Trust Policy		Worcestershire Acute Hospitals NHS Trust

Urgent and Emergency Care Referral Policy

Department / Service:	Trust Policy / Trustwide
Originator:	Dr David Raven Dr Jasper Trevelyan Mr Stephen Goodyear Mr Angus Thomson
Accountable Director:	Dr Christine Blanshard Mr Paul Brennan
Approved by:	Dr Christine Blanshard (Chief Medical Officer)
Date of approval:	22nd November 2022
First Revision Due: **This is the most current document and should be used until a revised version is in place**	22nd November 2025
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All Directorates
Target staff categories	All Clinical, Nursing and Operational Teams

Policy Overview:
This policy aims to standardise practice for the referral pathways of patients presenting to the Emergency Department who subsequently need speciality review or admission. This policy establishes a set of measurable standards and behaviours that are to be expected from all teams caring for patients who enter the emergency care pathway.

Key amendments to this document

Date	Amendment	Approved by:
November 2022	New policy approved	CMO meeting, Executive huddlle

Contents page:

Appendices

Supporting Documents

Supporting Document 1	Equality Impact Assessment
Supporting Document 2	Financial Risk Assessment

1. Introduction

The Emergency Department provides a fully comprehensive 24/7 service to manage life and limb threatening emergencies, and maintain patient safety and quality of care. This policy has been created to promote the shared ownership of risk across the organisation to eliminate Emergency Department overcrowding and ambulance offload delays which otherwise lead to avoidable patient harm.

In simple terms, if the ED is full, patients on ambulances can't be brought into the department. When this happens, that ambulance is unable to respond to emergencies in the community. Putting patients first means that all members of speciality teams providing an on-call or urgent care service, are responsible for timely review of patients by moving them out of the ED as quickly as possible, and also by providing alternative locations for assessment (e.g. SAU, AMU, GAU, PAU, AEC).

This policy sets out clear expectations and behaviours for all teams working within the Urgent and Emergency care footprint in order to manage referrals from the ED and other healthcare providers, in a timely fashion. These expectations exist to protect patient safety.

The role of the ED is to provide life-saving emergency care. To be able to fulfil this role inpatient speciality teams must take ownership and responsibility for patients referred to them, as quickly as possible. Each Division should have systems in place to allow patients to be moved in a timely fashion to their own areas for review by their clinical teams. If such areas cannot support this demand, it is expected that that Divisional teams develop plans to support the continued delivery of these organisational standards.

2. Scope of this document

This policy is a Trust-wide document that impacts on all clinical specialities.

It provides a clear outline for the procedural requirements for referral from the Emergency Department and Community services to:

- Acute Medicine / General Medicine On-Call Teams
- General Surgical Team
- Urology Team
- Vascular Surgery Team
- Trauma & Orthopaedic Team
- Ear, Nose and Throat Team
- Oral Maxillofacial Surgery Team
- Obstetric and Gynaecology Team
- Paediatric Team
- Acute Oncology Team
- Critical Care Team

- Stroke Team
- Haematology Team

3. Definitions

ED	Emergency Department – department that manages life and limb threatening emergencies
GP	General Practitioner – Specialist in Primary Care
SAU	Surgical Assessment Unit – Area to receive all referrals to surgical specialities from Primary Care, West Midlands Ambulance Service and the Emergency Department, excluding rapid access pathways.
AMU	Acute Medical Unit - Area to receive all referrals to surgical specialities from Primary Care, West Midlands Ambulance Service and the Emergency Department, excluding stroke, primary coronary intervention and select specialist pathways as outlined in this document. Maximum length of stay 24 hours
SDEC	Same Day Emergency Care – Managing a patient episode in less than 24 hours through rapid access to diagnostics and facilitated discharge through hot clinics or alternative access points
AEC	Ambulatory Emergency Care – Area in which medical patients who do not need to be on a bed are managed
GAU	Gynaecology Assessment Unit – Area where women with gynaecological or early pregnancy related problems can be managed
ITU	Intensive Treatment Unit - Area providing care to critically unwell or injured patients for whom ward-based care is unsuitable
PCU	Primary Care Unit – Area in close proximity to the ED where GPs and allied professionals manage a primary care stream for patients who self-present to the ED
MSSU	Medical Short Stay Unit – Area receiving patients from AMU that can be managed on pathways shorter than 72 hours

4. Responsibility and Duties

It is the responsibility of all on-call teams to provide a point of contact 24:7 to the Emergency Department and GP / out-of-hours services for all referrals to speciality teams in the hospital.

If a member of the on-call team is needed to attend theatre or an emergency that is likely to take some time to resolve, it is the responsibility of that team member to find someone to carry their bleep (e.g. Nurse Practitioner, Junior member of staff) and receive referrals from the Urgent and Emergency pathway.

GP Referrals

1. All patients who attend the Emergency Department with a GP Referral letter will be sent to the appropriate Assessment Unit. Patients who walk in with a GP Letter will not be registered or undergo any clinical assessment in the ED. If a patient looks extremely unwell on arrival, the ED Team will complete a set of observations and if the NEWS2 score is 5 or more, will initiate treatment in the ED and call the speciality team for immediate review.

- Surgical Specialities → Surgical Assessment Unit (SAU)
- Medical Specialities → Acute Medical Unit (AMU) / SDEC
- Children → Paediatric Assessment Unit (PAU) / Riverbank
- Gynaecology → Gynaecology Assessment Unit (GAU)
- Pregnancy >20 weeks → Maternity

2. Ambulance patients that have been referred from a GP will be signposted directly to the receiving assessment area by WMAS, unless they require immediate treatment in the Resuscitation Room

3. Clinicians or Advanced Clinical / Nurse Practitioners should only advise GPs to send patients to the ED if the patient is unstable, has diarrhoea and vomiting, cardiac sounding chest pain, or is FAST Positive for Stroke. The accepting clinician must inform the ED Nurse in Charge and provide patient details and a clinical rationale, and provide a contact number for the clinician who will assess the patient when they arrive.

4. If a patient attends with a “Dear Dr” letter from a GP or allied Community Practitioner, the ED team will decide which assessment unit should receive the patient and direct the patient to that clinical area.

5. If a GP has tried to contact a speciality team but has been unsuccessful and has therefore sent the patient to the ED, the patient will be signposted on arrival to the relevant assessment unit.

6. If a patient arrives in the ED following GP referral but has either deteriorated en route to hospital, or the ED team have clinical concerns about the stability of the patient that places a risk to life, the ED team will initiate treatment and contact the relevant Registrar for the receiving Speciality. The Registrar will be expected to attend as soon as possible. If the patient continues to deteriorate, the Registrar will be contacted again and if review isn’t possible within the next 15 minutes, the On-Call Consultant will be contacted.

Internal Referrals from the Emergency Department

1. Patients should be referred to the most appropriate speciality according to their needs, following clinical assessment by the Emergency Department team. It will be to the discretion of the ED team about the level of investigations that are performed in the ED.

2. Patients will be discussed with a senior ED clinician and then referred to the Registrar On Call, unless alternative arrangements to call another member of the on call team exist. The Registrar cannot refuse the referral, but if they feel that the referral is inappropriate, they should discuss this with their Consultant. The Consultant should then discuss this with the senior doctor on duty in the department.

3. Speciality teams should not decline referrals pending the results of investigations, or require that certain investigations are completed before accepting a referral, (with the exception of -

blood sugar, ECG, urine pregnancy test, lactate as clinically appropriate). Assessment units should have equal priority to the patients in the ED in terms of timeliness to imaging.

4. Patients will be transferred to the appropriate assessment unit for clerking as soon as possible after the referral, and after appropriate care has been provided (e.g. fluids resuscitation, analgesia, ED-based interventions, antibiotics etc…). Transfer to assessment units will not be delayed to allow clerking.

5. Patients will only be clerked in the ED if the assessment units are full and can no longer accommodate patients, or if it has been agreed that a patient is suitable for direct admission to a ward, theatre or ITU.

6. If a patient is unstable and in Resus, or will be moved into Resus, a senior ED clinician will contact the appropriate Speciality Registrar and request their attendance in the ED. Patients being admitted to ITU must have a designated parent speciality for ongoing care. If the Registrar is unable to attend and there are clinical concerns about the patient deteriorating, the On-Call Consultant for that speciality should be contacted.

7. Patients referred to Speciality teams for specific interventions (e.g. endoscopy for Massive Upper GI Haemorrhage, PCI for ST-Elevation Myocardial Infarction), must not be brought back to the Emergency Department once they leave for that intervention. As such, they should be prioritised by the clinical site team to go into the next available assessment unit or ward bed after their intervention.

8. Referrals from the Primary Care Unit (PCU) should be treated like a referral from a GP in the community, as per the Standard Operating Procedure – there should be no expectations for any radiology or pathology requests to be performed prior to moving the patient to an assessment area.

Referrals Between Specialities and Requests for Inter-Hospital Transfers/Advice

1. If a patient has been referred to a speciality and after review it is felt that the patient warrants an assessment from another speciality, it is the responsibility of the initial speciality team to make that referral. This subsequent review should happen as soon as possible, with the second speciality either agreeing to review the patient on the initial assessment unit, or accepting them for transfer to their own assessment unit.

2. Any patient who attends ED within 7 days of discharge from a speciality with a similar clinical problem will have an initial rapid assessment by a clinician in the ED and will be referred back to a senior member of the speciality team, and sent to the appropriate assessment unit for review.

3. If the ED team do not feel that there is an emergency indication for immediate transfer to another centre (e.g. hyperacute trauma transfer; significant intracranial bleed with midline shift; critically ill patient requiring stabilisation), the speciality team will liaise with other centres using the appropriate referral pathway (e.g. referapatient, NORSe)

4. Transfers to assessment units should not be delayed pending the outcome of the tertiary referral.

Assessment Unit Activity

1. Ambulatory, stable patients should be managed through an appropriate non-bedded area aligned to the assessment unit and attempts made to manage as many people as possible through SDEC (Same Day Emergency Care Pathways), unless it is inappropriate to do so.

2. All assessment units should have escalation plans to absorb referrals from GPs and the Emergency Department, to include:

    a. Moving patients that are likely to go home that day into seated areas, irrespective of length of stay
    b. Delaying the review of GP-referred patients until a more appropriate time by offering scheduled emergency access appointments (e.g. next day assessment unit clinic)
    c. Provision of supervised chaired areas 24:7 to accommodate late arrivals
    d. Continuous flow models (e.g. “Next Patient”)

3. **If an ambulatory patient** is seen in an assessment unit by one speciality but that speciality feels that another speciality would be more appropriate and a referral has been made, the patient should be moved to the appropriate waiting area on the assessment unit of the second speciality.

4. **If a patient requires a trolley or bed** and has been seen by one speciality but that speciality feels that another speciality would be more appropriate and a referral has been made, the site team and Matron in charge of the second speciality should be informed. If the patient can not be moved to the other assessment unit within 1 hour, the second speciality should come and review the patient where they are currently located. The site team should prioritise the move of the patient to the appropriate assessment area.

For The Acute Medical Unit and Medical Short Stay Unit

5. Patients must not stay on AMU for more than 24 hours, or Medical Short Stay (MSSU) for more than 72 hours. The Acute Medicine team will decide which patients can be moved from AMU to MSSU, and which patients can be discharged directly from AMU. Other moves out of AMU will be managed by the clinical site team in accordance with the Continuous Flow Model

6. The Acute Medicine team will determine which patients on AMU and MSSU will likely need episodes of care longer than 72 hours and refer to the relevant speciality team. Any provision of daily speciality in-reach should be prioritised to AMU and MSSU rather than to the ED. This ensures that patients are more likely to receive appropriate specialist care early on in their journey.

7. Once referred to a speciality, the patient will move as quickly as possible to the appropriate speciality ward, ideally the same day. If a speciality patient remains on AMU, the speciality

team will aim to provide daily specialist input and review until that patient is moved to the ward.

8. If a patient on AMU or MSSU has been referred to a speciality and that team have seen the patient they feel that another team should look after that patient, it is the responsibility of the speciality team to discuss this with the Consultant on AMU and document their assessment in the medical records.

Ward-Based Admissions and Referrals from Outpatients

Once a decision has been made to admit a patient from the community or an outpatient clinic, the preferred route of entry should be via the relevant Assessment Unit. This ensures that the clinical site team maintain operational oversight of all the risks in the system, and can balance the urgency of admitting that patient directly onto a ward against the current demands in the system.

For example, there may be a patient in need of a specialist bed in the community, but an urgent need to move patients from AMU to wards, to facilitate the offloading of patients from the back of ambulances. This is in turn would free those ambulances to attend unanswered Category 1 and 2 calls in the community. In such circumstances, the continuous flow model is needed to respond to the ambulance offload risk, and the patient in the community should be asked to attend through either the assessment unit or SDEC area and wait for admission

Attempts will be made by the clinical site team to accommodate early transfer to the relevant specialist ward, but this should not compromise safety for other patients in the system.

Admitting patients via assessment units rather than wards ensures that the assessment units don't become bedded down, thus losing their function. The exceptions to this include:

- Admission to CCU/Cardiology for patients following PCI, or with unstable arrhythmias in need of pacemaker/ICD insertion or closely observed cardiac monitoring;
- Admission to Gastroenterology ward for biological agents for inflammatory bowel disease;
- Admission to Hyper-acute Stroke Unit (HASU) for patients with acute ischaemic or haemorrhagic stroke
- Admission to Acute Respiratory Unit (ARU) for patients in need of non-invasive ventilation
- Admission to designated area or sideroom in light of specific infection control concerns
- Admission to designated fast-track neck of femur pathway beds
- Admission to Oncology ward for vulnerable patients whereby a sideroom is required (e.g. neutropaenic sepsis)

There will be occasions when Speciality teams are concerned that a patient requires Resuscitation Room-level care. In such circumstances, the Speciality team should contact the Nurse in Charge of the ED and provide them with patient details, the reasons why they feel Resus-Room care is needed, and the name and contact details for the member of their team that will attend to the patient when they arrive.

Operational Oversight and Site-Based Management

Urgent and Emergency Care Pathways require a high level of oversight by all Divisional teams and the Site Management Team. Patients should have similar rights of access to diagnostics such as imaging or pathology, irrespective of where they enter the pathway, according to their clinical need.

The Clinical Site Team should also ensure that patients in SDEC / Ambulatory areas have equal priority to beds / assessment unit spaces as other patients in the pathway. There will be an expectation that the site team liaise with the relevant Matrons for Assessment Units if an agreement has been reached to transfer one patient from one assessment unit to another.

5. Compliance and Shared Learning

- Each divisional team will nominate an Urgent Care Lead to attend the Acute Front-door meeting and discuss performance against this policy and raise challenge to any obstacles or additional service needs that lead to its non-delivery
- The Urgent Care division will provide a forum through which concerns and challenges regarding the policy and specific patient incidents or events can be raised from other divisions.
- Consistent issues with the policy and it's non-delivery will be escalated via the CMO group and discussed at Divisional Director level.
- Consistent non-compliance of clinicians with this policy will be dealt with via the Clinical Director, Divisional Director, and escalated to the CMO if non-delivery of these behaviours persists.

6. Implementation

6.1 Plan for implementation

- Initial sign off by CMO and Divisional Directors through CMO Forum
- Presentation to TME Committee
- Uploading of policy onto Key Documents webpage
- Integration of policy into all doctors' induction for all new rotations and new starters
- Integration of policy into ED and Assessment unit inductions for all new Nursing staff and allied health professionals

6.2 Dissemination

Distribution across all directorates and sharing with ICB

6.3 Training and awareness

The policy will be incorporated into all doctors' induction programmes across all directorates. It will be accessible via the Key Documents webpage.

7. Monitoring and compliance

All staff are responsible for complying with this policy and ensuring that they take appropriate action to monitor for non-compliance.

Local audit, compliance meetings between Divisional Leads and review of incidents will be used to monitor process of implementation and how this is sustained.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
All Document	Procedural steps within this policy	Audit and Incident Reporting	Initially at 1 month, 3 months then 6 monthly	Chief Medical Office and Chief Operating Officer	Trust Management Executive, CMO Divisional Leads Meeting, Trust Board	1mth, 3mths, 6mthly

8. Policy Review

Review by Chief Medical Officer and Chief Operating Office every 3 years

9. References

References: Code:

Royal College of Emergency Medicine	
ECIST Rapid Improvement Guide	
NHS England Priorities with Acute Hospitals	
CQC Patient First (October 2020)	

10. Background

10.1 Equality requirements

No risks identified

10.2 Financial risk assessment

N/A

10.3 Consultation

Consultation took place between end October 2022 – 21/11/22

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
CMO
COO
All Divisional Directors
Clinical Directors of Relevant Speciality Teams

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Divisional Directors and Clinical Directors
CMO
COO

10.4 Approval Process

This document will be approved at CGG, and is in line with the trust policy.

10.5 Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:

Supporting Document 1 – Equality Impact Assessment form

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust		Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust	☒	Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Christine Blanshard**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	David Raven	**Divisional Director Urgent Care**	**David.raven1@nhs.net**
Date assessment completed	**22/11/22**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Urgent and Emergency Care Referral Policy			
What is the aim, purpose and/or intended outcomes of this Activity?	The policy aims to standardise practice of referral pathways for patients presenting to ED or alternative access points who subsequently require admission. The policy puts into place a set of measurable standards			
Who will be affected by the development & implementation of this activity?	x❑ x❑ ❑ ❑	Service User Patient Carers Visitors	x❑ ❑ ❑ ❑	Staff Communities Other _____
Is this:	x❑ Review of an existing activity			

	x❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	ECIST and CQC Patient First recommendations; Walsall-based standard operational policy; review of demands of acute take and service reconfigurations to support more flexible assessment unit capacity
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Policy introduced at CMO meeting with Divisional Directors and amended through separate version controls of initial draft in light of feedback from Clinical Directors of different speciality teams
Summary of relevant findings	This is essential in defining how the urgent and emergency care referral pathway is supported by all teams and divisions responsible for providing an acute on call service. Behaviours and expectations should be embedded in local induction, Trust induction and possibly form part of the job planning process

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	X			Standardised expectations for what patients can receive when they access urgent and emergency care.
Disability	X			As above
Gender Reassignment	X			As above
Marriage & Civil Partnerships	X			As above
Pregnancy & Maternity	X			As above
Race including Traveling Communities	X			As above
Religion & Belief	x			As above

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sex	X			As above
Sexual Orientation	X			As above
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)	X			As above
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	X			As above

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	N/A	*N/A.*	**N/A**	**N/A**
How will you monitor these actions?	**N/A**			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**N/A**			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	22/11/22
Comments:	N/A
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	N/A
2.	Does the implementation of this document require additional revenue	N/A
3.	Does the implementation of this document require additional manpower	N/A
4.	Does the implementation of this document release any manpower costs through a change in practice	N/A
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	N/A
	Other comments:	N/A to policy

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval