any relatives into the hospital with them
- Excision must be planned with a **CLEAR macroscopic margin** and in one sitting to avoiding multiple visits

- Excision should be planned with a clear macroscopic margin (for recommendations on margins see below). **DO NOT** perform diagnostic punch/shave/incisional biopsies, minimizing multiple visits to the hospital / unit.
- Excisions on limbs should be **strictly axial (longitudinal)**.
- Aim to primarily close the incision.
- Use **absorbable sutures** to avoid need for suture removal. GP practices are unlikely able to support wound care.
- For suspected melanomas where a delayed sentinel node biopsy may be required, do not use a flap based reconstruction during the primary resection.
- Large lesions in high risk functional or cosmetic place are more likely to require MDT input for resection. Referral to specialist surgical teams (eg: Oncoplastics / Maxfacs) should be made using the agreed pathways and **MUST** include photographs and the minimum dataset (mandatory).

Recommended margins are stated in sections below.

It is recognised that there could be an increased number of non-malignant lesions excised.

5.2 Primary surgery for a clinically indeterminate lesion

- Aim for a clinically clear margin of at least 5mm with primary closure using absorbable sutures.
- Consent patient appropriately of scar length and wound complications.

5.3 Primary surgery of a clinical melanoma

- If an in situ melanoma highly suspected, excise with a 5mm peripheral margin.
- If clinically an obvious melanoma on limbs, aim for a 1cm clinical peripheral margin. Aim to leave scar in longitudinal orientation on limbs. This may negate the need for a secondary WLE and can facilitate a delayed SNBx as lymphatic drainage of limbs is more predictable.
- If obvious melanoma on head & neck area or trunk there are 2 options.
    - If patient is of age group and co-morbidities that is suitable for SNB then aim for a 2mm surgical margin and discussion at SSMDT.
    - If patient is not suitable for SNB or does not wish to be considered for SNB then aim for a 1-2cm surgical margin.
- When deciding between 1 to 2 cm margin, aim for the largest margin that allows direct closure.
- The location of some lesions will require a skin graft or local flap even with a 1cm margin. Consider MDT involvement and referral to the specialist surgical team.
- All results should be discussed at SSMDT.

- Criteria for staging scans and surveillance scans should be discussed at the SSMDT and decided on a case by case basis.

5.4 Primary surgery of a clinical BCC

- **Only consider surgery** on lesions that are in high risk critical areas (near the eyes / nose / ears) or if bleeding / infected. Management of any other BCC's can be deferred.
- Aim for 4mm surgical excision margin where possible (exception around the face). Accept margins of >1mm peripheral and >1mm deep with histology for low risk subtype BCC's.
- Limited use of Mohs in current situation unless reconstruction can be offered on the same day. Do not perform slow Mohs
- Letter / Telephone / Virtual clinic follow-up where appropriate

5.5 Primary surgery of clinical SCC

- If clinically looks like a well/moderately differentiated SCC, excised with a 5mm clinical peripheral margin.
- If clinically looks like a poorly differentiated SCC, excised with 10mm clinical peripheral margin.
- Extra care needs to be given to the deep margin. Scalp lesions should be taken to periosteum and other lesions to fascia where applicable. This is to minimize incomplete excisions and need for adjuvant radiotherapy.
- There are draft BAD guidelines to reduce the necessity of follow-ups for many SCC's. Follow-up should be limited to high risk SCC (poorly differentiated or moderately differentiated with high risk features such as perineural / lymphovascular involvement)

5.6 Primary surgery of a clinical Merkel Cell Carcinoma

- Aim for peripheral 1cm margin on face and 2cm elsewhere. Deep margin to fascia.
  Will be discussed in MDT if adjuvant radiotherapy is appropriate. However, by excising with large margins, radiotherapy may be avoided is some cases or delayed.MDT to discuss f/u protocol and staging / surveillance scans

6 Secondary management of New Cancer Patients

6.1 Confirmed skin cancers requiring specialist MDT input

- This applies to diagnosis of skin cancer made by other centres either clinically or histologically

- Referral for specialist surgery or oncology should include a photograph (this may be the one send by GP or patient) and the agreed minimum dataset

- Virtual clinics to be setup where possible

- If surgery is considered, where possible consider booking patients straight onto a list. The patient to be sent written information on the procedure or via telemedicine consultation

- Theatre lists need to be identified and staffed with appropriate grade of surgeons. Flexibility given to the surgeon to perform required resection and reconstruction with a detailed consent and consultation on the day.

6.2 Secondary management of Melanoma

- Each regional MDT will have to assess its own capacity for delivering SNBx. It is recognised this can change over a short period.

- As of 24 March 2020, significant drop in capacity has mean that all SLNBx have been stopped.

- If surgical / nuclear medicine capacity starts changing in the near future, SLNBx can be reintroduced in a focused step-wise manner. This should be reviewed bythe regional SSMDT on a week-week basis.
    - 50% capacity: pT2b-pT3b *(This focuses the service on patients who are mostly likely to benefit from a SNBx).*
    - 75% capacity: pT2b-pT4b
    - Normal capacity: pT1b – pT4b *(as per standard protocols)*

- Head and neck and truncal primaries will have greater variability in their lymphatic drainage and delayed SNBx may not be appropriate and clinical monitoring of nodal basins should be discussed with patients.

- Consider resection of clinically node positive disease for local control only after SSMDT discussion and if no other treatment options (ie: systemic) available. Aim to carryout lymphadenectomies with minimal hospital stay.

- Patients should be advised that they will be phoned with the results and only seen if there are postoperative problems (eg: seroma). Patients with high risk sentinel node tumour burden, need to be carefully observed for recurrent nodal disease.

6.3 Management of recurrent disease

Management of recurrent disease should be discussed and decisions made on case-case basis. The following is guidance only.

Melanoma:

- Consider excising an isolated resectable recurrence with >5mm margin, where possible under local anaesthetic.

- Recurrent lesions causing significant morbidity should be prioritised (eg: fungating tumour, pain, involving critical structures)

- Resection of recurrent nodal disease should only be considered if there is a local control problem and no systemic therapy options.
- All decisions should be reviewed and clearly documented at the SSMDT.

Non-melanoma skin cancers

Decision for surgery will requires SSMDT input and should be decided on case-case basis. Consider deferring treatment for recurrent BCC's if safe to do so.

6.4 Pathology

Staffing of this service is likely to be affected too, therefore workload needs to be kept to a minimum. Local conditions will dictate the level of service available. Minimising work eg excision rather than biopsy then excision; highlighting urgent cases; defining local population to be offered SNBx; local policy on the need for double reporting of all cases.

7 Oncology

7.1 Adjuvant Treatment

It is anticipated that as the Covid-19 situation escalates, there may be a need to withhold all adjuvant treatment.

Adjuvant Radiotherapy (for non-melanoma skin cancers)

Decision for adjuvant radiotherapy should be made on a case-case basis at the SSMDT and clearly documented. Consideration should be given to length of treatment, number of fractions, risk of relapse and age/comorbidities of patient putting them at risk of adverse outcomes from Covid-19.

Adjuvant systemic therapy for melanoma

All decisions to give or deescalate adjuvant systemic therapy should be discussed on case-case basis and documented at SSMDT's. Please refer to local oncology guidelines.

7.2 Therapeutic Systemic Treatment

This should follow established practice with decisions documented at the SSMDT.

Please refer to local oncology / cancer center guidelines. Advice is due to be published on Melanoma Focus website (https://melanomafocus.com)

8 Follow-Up of Cancer Patients

All patients due for review should have their previous clinic letter assessed and offered the choice of a telephone consultation only or standard clinic follow up.

Routine review can be done by telephone. The NHS has provide useful information around information governance;

https://www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance).

Patients should be asked to assess: -

- The area around their primary scar
- The skin draining towards the appropriate nodal basin(s)
- The node basins themselves
- The presence of any other new lesions - photographed and emailed
- Whether they have any systemic symptoms

**** Avoid face-face consultation with Patients over 70 and/or with significant medical co-morbidity *****

9 MDT Meetings

It is acknowledged that local situations will vary and this will determine local practice. However, this should not be used to significantly deviate from current recognised high standards. The SSMDT should be used for advice. Attendance at the MDT meeting could be done remotely. Each local skin MDT and SSMDT should document how patients are managed and their outcomes for future management strategies.

10 Research Activity

It is recommended that all recruitment and screening to all clinical trials be suspended with immediate effect. No new trials should be opened.
The exceptions to this are:

- Research into COVID-19, or
- 'The experimental treatment is essential for serious, or life-threatening conditions, and in the opinion of the treating clinician, receiving treatment in the context of the clinical trial may be very significantly advantageous to the patient concerned compared with receiving standard of care treatment. These individual cases need to be discussed with and approved by the divisional research lead.

11 Workforce

The following should be used as a guide to change in practice. It is anticipated that this situation will change weekly and requires regular review at local level.

Assuming up to - 25% Capacity loss	A - 50% Capacity loss (estimated current situation)	B - 75% Capacity loss
Weekly Covid-19 Status Meeting	**As per 'Now' and to also to include:**	**As per 'Now' and 'A' and to also to include:**
2WW referrals and triaging Cancel routine OPD activity Routine follow-ups to be seen remotely Remote triaging patient with clinical photos and minimum dataset See and treat with high risk cases or those without clinical photography **Surgery:** See and treat where possible Avoid surgery to > 70 / high risk patients Primary excision to be done as per above protocols Focused SLNB (pT2b-3b) **Oncology:** **Follow current oncology guidelines**	Primary excisions only for SCC, Merkel cell and Melanoma excision (margins as described above) No excision for any BCC No SLNB Therapeutic lymphadenectomy for local control only and if no systemic therapy available. Adjuvant treatment to be decided on case-case basis via the SSMDT Excision of resectable recurrent disease if no systemic therapy options available and patient low risk or Covid-19 complications (to be decided on case-case basis via the SSMDT).	Primary excision of high risk SCC, melanoma and Merkel cell only (as daysurgery and under LA - see above) All other treatments to be deferred No adjuvant treatment. Only therapeutic systemic therapy.

DRAFT

NHS

Publications approval reference: 001559

30 March 2020

Dear colleagues,

Advice on maintaining cancer treatment during the COVID-19 response

Thank you for all you are doing to respond to the COVID-19 emergency and, in particular, to continue to care for and support our cancer patients during these unprecedented times.

As you know, we are clear that the NHS must ensure that cancer diagnosis, treatment and care continues during the response to the COVID-19 emergency. This means:

- **Essential and urgent cancer treatments must continue. Cancer specialists should discuss with their patients whether it is riskier for them to undergo or to delay treatment at this time.**
- Where referrals or treatment plans depart from normal practice, safety-netting must be in place so that patients can be followed up.
- Urgent consideration should be given to consolidating cancer surgery in a COVID-free hub, with centralised triage to prioritise patients based on clinical need.

We have secured the use of almost all independent hospitals across England and their capacity should be used for cancer diagnosis and treatment.

In short, given the COVID situation is likely to persist for some time, rather than deferring cancer care, continuing to provide it through ringfenced facilities and reconfigured care pathways is generally more appropriate.

In London, the spread of the virus has been ahead of many other parts of the country, and local systems have been planning how best to maintain cancer services during the response period. The purpose of this note is, based on the London experience, to provide advice to local systems on how they should continue to manage cancer referrals and cancer surgery during the COVID-19 pandemic.

2WW referrals and cancer diagnostics

All patients should be considered on the basis of clinical need, and the level of risk, both patient- and service-related.

National advice has already been issued on the management of 2WW referrals for cancer. Local systems should continue to manage referrals in line with NG12 and this additional advice wherever possible.

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/cancer-allianceinformation-on-managing-cancer-referrals-19-march-2020.pdf

In primary care, where a patient meets the criteria for urgent referral under NG12 but, in view of current circumstances, the GP in discussion with the patient decides not to make a suspected cancer referral because this might be more clinically risky for the patient, the general practice should ensure the patient is appropriately safety netted, monitored and can be followed up if symptoms worsen or do not resolve.

Where a patient is referred as a suspected cancer referral and assessed virtually/by telephone, and a decision is taken not to undertake diagnostics currently due to risk to the patient, the secondary care provider should keep this patient on their patient tracking list (PTL) to ensure they can be appropriately followed up. Patients should be fully involved in reaching this decision and given advice on how to report worsening or new symptoms.

If a patient is referred as a suspected cancer referral and is not available or declines a diagnostic or other appointment due to self-isolation or shielding guidance, they should remain on the secondary care provider PTL to enable their appropriate and proactive follow-up.

Where a diagnosis of cancer is confirmed, and to minimise the patient's overall risk they are not listed for treatment immediately, then the patient should remain on the trust PTL and a decision to treat recorded if the patient has agreed to treatment. Again, patients should be involved in reaching this decision and given advice on how to report worsening or new symptoms.

It is essential that we retain records of those people who need urgent investigation for possible cancer, so that they can be followed up and diagnosed or have cancer ruled out at the earliest opportunity.

Cancer surgery hubs

Regional offices, Cancer Alliances, local systems and providers are already making plans for the continuity of cancer services during the COVID-19 response. Each local system will have its own challenges, and many will be

different from those in London. However, based on the experience in London (which in turn has drawn on the experience of Italy), we are recommending to regional offices and local systems that, as you develop and implement your own local plans for cancer, you consider incorporating the following features:

1. **A central triage point within a local cancer system**

   All cancer patients should be considered by their MDT.

   Any patients recommended for cancer surgery should be referred to a central, clinically-led triage point. This may be placed at a regional or local cancer system (Cancer Alliance) footprint level, depending on local circumstances.

   The triage system will: prioritise patients for surgery on the basis of clinical need, and the level of risk, both patient- and service-related; and match patients with appropriate surgical specialisms and capacity across the cancer system.

2. **Consolidation of cancer surgery on 'clean' sites**

   Where local circumstances permit, cancer surgery should be consolidated on a 'clean', COVID-19-free site within the local system. This could include independent sector provision where this has been secured.

   This will require arrangements for COVID-19 testing for all potential admissions 48 hours before surgery.

   For any cancer patient found to be COVID-19 positive, clinicians will need to decide locally when that patient will be considered fit for surgery, and be considered alongside other urgent surgery within a hospital treating COVID-19 patients.

3. **Clinical guide for the management of non-coronavirus patients requiring acute treatment: Cancer**

   Advice has been published to support clinicians in treatment decision-making and prioritisation, and to inform conversations about treatment with patients:

   https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acutetreatment-cancer-23-march-2020.pdf

   We will share with Cancer Alliances details of the structures put in place in London to assist with your local planning.

Cancer Alliances and national support

In many local systems, Cancer Alliances will be well placed to lead or support work to organise the configuration of local cancer services and manage patient flows, particularly for those patients for whom the clinical risk of delay is high. Regional teams will Cancer Alliances to help them deliver these arrangements.

All current advice on handling cancer patients is available on the NHS England and NHS Improvement website:

- https://www.england.nhs.uk/coronavirus/wpcontent/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23march-2020.pdf
- https://www.england.nhs.uk/coronavirus/wpcontent/uploads/sites/52/2020/03/cancer-alliance-information-on-managingcancer-referrals-19-march-2020.pdf

The national cancer team and national specialised commissioning team will work with regional offices and Cancer Alliances to monitor preparations across the country, and will offer more intensive support where requested in areas where plans are not as advanced. This may be of particular relevance in the context of rarer cancers where there are relatively small number of providers.

If you have any questions or you feel the national cancer team can provide any particular support, please don't hesitate to contact us at: england.cancerpolicy@nhs.net.

Kind regards,

Dame Cally Palmer National Cancer Director	Professor Peter Johnson National Clinical Director for Cancer	Professor Steve Powis National Medical Director

Appendix 3

Queen Victoria Hospital NHS
NHS Foundation Trust

Adult Transfer & Discharge Policy

CLASSIFICATION	Clinical
TRUST POLICY NUMBER	CL.3007.5
APPROVING COMMITTEE	Clinical Governance Committee
RATIFYING COMMITTEE	Clinical Governance Committee
DATE RATIFIED	14 August 2017
DATE FOR REVIEW	14 August 2020
DISTRIBUTION	All staff
RELATED POLICIES	Care of Patients with Acute Mental Health Needs Admission Policy
DIRECTOR LEAD	Director of Nursing & Quality
AUTHOR	Kathy Brasier – Elective Head of Nursing
CONSULTATION	
EQUALITY IMPACT ASSESSMENT	061017-1
THIS DOCUMENT REPLACES	CL3007.4

Contents

Section		Page
	Executive Summary	3
1	Introduction	4
2	Scope	5
3	Duties	5
4	Patient group	6
5	Minimum patient information for all external transfer and discharge	7
6	Internal transfer / handover of care	7
7	External transfer / handover of care – non-emergency transfer to another hospital	8
8	External transfer / handover of care – emergency transfer out from the QVH (this is also the out of hours process)	9
9	General discharge process	10
10	Discharge planning for special circumstances	11
11	Medication on discharge	13
12	Joint discharge planning and delivery	13
13	Home assessment visits prior to discharge	14
14	Training and awareness	14
15	Equality	14
16	Review	14
17	Monitoring compliance with this policy	14
18	References	15

Appendices

Appendix 1	Adult Critical Care Network transfer form	16
Appendix 2	Electronic Discharge Notification	20
Appendix 3	Self Discharge form	22

Appendix 3

Executive Summary

- All admissions, transfers and discharges will be planned with the involvement of the family, close friends or carer.
- Transfer and Discharge are essential to equip patients and carers with the knowledge, understanding and support to prevent or minimise further episodes of ill health.
- Discharge Planning will begin in Pre Assessment Clinic prior to Admission or on Re-admission as required. The Estimated Date of Discharge (EDD) must be identified by the multidisciplinary team within 24 hours of admission.
- For the purpose of this policy, adult refers to any person 17 years and over.
- For adults with Acute Mental Health needs please refer to Section 10 as well as following all general principles and other related policies.
- The following minimum information must be provided (where applicable) to either the receiving hospital, GP, or community nurse on discharge of the patient:

    - name
    - date of birth
    - address
    - unique identifier (where possible this must be the NHS number)
    - Emergency contact details (Next of Kin)
    - Presenting condition, treatment received and investigations performed
    - records of care
    - known preference and assessed needs
    - previous medical history including GP's contact details
    - any infection requiring ongoing management, with current plan included
    - medicines
    - any medication changes
    - Known allergies
    - key contact person from the Trust
    - reason for transfer if appropriate
    - Any unresolved issues or known risks
    - Future appointment details
    - Comments on patient's dependency levels
    - Any psychological issues identified or risk of harm to self or others.

- Information provided to the department must be documented in the patient's health

records for any inpatient transfer.

- Information provided to the patient and healthcare provider on discharge must be documented in the health records in the form of an Electronic Discharge Notification (EDN).
- Paediatric patients are covered in the separate Paediatric Admission, transfer and discharge policy.

1 Introduction

- This policy is designed to standardise and provide a safe co-ordinated approach to the management of Transfer and Discharge for all adult patients at the Queen Victoria Hospital NHS Foundation Trust (QVH). The whole process must be seen as a multi-professional approach involving input and effective communication from all healthcare staff.

1.2 The Transfer and Discharge are important components of a patient's healthcare journey and must be achieved to ensure the transition is completed without undue stress to the patient providing all the information required to ensure continuity of care in the receiving hospital or department, community services or with the family and or carer. There are four distinct stages which combined together complete the patient experience. These may be defined as:

Inpatient episode
Process of discharge
Transfer / Handover of Care – Internal transfer and external transfer including Emergency (out of hours)
Outpatient Follow up

Patient groups

Inpatient – any adult receiving overnight care
Outpatient – any adult using hospital services on an appointment basis
Day Case – any adult who is admitted and discharged on the same day

1.3 This policy aims to clarify the support and information required along with the responsibilities of all staff involved in the adult Transfer and Discharge process. All clinical staff will along with appropriate managers and administration staff be involved at some stage with the requirements of this policy.

1.4 Throughout this document the title Ward Matron /Deputy/ Discharge Coordinator is used to denote the registered health care professional (i.e. Nurse) with overall responsibility for planning the assessment and discharge of patients.

1.5 Unless defined otherwise the term "movement" will include the Transfer and Discharge of a patient.

1.6 Unless defined otherwise, an 'Outlier' will be an adult patient waiting to come into the

Trust from another hospital and / or waiting to return.

1.7 This policy will apply for transfer and discharge at all times of the day or night.

Definitions

- Handover of care is the exchange of quality documented information provided to the receiving department / hospital detailing the treatment and important factors relating to the care and safety of the patient being transferred. The transfer of patients is the same as handover of care.
- Electronic Discharge Notification (EDN) (appendix 1) – This is an electronic form used to document patient discharge information such as medication and treatment that can be sent to the General Practitioner (GP) electronically and printed for the patient or other healthcare providers.

2 Scope

This policy applies to all staff involved with the transfer / handover of care or discharge of adult patients.

3 Duties

All staff – responsible for adhering to this policy

Chief Executive – overall responsibility for all movement of patients involving the Trust.

Ward Matron/ Deputy – The Ward Matron or Deputy is responsible and accountable for ensuring all the information necessary to plan and manage movement arrangements is communicated and used in the patients best interests. They must ensure all the processes outlined in the policy are followed enabling a safe and timely high quality outcome. To ensure the elective bed booking system is always kept up to date and to complete a DATIX report in the event that something untoward occurs in relation to transfer or discharge.

All Clinical Staff must ensure the following:

4

- documentation is completed, up to date and accurate prior to following the transfer of a patient
- relevant people involved in the process have been informed
- all equipment required for the transfer is available and ready for use
- arrange a competent escort for the patients movement if required
- accurate and timely information regarding the infection status to the receiving area is provided

- the policy is adhered to and any deviations must be safe and in the patients best interest.
- Liaise with external Multidisciplinary Team (MDT) to ensure a safe discharge process
- Completion of the EDN, ensuring that the patients GP has received a copy within 24 hrs of discharge.
- Patients and their GP's are given full information on medication changes including medication prescribed at the time of discharge, reason for medication changes and any adverse reactions or allergies to medicines experienced by the patient during admission. To assist discharge, doctors must ensure that take home medications (TTO) are written up before patients leave Recovery to ensure safe and effective discharge can take place.

Site Practitioner - responsible for first line site management decisions out of hours**.**

*Head of Nursing - t*o provide support for the processes within the policy and ensure any operational problems encountered with any patient movement are resolved.

Infection Prevention and Control Team – to provide support and advice to staff for a patient with a possible or known infection.

Administration Staff – to provide accurate and timely information regarding the patient to the relevant areas, particularly in relation to patient transport or the need for step down/HDU or ITU beds.

Multi Disciplinary Team (MDT) A group of healthcare professionals with shared responsibility for care – to facilitate the safe discharge of patients from the Trust by ensuring they receive effective assessment, treatment and if required necessary equipment to overcome the problems that may affect their ability to carry out essential daily activities of living once at home.

Pharmacy Department – to ensure prescriptions are checked and medication dispensed according to the information within the Electronic Discharge Notification form

Discharge Coordinator – to ensure complex patient discharges are managed in a safe and timely manner liaising with relevant members of MDT to facilitate effective transfer of care.

4 Patient Groups

Patient groups can be categorised as follows:

- Discharge - Adult patient being discharged from QVH to their home or place of care. The discharge process is the same for all adult patients however there are additional requirements to specific categories of patients detailed in section 10 below. (These special groups are mental health, elderly patients from Minor Injuries Unit (MIU), homeless, Self-discharge against medical advice and patients with learning disability needs).
- External transfer/ handover of care (transfer out) - Adult patients transferred to another hospital. This can be either:

- An emergency transfer which is also classed as transfer out of normal hours.
- A non-emergency transfer – due to the nature of the work at the QVH this will always be arranged during normal working hours (08:00 – 20:00).
- Internal Transfer (handover of care) - Adult patient being transferred from one department to another within QVH for continuing care.

5 Minimum Patient Information for all External Transfer and Discharges

All patients being transferred out or discharged regardless of circumstance will have as a minimum the following information:

- name
- date of birth
- address
- unique identifier (where possible this must be the NHS number)
- Emergency contact details
- Presenting condition, treatment received and investigations performed
- known preference and assessed needs (transfer)
- any infection requiring ongoing management, with current plan included
- medicines given
- any medication changes
- known allergies
- key contact person from the Trust
- reason for transfer if appropriate
- Any unresolved issues or known risks
- previous medical history including GP's contact details (for transfers)
- Future appointment details if arranged
- Comments on patient's dependency levels
- Any psychological issues identified or risk of harm to self or others.

6 Internal Transfer / Handover of Care (including out of hours)

6.1 *Transfer / handover from one ward to another ward (giving and receiving information)*

The Lead Nurse or Ward Matron/ Deputy, together with the Site Practitioner and surgical team will discuss and finalise the plan for transfer. The level of care must be

discussed with the nurse of the receiving department to ensure the staff have the required expertise and facilities to continue to provide the appropriate level of care;

The following needs to be completed prior to transfer:

- The transferring department must document in the patient health record the transfer confirming the following;
- The surgical team have reviewed the patient, agree the transfer and have documented this in the medical notes;
- The risk of the transfer has been assessed prior to the movement to ensure emergency equipment is provided where necessary;
- The patient's infection control status has been confirmed. If there is a risk, the receiving ward has been notified and an appropriate environment allocated.
- All relevant notes (this contains the minimum information detailed in section 5 above), charts, medication, dressings and patient's belongings have been provided for the transfer;
- A qualified nurse familiar with the patient's history will accompany the patient and provide a handover to the receiving department;
- The relatives have been informed of the transfer.

6.2 *Transfer handover of care to and from theatres and recovery (giving and receiving information)*

All patient notes (including the prescription chart and risk assessment booklet but excluding other nursing documentation) must accompany the patient to theatre and on return post surgery.

The WHO Checklist will record the handover between the ward and theatre (including recovery) and on return. The following sections must be completed and signed at each stage by the person handing over responsibility of care to ensure the appropriate information has been handed over to the receiving department;

- Prior to transfer to theatre
- Sign in before induction of anaesthesia
- Time out before skin incision
- Sign out on completion of surgery
- Recovery handover and discharge (back to the ward/ department)

7 External transfer / handover of care – non-emergency transfer to another hospital

The Discharge Coordinator in conjunction with the nurse caring for the patient and the surgical team must finalise arrangements for the patient to be transferred once the decision has been made. This includes communication with the receiving hospital, the patient and their relatives ensuring the appropriate paperwork is completed. The following must be completed and confirmation written in the nursing notes prior to transfer:

- The surgical team has documented in the medical notes / EDN that the patient

has been referred to and accepted by the receiving hospital, the names of individuals concerned should be highlighted in the medical notes. The name of the accepting Consultant must be clearly written within the medical notes.

- Correct transport arranged, with appropriately trained staff available for the escort if required;
- The patient's property is packaged and ready to go with them and the Patient Property Book is completed.
- Specialist equipment is available for the transfer as required;
- The relatives or carers have been informed;
- The receiving hospital staff have all the necessary information and are aware of the estimated time of arrival;
- The minimum patient information detailed in section 5 is provided to the receiving hospital by ensuring the Transfer letter is inserted in the Extra Section of the EDN which is printed and sent with the patient and a copy sent to the patient's GP. If for any reason the EDN cannot be printed the information in section 5 must be included and documented within the handover process.
- Photocopies of medical notes, drug charts, latest and/ or relevant test results, transfer letters and medical photographs may be sent in a post-safe envelope for the journey and the hospital informed if photographs are deemed to be distressing. Patients will not have access to their notes or photographs during transfer.

8 External transfer / handover of care – emergency transfer out from the QVH (this is also the out of hours process)

The Site Practitioner and a senior clinician must be involved in the transfer process. The actions detailed below must be documented in the patient's nursing notes by the nurse responsible for care;

- The patient's condition is stabilised
- Correct transport arranged e.g. Paramedic Ambulance;
- The receiving hospital has been contacted and has all the necessary information for patient transfer;
- Adult Critical Care Network Transfer Form (Appendix 2) is completed and copy sent with patient if applicable;
- The minimum patient information detailed in section 5 above, is provided to the receiving hospital; by ensuring the EDN is printed and sent with the patient and a copy sent to the patient's GP. If for any reason the EDN cannot be printed the information in section 5 above must be included and documented within the handover process.
- Appropriately trained staff are available for the escort if required eg: nurse/ anaesthetist;
- Photocopies have been made of the medical notes including drug charts, latest and/ or relevant test results, operation notes, history sheets and medical photographs. These should be in a post-safe envelope for the journey and the receiving hospital informed if photographs are deemed to be distressing;

- The Consultant has been informed of the transfer;
- The patient's property is sealed and ready to go with them and the Patient's Property book has been completed;
- The relatives or carers have been informed and given travel instructions if following in a car;
- Specialist equipment is available for the transfer. E.g. tracheostomy kit, portable suction, listed and returned to QVH after a safe transfer.
- Clinical handover by a competent individual to the ward/ departmental staff and relevant members of the team at the receiving hospital.
- Complete a DATIX.

9 Discharge – general process for all adult discharge from the QVH (see section 10 for additional requirements)

9.1 Pre assessment Clinic (PAC) must flag up post-operative care needs which may arise on discharge. Discharge planning begins as soon as the patient is admitted to the ward area. The estimated date of discharge is identified within 24 hours of admission. The MDT has a shared responsibility for ensuring a discharge date and plan is implemented within 24 hours. The Ward Matron/ Deputy has ultimate responsibility to ensure the discharge process has been commenced. Prior to the day of predicted discharge, the nurse allocated to the patient must ensure all elements of the discharge process are completed. It is critical any equipment or community service requirements are arranged at the earliest opportunity to avoid delays to the patient discharge.

9.2 The EDD is recorded and reviewed on a daily basis by the MDT following the surgical ward rounds.

9.5 Patients, relatives and carers are informed during admission that they will be discharged from the ward as early as possible on the day of discharge, once deemed medically fit by the surgical team;

9.6 Patients are fit for discharge when physiological, social, functional and psychological factors or indicators have been taken into account following a multi-disciplinary assessment if appropriate;

9.7 One day prior to discharge, the nurse needs to ensure that the patient's EDN has been completed and checked by the pharmacist and appointments have been requested for their follow up;

9.8 On the day of discharge, the nurse is responsible for ensuring that written and verbal advice (where required) has been given to the patient, relatives or carers regarding their medications/ dressings/ equipment required.

9.9 The following documentation will accompany the patient on discharge:

- Copy of Electronic Discharge Notification Form (Appendix 2) (please ensure all the minimum data in section 5 above is included)
- Appointments Information;
- Written information regarding treatment where required;
- Contact details of ward

9.10 The minimum information provided to any receiving healthcare professional (District Nurse, GP, Nursing Home) on discharge is the following;

- Copy of Electronic Discharge Notification Form (Appendix 2) (please ensure all the minimum data in section 5 above is included)
- Additional information sent as required

9.11 The recording of the information provided on discharge is documented by the nurse responsible for the patient who must ensure the Discharge Checklist/ Complex Discharge Planner (See page 22, adult admission booklet) is completed.

9.12 Discharge out of normal working hours should follow the same process as above.

9.13 Discharge between 21.00 and 06.00 is required to follow the standard processes but must be at the patients request and not the request of QVH.

10 Additional Discharge requirements for Patients with Specific Requirements

10.1 *Patients with Psychiatric illness*

Refer to the Trust policy, Care of Patients with Acute mental Health Needs located on the Qnet/ policy and procedures/ clinical policy folder. Patients suffering from a psychiatric illness must be discharged to the relevant mental health team under the direction of a consultant psychiatrist if required. This must have been agreed prior the admission of the patient to the hospital. If patients are discharged directly to their home, the psychological therapy team within the Trust need to be consulted to ensure appropriate follow-up in the community has been organised.

10.2 *Discharge of the elderly from the Minor Injuries Unit (MIU)*

Patients must be assessed on general health/ social factors. These must include the adequacy of home arrangements. Elderly frail patients should receive priority for transport and their GP informed of their discharge within 24 hours of this taking place. Prior to discharge of any patient from MIU it must be ascertained whether that patient requires a full community assessment following discharge, this should be instigated by the practitioner looking after the patient in conjunction with the patient's GP.

10.3 *Self Discharge against medical advice*

The decision that a patient is fit for discharge can only be made by the Consultant responsible for the patients care or someone to whom the Consultant has delegated authority. Every effort should be made to persuade the patient to stay and complete their treatment. Self-discharge against medical advice usually falls within the following categories:

- *The patient understands the risks they are taking in leaving hospital* – in this instance the patient has the right to refuse treatment and leave.

- *The patient is unable to understand the risks associated with discharge* due to their medical condition (i.e. confusion, shock, pain etc) or due to mental health problems – In this situation the surgical team will need to act in the patient's best interest and

should involve psychology at the earliest opportunity following both the Mental Capacity Act (MCA) and Deprivation of Liberty guidance (DOL's) available on the Qnet.

If a patient wishes to self-discharge, the Ward Matron/ Deputy should contact:

- A member of the Surgical Team
- Site Practitioner
- Social Services if it is felt necessary, in and out of hours following a risk assessment
- Psychological therapies if appropriate
- A DATIX should be completed

The self-discharge form (Appendix 3) should be signed by the patient and the doctor and filed in the patient's medical notes.

In the event of the patient refusing to sign the self-discharge form, this must be recorded in the patient's medical/nursing notes. The doctor/nurse must inform the patient's General Practitioner within 24 hours.

10.4 *Discharge needs of people who are homeless*

It is vital that consideration is given to the housing situation of patients to ensure that patients are not discharged to inappropriate places, or become homeless as a result of their stay in hospital. Appropriate risk assessments must be carried out and passed on to primary care staff or other service providers as appropriate.

It is usually the role of Social Services to facilitate the care of people over 65 in liaison with the local homeless unit. The needs for those under 65 are covered by the local homeless unit. All Social Services have a homeless department attached to them. Patients should be referred back to the area they have come from, if safe and agreeable, and if any concerns refer to the local homeless unit. Referrals should be made within office hours as early in the day as possible to ensure that accommodation can be found. Information and resources can be found on the internet under Homeless Pages and Homeless UK.

10.5 *Discharge of patients with specific care needs*

Where patients experience difficulties in understanding and agreeing with the discharge care planned for them, it is the responsibility of all staff to ensure that they have access to the services of an interpreter or access support to ensure the patient or carer has a full understanding of the plan. In this context an interpreter may include a signer or Braille contact for hearing and visually impaired patients respectively. Additional written information appropriate to the level of understanding may be sourced.

Additional planning by the senior clinician in charge of the patient and nursing team may be needed for the following specific care needs on a case by case basis:

- Patients who are living alone, who are frail, elderly or live with a carer who may have difficulty coping. People living in sheltered housing or other warden assisted accommodation should be treated as living alone, as wardens will only assist in emergencies and cannot provide continuing care;

- Vulnerable Adults at Risk;
- Terminally ill patients;
- People with a continuing disability, including those discharged from long stay hospitals to return to the community, and those with sensory impairment;
- For patients requiring community care, it is the responsibility of the Lead Nurse to give a minimum of 24 hrs notice of discharge to community agencies and inform carers or relatives (with the patient's permission). Should a longer period of notice be requested this will be negotiated between the Trust and the agency/ individuals concerned.

10.6 Any additional discharge issue detailed in section 10 must be documented in the patient notes.

11 Medication on Discharge

11.1 *Medication process on discharge for in-patients*

Any medication required for the patient must be documented on the EDN by the clinician responsible for the care of the patient. This must be sent to the pharmacy department during normal working hours for screening prior to dispensing either from ward stock or by the pharmacy department who will arrange delivery of patient's medication to the ward.

Out of normal working hours the doctor must complete the EDN and the nurses on the ward will provide a TTO pack as available on the ward. In exceptional circumstances following discussion with Site Practitioners the patient will be given a completed FP10 prescription form for any drug not available as a TTO pack if it has not been prepared previously by the pharmacy department.

Patient's own medications must be returned to them including CD's.

11.2 *Medication process for day case patients*

The EDN is completed by the doctor and the medication is dispensed by the nurse in charge of the patient's care. Any drug that is not within the ward stock must be obtained from pharmacy.

11.3 *Medication information for the patient*

The patient must be given the medication along with relevant information for each drug in addition to a medicines helpline card. The nurse or pharmacist dispensing the medication for the patient must ensure they have the correct information.

12 Joint Discharge Planning and Delivery

12.1 When a patient has been identified through screening as needing a community care assessment or community care, the Discharge Coordinator must liaise with the MDT to plan, coordinate and manage the care of the patient. When care needs are identified to enable a safe transfer of care, a notice request for assessment must be

completed and sent to the relevant Social Services. Consent must be obtained prior to this process being completed.

12.2 It is the Ward Manager/ Deputy responsibility to ensure all service providers participating in the planned community care are kept fully informed of the plans, status and their contribution to it. The allocated social services care manager and the nominated multi disciplinary team member is responsible for notifying the Ward Matron/ Deputy of the progress and the outcome of their discharge planning.

12.3 Disputes between the Trust and other agencies participating in the assessment and discharge planning process will be handled in accordance with the principles and procedures laid down in the appropriate Clinical Commissioning Group (CCG)/ Social Services department resolution of disputes document. These can be obtained from the relevant Social Services department. Complex issues should be discussed with the Trust's legal department.

13 Home Assessment Visits Prior to Discharge

13.1 Where it is considered necessary, and appropriate, a home assessment visit and the fitting of home equipment, adaptations or individual aids, the needs and wishes of the patient and their carers must be assessed by an Occupational Therapist and / or Physiotherapist, possibly in conjunction with the Social Services in the patient's home locality where possible. However, this is a rare situation.

13.2 Where it is determined that the patient's ability to cope at home will be aided by the fitting of appropriate equipment, the patient and their carers must agree and be involved in the choice, understand its purpose, be trained in its use, and be fully informed of the costs involved. Discharge planning procedures must accommodate the identification of essential adaptations required to the place of discharge.

13.3 It is the responsibility of the therapists to ensure that any essential home equipment, adaptations, individual aids/ orthotics have been installed, provided, or arranged before the patient is discharged.

14 Training and Awareness

New staff will be introduced to the policy if relevant during their local induction process.

15 Equality

This policy and protocol will be equality impact analysed in accordance with the Trust Procedural Documents Policy, the results of which are published on our public website and monitored by the Equality and Diversity team.

16 Review

This policy will be reviewed in 3 years time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

17 Monitoring Compliance with this Policy

Appendix 3

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual or dept. responsible for the monitoring	Frequency of the monitoring activity	Group/committee which will receive the findings/ monitoring report	Committee/ individual responsible for ensuring that the actions are completed
The handover/transfer requirements between care settings for giving and receiving information. Recording of handover /transfer Out of hours handover / transfer process	Compliance in Practice (CiP) and ad hoc audit	Discharge Coordinator	Monthly audit.	Nursing Advisory Group (NAG)	Head of Nursing, Matrons and Director of Nursing and Quality to review compliance and subsequent actions monitored and communicated to directorate meetings or taken to ward meetings.
The discharge requirements for all patients The discharge information to be given to the receiving healthcare professional The information to be given to the patient on discharge How a patients medicines are managed on discharge Recording of information to the receiving healthcare professional and patient Out of hours discharge process	Compliance in Practice (CiP)	Discharge Coordinator	Monthly audit.	Nursing Advisory Group (NAG)	Head of Nursing, Matrons and Director of Nursing and Quality to review compliance and subsequent actions monitored and communicated to directorate meetings or taken to ward meetings.

18 References

- National Health Service Litigation Authority Risk Management Standards 2012-13 - http://www.nhsla.com/RiskManagement/

3/3/2010

SUSSEX CRITICAL CARE NETWORK

NHS

Adult Critical Care Transfer Form

To be used for all adult patients transferred to Critical Care - this is a legal record of transfer

PATIENT DETAILS

Name .....

Address .....

.....Postcode .....

NHS Number .....

DOB ..... Male ☐ Female ☐

ADMISSION DETAILS

Transferring Hospital .....

Receiving Hospital .....

Transferred to ITU ☐ HDU ☐ Theatre ☐ Ward ☐ Other ☐

Level of care: Level 1 ☐ Level 2 ☐ Level 3 ☐ Vent ☐

STAFF ARRANGING TRANSFER

At Transferring Hospital: Referring Consultant

Name .....

Speciality i.e. A/E, ITU, Med, Surg, Other .....

At Receiving Hospital: Receiving Consultant

Name .....

Speciality i.e. A/E, ITU, Med, Surg, Other .....

Checklist – Must be completed before transfer

Decision made by consultant ☐

Formal referral letter complete ☐

Patients health records photocopied ☐

Results/X-rays/Scans present/transferred ☐

Relatives aware of transfer ☐ .....
Name/relationship

Fracture Precautions, Spinal, Long Bone, Cervical, Thoracic, Pelvis ☐

Informed Receiving Hospital of Departure ☐

Neuro checklist if appropriate ☐

Transferred from: ICU ☐ WARD ☐ A&E ☐ THEATRE ☐ OTHER ☐

REASON FOR TRANSFER

Non-clinical ☐ Repatriation ☐ SPECIALIST TREATMENT/TERTIARY REFERRAL ☐

Diagnosis .....

AMBULANCE DETAILS

Time contacted ☐☐ Ambulance Reference number ☐

Estimated arrival time ☐☐ Time arrived at unit ☐☐ Time left unit ☐☐

PRE TRANSFER – VENTILATION, MONITORING & LINES

VENTILATION		ABGs		MONITORING & LINES	
Spontaneous, mechanical, bag	☐	PO_2	☐	Please circle monitoring, lines required for journey	
T/ET Size ☐ Lip Level	☐	PCO_2	☐	ECG	☐
Ventilator Mode	☐	HCO_3	☐	ABP NIBP	☐
Tidal Volume (V_T)	☐	PH	☐	Temperature	☐
PEEP	☐	SPO_2	☐	SPO_2	☐
FiO_2	☐	Post Intubation CXR	☐	$ETCO_2$	☐
Peak Inflation Pressure	☐	Other		CVP	☐
Resp Rate	☐			Peripheral lines	☐
Saturation	☐			Urinary Catheter	☐
				NGT/OGT	☐
				Balloon Pump	☐

UNDER OBSERVATION CHART *for use during transfer*

TIME use 24 hr clock	HRS / MINS	UNIT / AMB												
Drugs/Fluids														
Tidal Volume														
Peak Inflation Pressure														
PEEP														
FiO_2														
Respiration Rate														
SpO_2														
$ETCO_2$														
Temp														
Rhythm														
Pupils Reaction/Size	L	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Pupils Reaction/Size	R	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
GUIDE CHART FOR PUPIL SIZE	220													220
	210													210
	200													200
9mm	190													190
	180													180
8mm	170													170
	160													160
7mm	150													150
	140													140
6mm	130													130
	120													120
5mm	110													110
	100													100
4mm	90													90
	80													80
3mm	70													70
	60													60
2mm	50													50
	40													40
	30													30
URINE OUTPUT														
OTHER FLUID OUT														

ANY PROBLEMS - Equipment, Clinical or Organisational

This is the legal record of transfer and must be dated, signed & returned

BLUE	- Insert in Patient Notes at Recipient Site
YELLOW	- Post to the Critical Care Network, 36-38 Friars Walk, Lewes BN7 2PB
GREEN	- Fix into the Transferring Hospital's Notes

ESCORTING PERSONNEL

Doctor

Name.....

Grade..... Spec.....

Transfer Course Attended ☐ YES ☐ NO

Nurse/ODP

Name.....

Grade..... Spec.....

Transfer Course Attended ☐ YES ☐ NO

Signature of Escorting Doctor + bleep no..... **Date**.....

Appendix 3

SUSSEX CRITICAL CARE NETWORK

NHS

Adult Critical Care Referral Letter (to be completed by referring Doctor)

PATIENT DETAILS	ADMISSION DETAILS
Name	Referring Hospital .....
Address	Consultant .....
.....	Referred by ..... Bleep No .....
Postcode	Date and time referred .....
DOB ..... Male ☐ Female ☐	Accepted by .....Bleep No .....
	Date and time accepted .....

HISTORY (including date and time of incident and cranial/spinal injuries)

PAST MEDICAL HISTORY

USUAL MEDICATION

NEURO-ASSESSMENT (non-ventilated patient)

Neuro patients only Have the following parameters been achieved?	$PaO_2 \geq 13$ kPa		$PaCO_2$ 4.5-5 kPa	
	MAP $\geq$ 80		Sedated and paralysed	

RESULTS

Date/Time		**Date/Time**	
Hb		Na^+	
WCC		K^+	
Platelets			
Glucose		HCO_3	
Date/Time		Urea	
INR		Creatinine	
APPT			
Others			

SUMMARY OF CARE/INTERVENTION

Drugs/IV fluids given	Dose/volume infused	Date/Time
Tetanus toxoid		
Mannitol Urinary catheter must be inserted if Mannitol given		
Phenytoin		
Crystalloid		
Colloid		
Blood		

Next of kin:	Tel No:	Notified: Yes ☐ No ☐
Transfer with the patient: Observation chart ☐ Medical notes ☐ X-rays ☐ CT scans ☐ Adult Critical Care Transfer Form		
Signed:	Print:	Grade:
Date:		

JP/AL March 2010

Appendix 3

Appendix 2 Electronic Discharge Notification

Queen Victoria Hospital NHS Foundation Trust NHS
NHS Trust

Date:

GP Surgery

Discharge Id:

Dear Dr

Discharge Notification

The patient was admitted under the care of MR (Specialty:) into Ward at QUEEN VICTORIA HOSPITAL on The patient was discharged on

Patient:
D.O.B.:
NHS No.:
Hospital No.:

Address:

Clinical Assessment

Mode of Admission:

Presenting Problem:

Diagnosis:

Past Medical History:

Procedures / Investigations:

Complications / Problems During Stay:

Patient Status:

Summary and recommendations to GP:

Allergies

Allergy: Nature of reaction.

Medication on Discharge

Clinician: **Designation:** **Date:** **Bleep:**

Comments: Free text

Drug	Dose	Frequency	Route	Duration	Supply	GP continue?
Drug name	Dose	Frequency	Route	Duration	Ward TTO Pack	No

Notes

Management

Primary Care Plan

Destination on Discharge:

GP to Review On Discharge:

Care Arrangements Made:

Information Given to Patient and Relatives:

Secondary Care Plan

Future OP Appointment Booked:

Appointment Details:

Certificate Given:

Further Report:

OPD Plan:

Copy to Patient/Family:

Completed By:

Appendix 3

SELF DISCHARGE FORM FOR PATIENTS

I confirm that I have decided to discharge myself from the Queen Victoria Hospital against medical advice and that I fully understand the consequences of that decision and the risks I am taking for myself and my health. These have been explained to me by the responsible health professional. I take full responsibility for this decision and its consequences.

ID LABEL

Signed……..

Witness ……

Date……..

In the event of a patient refusing to sign a form, a note to this effect must be made in the patient's medical records.

COVID-19 PCR Swabbing Skin

Inpatient Admissions – performed at QVH

Skin

The schedulers will contact the IPACT on a Monday, listing the patients booked for the following week, including their date of admission.

The IPACT will contact each patient, via telephone to arrange a date, time and location at QVH to perform the PCR swab.

The PCR / swab will be performed at least 48hrs ahead of the date of admission.

The IPACT will monitor the results and contact, via email the consultant and scheduler, stating positive or negative for COVID-19

A decision will be made, by the consultant to either proceed to admission or defer admission and advise the patient to self-isolate for a further 14 days. The scheduler will contact the patient following this self-isolation to arrange a further date of admission.