

Sussex Trauma Network

Repatriation Policy



April 2021

Repatriation Policy

Control Page

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1. Introduction

Optimal care for patients with major trauma is delivered through an inclusive model of care throughout an Operational Delivery Network (ODN). This model facilitates the smooth operation of the regional major trauma system within a defined geographical region.

The Sussex Trauma Network has one Major Trauma Centre (MTC) based at the Royal Sussex County Hospital in Brighton. This MTC acts as a Major Trauma 'hub' serving the three local Trauma Units (TUs) at Conquest (East Sussex), Worthing, and St Richards Hospitals (West Sussex). MTCs deliver specialist trauma services to ensure patients can receive immediate care 24 hours a day regardless of location. TUs are responsible for providing local management of patients with less severe injuries.

To ensure patients are able to receive care in the most appropriate location, the Network operates on two basic principles: **automatic acceptance** and **repatriation**. Automatic acceptance means that appropriate patients are accepted by the MTC irrespective of availability of beds and ensures that patients needing it can immediately access specialist trauma care. Repatriation is the reverse process of automatic acceptance, enabling patients to return to their local hospital when the acute phase of their treatment is concluded. Without effective repatriation the concept of automatic acceptance is jeopardised.

Timely repatriation of patients back to their local Trauma Unit (TU), or other appropriate local hospital is key to the availability of resources in the Major Trauma Centre, 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. It is essential therefore to have systems in place to repatriate patients to an appropriate hospital to continue their treatment closer to home at the right phase of their treatment.

Delays in repatriation across the Sussex Trauma Network are often related to issues with gaining acceptance and poor documentation of when a patient has been accepted and by whom. Documentation provided to TUs often lacks detail which has led to confusion around patients' management plans and reason for repatriation.

2. Purpose of the Policy

The repatriation of Major Trauma patients to a local hospital has the potential to be challenging for patients, carers, staff members and local organisations. Unnecessary delays with repatriation can result in:

- difficulty accessing social services and planning discharges from outside the patient's home area
- the need for relatives and carers to travel long distances to visit their loved ones
- a source of conflict and frustration between hospitals
- preventing acutely ill patients from accessing Major Trauma beds

The purpose of this policy is to provide guidance to key individuals and organisations within the Sussex Trauma Network with the intention of reducing variation in processes and improving the patient experience.

3. Scope

The policy covers all major trauma patients within the Sussex Trauma Network. It replaces and supersedes all previous Trauma Repatriation Policies covering Sussex Trauma Network and is applicable to adults and children.

It also covers patients who warrant inter-Network repatriation, both into this Network or to another. In doing so it reflects the principles and outcomes of National Major Trauma Network-to-Network Repatriation Agreements.

4. Aims / Objectives

- To provide a standardized process for the referral, acceptance, and transfer of care of Trauma patients after the initial period of specialised trauma care is complete.
- To achieve transfer of care / repatriation of patients within 48 hours of notification.
- To provide a robust escalation and response for any delay in or deviation from this process
- To ensure equity of access to the services available at the Major Trauma Centre and ensure access to the MTC is not compromised by lack of capacity
- To comply with national standards, policy and requirements. It is possible that in future, Trauma Units will have a Best Practice Tariff applied, which rewards for achieving timely repatriation. Therefore, there is impetus to implement an effective policy.

5. Principles

There are 6 Key principles listed in the “National Major Trauma Network to Network Repatriation Agreement” (June 2018), which are labelled as such. It also includes principles suggested in the document “Major Trauma ODN Repatriation/Reverse Transfer Principles DRAFT v1.6”.

a) *The following principles will apply to all repatriation transfers covered by this policy:*

- **Key Principle 2** - Trauma Networks will work together collaboratively to ensure patients have seamless access to care and transfer back to their locality hospital, TU or MTC as appropriate when medically stable for repatriation and will be explicit about what types of specialist care is available to ensure suitable on-going treatment and care.
- **Key Principle 1** - Patients will be transferred to an appropriate healthcare provider within 48 hours of notification of the on-going requirement based on patient need, not hospital designation. Where feasible, this will be as close to the patient’s home as possible.
- **Key Principle 3** - All repatriations will be patient focussed and as a result of a clinical decision and, will be supported by the Major Trauma Practitioners, or other contact identified by the local hospital. The transfer process will include a clinician-to-clinician handover of care where both parties agree that the patient is clinically fit for transfer of care/repatriation. The receiving healthcare provider 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.
- **Key Principle 4** - Once the decision for repatriation is made, the referring Trust/team will make a formal referral to the receiving Trust/team. The receiving Trust will ensure that a bed becomes available within 48 hours of the referral being made. Both parties will maintain effective communication on the patient’s condition and needs during the repatriation process.
- **Key Principle 5** - Patients and/or relatives/carers will be informed of repatriation arrangements as soon as possible and will be informed of progress throughout by the provider caring for them at the time.
- **Key Principle 6** - All transfers should take place within normal working hours 7 days a week (between 8.00 am and 5.00 pm, or later by local agreement) except in exceptional circumstances (i.e. major incident). Patients will be transferred with the appropriate documentation including a full clinical summary of injuries and treatment

procedures, current Rehabilitation Prescription and imaging. Where repatriation is not occurring within the agreed timescale, both Trusts should activate escalation in line with local Trust and Network escalation policies.

- The Rehabilitation Prescription informs the discussion for onward care. This should be completed and sent with the patient and shared with the patient before transfer.
- Patients who warrant repatriation are to be regarded as “shared patients”, belonging both to the MTC and the local hospital.
- Identifying the local hospital for repatriation should follow a fair and consistent process. This is usually by identification of the patients GP or home address; however other methods exist and should be supported where local agreement has been reached.
- Patients with no home address will remain under the care of the admitting MTC or TU until further information is obtained. However, the principle of repatriation to the place of last known links will be applied where appropriate.
- Patient choice is not generally enacted for repatriation so should not create delay.
- It is recognised that not all clinical specialties are available at all the receiving Trusts and this must be considered when assessing a patient for onward care. Where necessary, patients will be referred to an alternative hospital other than their local hospital to better suit care needs.
- The latest COVID 19 guidance should be followed to avoid unnecessary delays to repatriation whilst protecting the status of sites or wards that are protected COVID negative areas.
- Any changes to the condition or COVID 19 status of a patient, which may affect transfer or future care should be communicated. Infection status should not prohibit the patient from being transferred.
- In respect to patients waiting for placement at a specialist rehabilitation facility, if the waiting time is more than 5 working days, the patient will be repatriated to the receiving Trust for the interim period of time.

b) The following principles should apply to all repatriation within the Sussex Trauma Network.

- Each Hospital within the Network that participates in management of patients with major trauma should have a Single Point of Contact (SPOC) – see below - for initiating

and receiving initial contact details of any patient warranting repatriation. The SPOC should have a single, unique, monitored e-mail address.

- The SPOC Team should include all the relevant people involved in the escalation process should repatriation timelines breach 48 hours.
- Each Acute Trust is responsible for ensuring their contact list is up to date and any changes communicated to the Sussex Trauma Network Manager (see [Appendix 2](#) for contact details) at the earliest opportunity.
- TUs and Local Emergency Hospitals (LEH) - should be informed through the SPOC of each new major trauma patient from their catchment area that has been received at the MTC, with a predicted date of discharge (PDD) within 48 hours of admittance, or as soon as practical to allow the SPOC sufficient time to plan for potential repatriation of the patient. This will NOT be a formal repatriation request, which should be made by the MTC once the patient is close to being medically fit for transfer, through the same route.
- The SPOC of the MTC should publish and circulate a weekly update of total patients remaining within the MTC. This update would be sent to the SPOC of each Network TU/LEH to help them forward plan and avoid any unnecessary delays.
- After a formal repatriation request has been received by the SPOC of an accepting TU/LEH, the receiving SPOC should respond within one working day as to who the accepting consultant will be. This process within the TU/LEH should be included in internal policies and procedures.
- Any patient for whom a repatriation request has been made where an accepting consultant/speciality has not been identified within 24 hours of notification of repatriation should have their case escalated through the [Escalation Process](#).
- Any patient not repatriated within the 48 hours of repatriation request should be escalated through the [Escalation Process](#) which includes informing executive teams within the relevant organisations and the relevant Clinical Commissioning Group (CCG) or Sustainability and Transformation Partnership (STP) or their representing Support Unit.
- The timescale of repatriation within 48 hours is a national standard and applies 7 days a week. Trusts should work towards developing ways of meeting the standard.

- Where an identified Consultant (or their team) refuses to accept a patient that they have been allocated to accept, this will be immediately escalated to the receiving Trust's SPOC for prompt resolution in accordance with ODN policy.
- If the accepting Trust is advised that the patient is not fit or ready for transfer, the accepting Trust's SPOC should immediately escalate this to the MTC SPOC for resolution, to prevent loss of the allocated bed at the accepting hospital.
- Repatriation turnaround times should be monitored by individual Trusts and reported to the Trauma Network, which will have an assurance and governance system in place for escalation and informing commissioners as appropriate.
- Repatriation turnaround times should form part of the Trauma Unit (and where they take place Local Emergency Hospital) Network-led Peer Reviews.

c) *For inter-network transfers, the following additional principles will apply.*

- If there is no clinical agreement for MTC to TU or other local hospital repatriation, then escalation/repatriation should be MTC to MTC.
- Where repatriation outside of the Network has not occurred within 48 hours, refer to the Network to Network repatriation agreement (see appendix 1). During times of surge, the Trauma Network Manager will advise other relevant Trauma Network Managers to ensure they are sighted and can support the repatriation.

6. Single Point of Contact

Before transfer of care can be completed, an accepting consultant at the receiving Trust must be identified and agree to take over patient care. To ensure the most appropriate consultant is assigned to each patient, it is appropriate that this conversation happens internally within the receiving Trust.

To this end, each Trust in the Network, which is involved in management of major trauma patients should have a Single Point of Contact (SPOC) for sending and receiving patient transfers. The SPOC should be contacted via single unique e-mail address and ideally also a single unique telephone number. See [Appendix 2](#) for list of contact details.

The SPOC should be monitored by a team of people which may include representatives from the Site/Bed Management Team, trauma practitioners, co-ordinators, and lead therapists. It is the responsibility of each Trust to determine who is responsible for this role.

The SPOC team must be available at least 9 - 5 Monday-Friday, the majority of routine repatriation requests will be identified during Multi-Disciplinary Team (MDT) discussion during these hours. Ideally the SPOC and the repatriation process should function 7 days a week. Where not available, expansion to a 7-day system should be considered for the future. Until that time, emergency repatriations required at weekends and bank holidays should be undertaken through a medical lead to medical lead phone call. This process will be audited regularly.

Routine referral to an organisation for patient transfer for repatriation should be via the SPOC.

The SPOC of a sending organisation will be responsible for identifying the most suitable hospital to receive the repatriation, communicating the referral to the receiving hospital's SPOC. This referral will include written documentation of the patients' injuries and management plans using the standardised Repatriation Form ([Appendix 5](#)).

The SPOC of a receiving organisation will be responsible for identifying a suitable consultant and clinical team to accept the referral, and for organising for a suitable bed for the patient within timeframes above.

See [Appendix 3](#) for a list of the duties of the SPOCs.

7. Repatriation Process

See [Appendix 4](#) for an algorithm of the process for identifying patients suitable for repatriation, and [Appendix 7](#) for an algorithm of the overall process of repatriation.

- a) **Identification of local hospital** (to be referred to as the 'receiving Trust'). Ideally this process should be started as soon as the patient is admitted to the MTC and is co-ordinated by the MTC SPOC.
 - i) The patient's postcode or the area to which the patient has the last known link is to be used to determine the local hospital according to the NHS Choices website
 - ii) If the patient postcode is insufficient to provide clarity, the Emergency Bed Bureau will be consulted and their response is final.

- b) **First notification of local hospital**
 - i) On identification of the patient's local hospital or within 48 hours of admission, the SPOC of the MTC will notify the SPOC of the local hospital of the patient's admission to the MTC and the intention of repatriation when medically appropriate.

- c) **Formal referral for repatriation to local hospital** - communication of decision to repatriate
- i) On identification by the medical team at the MTC assess that a patient is ready for repatriation using pre-defined criteria ([Appendix 4](#)) a repatriation notification form ([Appendix 5](#)) will be completed, it will include the Rehabilitation Prescription, and be sent to the SPOC at the receiving hospital, copying in the Trauma Network Manager.
 - ii) From the time that the referral is sent, the receiving TU should allocate an accepting consultant and speciality within 24 hours. The SPOC team at the receiving TU are required to find the most appropriate consultant and speciality for the patients' needs. Transferring patients to other hospital sites within the TU's trust will be at the SPOC team's discretion.
 - iii) Once the receiving TU SPOC has identified an accepting specialty and corresponding named consultant, they must notify the MTC SPOC by return email. The receiving TU should also ensure that the bed management team is aware and has a plan in place for identifying a bed.
 - iv) The patient and next of kin should be kept fully informed of the intention to seek repatriation and from admission, or whenever appropriate, onwards. It is the responsibility of the MTC to ensure this is completed.
 - v) For patients with on-going rehabilitation needs the MTC should initiate rehabilitation referrals, however this should not hinder repatriation.
 - vi) Following completion of i) to v) above the TU SPOC should initiate and lead the management of the process for repatriation.
- d) **Transfer of Care Process**
- i) The receiving TU is expected to find a bed for the patient within 48 hours of the formal referral for repatriation being sent by the MTC.
 - ii) Once the receiving TU has allocated a bed, their SPOC must contact and inform the MTC SPOC team of the bed placement and the identity of the receiving speciality and consultant.
 - iii) The MTC SPOC inform the MTC clinical team(s) caring for the patient of the above details.

- iv) Prior to transfer the MTC clinical team must give a verbal medical and nursing handover to the receiving TU team(s).
 - v) Between formal referral and actual physical transfer, if there is a substantial and relevant change in the condition of the patient, the relevant team in the MTC should communicate to the receiving SPOC and clinical teams.
 - vi) The MTC ward should request transport for the patient transfer.
 - vii) Transfer of patients should occur between 8am and 5pm unless there are extenuating circumstances, such as a Major Incident.
- e) **Escalation Process** – if required. See [Appendix 6](#) for fuller description.
- i) Patient transfer should occur within 48 hours of the repatriation notification being sent by the MTC. Earlier transfer, if safe and appropriate, should be encouraged.
 - ii) If the patient is delayed beyond 48 hours the escalation process will commence, with escalation to the executive team and local commissioner where required.
 - iii) In this case the MTC will call the receiving Trust SPOC daily for a situation update and plan for transfer
 - iv) If after a 3-day delay, there is no satisfactory plan for repatriation the MTC will inform the ODN manager / clinical lead to request further escalation.

Appendix 1 – Abbreviations

CCG	Clinical Commissioning Group
LEH	Local Emergency Hospital
MDT	Multi-Disciplinary Team
MTC	Major Trauma Centre
ODN	Operational Delivery Network
SPOC	Single Point of Contact
STP	Sustainability and Transformation Partnership
TU	Trauma Unit
TUs	Trauma Units

Appendix 2 – Hospital SPOC and Contact details

Hospital	SPOC and Contacts	Trauma Lead	Escalation
UHSussex - RSCH MTC	<p>SPOC uhsussex.major.trauma@nhs.net</p> <p>MTC Clinical Lead – Duncan Bootland d.bootland@nhs.net</p> <p>COO – Ben Stevens benstevens@nhs.net Ben Stevens, COO</p>	Duncan Bootland MTC Clinical Lead	
UHSussex - Worthing	<p>SPOC wshnt.westernsussex.majortraumarepatriation@nhs.net</p> <p>TU Clinical Lead – Dan Negrulescu daniel.negrulescu1@nhs.net</p> <p>Interim COO – Gethin Hughes gethin.hughes2@nhs.net Gethin Hughes, Interim COO</p>	Dan Negrulescu Worthing TU Clinical Lead	
UHSussex - St Richards, Chichester	<p>SPOC wshnt.westernsussex.majortraumarepatriation@nhs.net</p> <p>TU Clinical Leads – Liz Cheshire & David Neal Elizabeth.Cheshire@wsht.nhs.uk davidmneal@nhs.net</p> <p>Interim COO – Gethin Hughes gethin.hughes2@nhs.net Gethin Hughes, Interim COO</p>	Elizabeth Cheshire & David Neal St Richards TU Clinical Leads	
ESHT - Conquest & Eastbourne	<p>SPOC esht.majortraumarepatriation@nhs.net</p> <p>TU Clinical Lead – Paul Cornelius p.cornelius@nhs.net</p> <p>COO – Tara Argent Tara.argent@nhs.net</p>	Paul Cornelius Conquest TU Clinical Lead	
Sussex Trauma Network	<p>Network E-mail uhsussex.sussestrauma@nhs.net</p> <p>Clinical Director – Pete Westhead peter.westhead@nhs.net</p> <p>Network Manager – Erin Burns Erin.burns@nhs.net</p>	Peter Westhead, STN Clinical Director	

Appendix 3 – Duties of the SPOCs

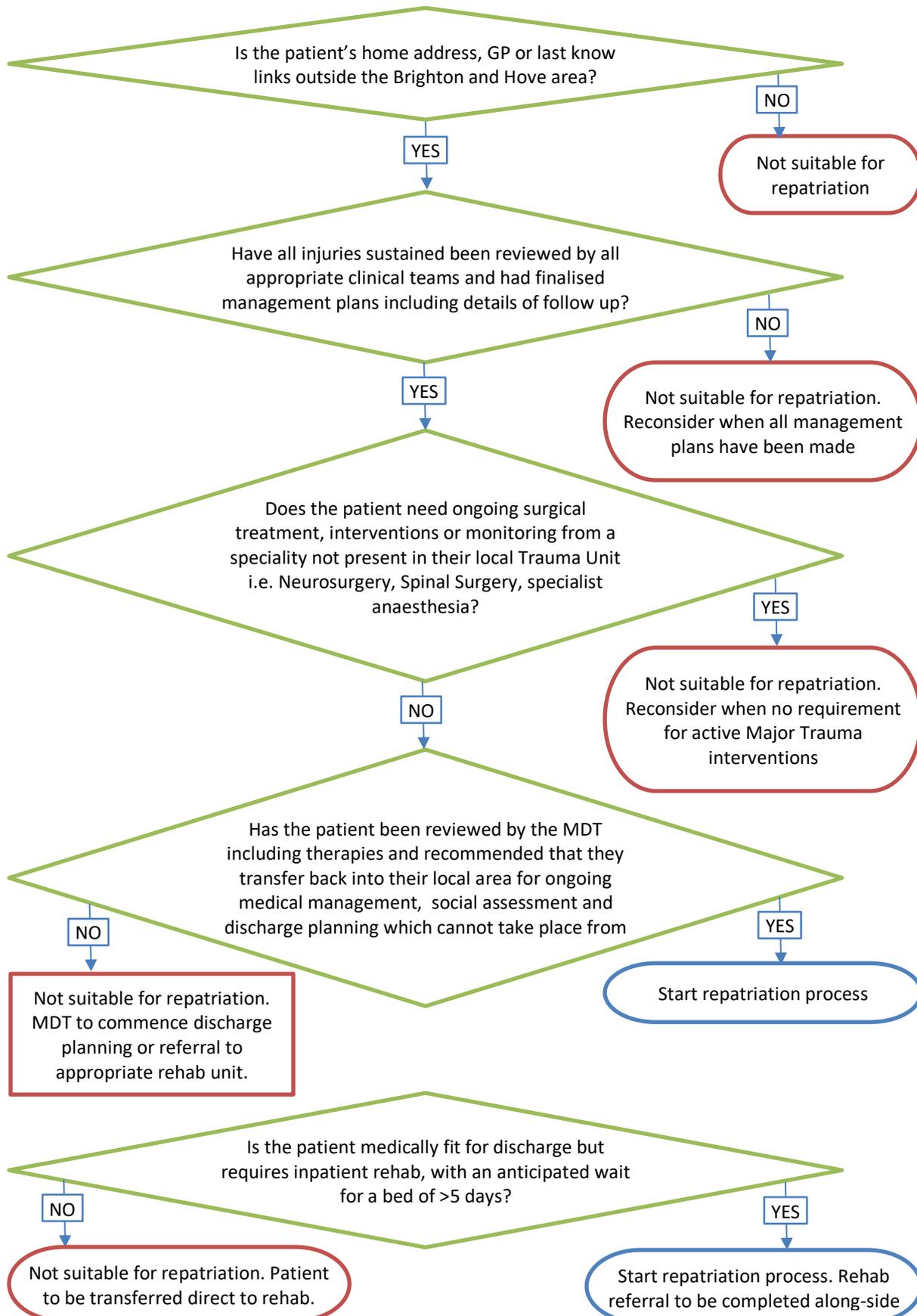
MTC SPOC

- Identify local hospital of patient after admission to MTC – within 48 hours
- Inform SPOC of local hospital (if it is not the MTC) of the admission and potential later repatriation – **First notification** - within 48 hours
- Determine in collaboration with consultant and MDT whether and when the patient is suitable for repatriation
- Complete Repatriation Form and e-mail it and the Rehabilitation Prescription to SPOC of local hospital – **Formal referral**
- Escalate if repatriation information is not received from local hospital within the required timeframes – on a daily basis until conclusion
- Inform MTC clinical staff of who at local hospital to do handover with

TU SPOC

- Receive and read e-mails from MTC - **First notification** and **Formal referral**
- After **First notification** start to identify appropriate specialty and receiving consultant
- Ensure bed management team are informed.
- After **Formal referral** is received, finalise identification of appropriate specialty and receiving consultant
- Inform MTC SPOC of speciality and receiving consultant with contact details within 24 hours of receipt of **Formal referral**
- Inform MTC SPOC of receiving ward within 24 hours of receipt of **Formal referral**
- Escalate if repatriation decisions are not made within the required timeframes – on a daily basis until conclusion

Appendix 4: Process for identification of patient suitable for repatriation: Major Trauma



Appendix 5 – Repatriation Form

Notification of Repatriation from Brighton Major Trauma Centre

Demographics			
Patient:		DOB:	
Hospital No:		NHS No:	
Postcode:		GP:	
Current clinical team			
Consultant:			
Speciality			
Location of patient			
Injury	Management	Follow up details	
Reason for admission			
Reason for repatriation and current medical needs			
Current therapy input and ongoing needs			
Rehab prescription attached: Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Rehab referral already made: Yes <input type="checkbox"/>		No <input type="checkbox"/>	
To whom:			
Infection: Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details:	
Tracheostomy: Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details:	
Specialised: Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details:	
	Date	Time	
Patient identified suitable for repatriation			
Repatriation form sent			
Consultant allocated			
Name of consultant			
Speciality			

Appendix 6 – Timeframes and Escalation

Day	Situation	Communication	Who
0	Patient identified as ready to transfer to receiving TU	Repatriation notification sent to TU SPOC	MTC SPOC
1	Bed, specialty and named Consultant identified at receiving TU	MTC informed of location of bed and name of consultant	TU SPOC
2	Transfer of care happens	Medical, nursing	MTC and TU
3	Bed has not been identified 24-hour delay in repatriation.	MTC SPOC/ Site team to communicate with SPOC/ Site at TU to expedite transfer of care.	MTC SPOC escalates to: <ul style="list-style-type: none"> • MTC Head of Site Operations • Listed point of escalation • Trauma Network Manager
4	Bed has still not been identified 48-hour delay in repatriation	MTC Chief Operating Officer/Chief Executive to communicate with equivalent at receiving Trust.	MTC SPOC escalates to: <ul style="list-style-type: none"> • CEO/COO • CCG
5	Bed has still not been identified 72-hour delay in repatriation	Patient repatriated hospital. If not, then daily MTC CEO/COO to TU CEO/COO conversations.	MTC SPOC escalates to: <ul style="list-style-type: none"> • Trauma Network Director • MTC Clinical Director

Appendix 7 – Repatriation Algorithm

