LONDON INTER-HOSPITAL TRANSFER POLICY

FOR

NON-ELECTIVE CARDIOLOGY AND CARDIAC SURGERY

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The document may be subject to review prior to the stated review date, if there are any significant local, regional or national changes to service delivery or standards.
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1.0 INTRODUCTION

A key aim of national and London strategies for cardiovascular services has been to improve patient pathways for non-elective cardiology and cardiac surgery patients who are transferred across hospitals for treatment\(^1\). Recommendations have included the use of electronic transfer systems, implementation of clear referral protocols and processes and the setting and monitoring of waiting time targets for the relevant parts of the non-elective pathways.

Commissioners in London have addressed these issues through mandating the use of an electronic inter-hospital referral system and setting waiting time targets (by days in hospital) across the patient pathway. This document is a policy which governs all operational aspects of transferring cardiology and cardiac surgery patients between hospitals in London and is aimed at medical, nursing, administrative and management staff. It also details how providers should use the IHT electronic referral system for the transfer of these patients; it should be used in conjunction with the quality standards of the Quality and Safety Programme Inter-hospital transfers\(^3\).

This policy has the following aims:

1. To outline minimum standards for the referral, transfer, return and discharge of inter-hospital transfer patients requiring non-elective cardiology or cardiac surgery
2. To outline the roles and responsibilities of the IHT co-ordinators and managers
3. To ensure equity of access
4. To minimize unnecessary delays

This policy should result in the following benefits:

1. Improved communication across providers
2. Improved patient experience
3. A more efficient use of NHS resources

The table in Appendix 1 sets out the lead roles of each London Trust in relation to this policy.

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\(^1\) [http://www.improvement.nhs.uk/heart/Portals/0/IHT/web_referral_system_IHT_sep06_hip016.pdf](http://www.improvement.nhs.uk/heart/Portals/0/IHT/web_referral_system_IHT_sep06_hip016.pdf)


\(^3\) Quality and Safety Programme inter-hospital transfers – Adults (February 2013), London Health Programmes
2.0 BACKGROUND

The London Cardiovascular Project (LCVP) brought together Cardiovascular clinicians from across London to propose best practice models of care for Cardiac Surgery, Cardiology and Vascular Surgery. These models were subsequently commissioned and implemented across London. The Model of Care for Cardiology and Cardiac Surgery required the mandatory use of an inter-hospital transfer electronic referral system (IHT system) for all patients needing to be transferred for urgent, non-elective cardiac surgery.

The LCVP highlighted that up to 40% of cardiac surgery patients across London were on a non-elective pathway (based on 2009 data). There are also a considerable number of other patients who are transferred across secondary and tertiary providers in order to undergo cardiology procedures. There is therefore a clear need for consistent processes for these patients. Reducing excessive waits partly due to bed management at the receiving centres for inpatient cardiac procedures (particularly cardiac surgery) continues to be a key area of focus at a local and national level. It was agreed that the total pathway length for cardiac surgery is a maximum of 21 days from admission to discharge.

During the review it was highlighted that the various IHT systems across London were not fit for purpose and required an upgrade. There existed in places a two-tier referral system with some referrals sent via fax and others using the inter-hospital transfer electronic referral system (IHT system). Furthermore, cross-sector referrals were not being captured and reported. The system upgrade would resolve these issues and would also enable a single London-wide platform for collecting the key information required to monitor and track all inter-hospital transfers across London.

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3.0 DEFINITIONS

For the purposes of this policy, the following definitions apply:

**Referring hospital**

A hospital or ward (which may be part of a multi-site NHS trust), which makes referrals for non-elective cardiology, cardiac catheterisation, electrophysiology or cardiac surgery procedures to a receiving centre. They will also accept patients returned by the receiving centre.

**Receiving centre**

A hospital or ward (which may be part of a multi-site NHS trust), that undertakes elective and non-elective cardiology, cardiac catheterisation, electrophysiology or cardiac surgery procedures, and which receives referrals from referring hospitals for this purpose. Where relevant they will return patients to the referring hospital.

*Receiving centres Internal Referrals:* A hospital that is a receiving centre should use the IHT electronic referral system to refer patients internally for cardiac surgery. For example, patients admitted directly to Cardiology for an angiography should be referred using the electronic system for cardiac surgery, even though the patient is being referred within the same hospital. This will allow direct comparison of internal and external referrals.
4.0 PATHWAY FOR ALL CARDIOLOGY AND CARDIAC SURGERY PATIENTS

4.1 Acute Coronary Syndrome (ACS)

The ACS pathway is sub-classified into the ST elevation MI (STEMI) pathway and the non-ST elevation MI (non-STEMI) pathway. This section deals with the NSTEMI section of the pathway only. NICE recommends that patients with ACS may require diagnostic cardiac catheterisation (angiography) to assess the coronary anatomy and review the need for referral for an interventional procedure. Once diagnostic angiography has been performed a clinical decision will be made (usually on the same day) for a number of treatment options, which can include;

a) No therapy required
b) Further invasive investigation required and to be undertaken at the referring centre
c) Percutaneous Coronary Intervention (PCI) – this can be done as a direct follow on procedure to the coronary angiogram (in those sites that have the facility to do so)
d) Coronary artery bypass graft surgery (CABG) and/or cardiac valve surgery – performed at the receiving Centre
e) Other surgical procedures such as Transcatheter Aortic Valve Implantation (TAVI) – performed at the receiving centre
f) Medical therapy

London providers have agreed specific standards for NSTEMI patients depending on the risk of the patient. High-risk patients should be transferred directly from A&E to a NSTEACS centre that can provide angiography (with PCI if required) within 24 hours of presentation. These patients are excluded from this policy and any transfer of these patients between sites for these purposes should NOT be recorded on the IHT electronic referral system.

Patients with intermediate or lower risk NSTEACS should be able to access these interventions within the 96 hours as specified by NICE. Where a site does not have access to this facility, a referral is made via the IHT electronic referral system to the receiving centre for this.

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Where a site does have access to this facility and the angiography results indicate that surgery is required, a referral is made via the IHT electronic referral system to the receiving centre for this.

4.2 Non-Elective Electrophysiology (EP)

A cohort of patients with arrhythmias may require referral to a receiving centre for:

a) Assessment with a view to further invasive treatment e.g. ablation, device implant or

b) In some cases the decision can be made at the point of referral that an interventional electrophysiology treatment plan can be instigated. Thus the referral is for the procedure rather than assessment.

Referral is made in the same way for any IHT patients, via the IHT electronic referral system. Once all of the clinical information has been received then an Electrophysiology consultant will accept the case and a date for the procedure can be offered. Note: emergency arrhythmia calls, which should result in immediate transfer are NOT required to be on the IHT system. Referrals back to the referring hospital may be logged in retrospect however.
5.0 EXCLUSION CRITERIA

This policy excludes the following groups of emergency/high risk patients:

- PPCI/PAMI/ST-Elevation Myocardial Infarction (STEMI), and high-risk NSTEACS (Non-ST-Elevation Acute Coronary Syndrome) patients who are transferred to the receiving centre along the Heart Attack Centre pathways. The best practice model of care for these patients is outlined in section 4.0.

- ‘High risk ACS Cases’ i.e. those patients with unstable disease requiring intervention within a very short time period – see new ACS guidelines:
  - Ongoing/recc CP Plus
  - Either
    - ECG change
    - OR Trop-T rise >0.1
    - OR Haemodynamic instability/electrical instability

- Emergency Arrhythmia calls:
  - Complete Heart Block
  - AICD with multiple discharges
  - Ventricular Tachycardia requiring immediate transfer

- Patients that are deemed clinically fit to be discharged home from the DGH and admitted to the receiving centre at a future date, on an elective pathway.

- Residents and individuals registered with London GPs that elect to have their interventional procedure outside of London.

- Residents and individuals registered with London GPs that elect to receive healthcare outside of the NHS.
6.0  THE IHT ELECTRONIC REFERRAL SYSTEM

The use of the IHT electronic referral system is mandatory and is the mechanism for recording and monitoring activity as part of the LCVP for all referring and receiving units in London. The IHT electronic referral system in place in London is the Telelogic Inter-Hospital Transfer System.

It records the information required to performance monitor and manage the length of stay of patients, patient pathway and is used to support service improvement.

6.1  Data Sharing Agreement

For an effective and efficient system and improved patient experience, there is a need for all stakeholders to be transparent and open. Hence, it is paramount that the NHS Confidentiality Code of Practice\(^6\) is strictly adhered to as it promotes completeness for audit and reporting purposes and standardisation of data.

6.2  Users

It is the responsibility of each hospital in London to ensure that staff are adequately trained to understand the process and use of the system. It is the responsibility of designated managerial and clinical leads at each Trust to determine the most appropriate individual or group of individuals who input clinical data and make referrals using the IHT system and to nominate an IHT co-ordinator for the Trust.

The local coordinator must arrange for training of new staff during their induction; ensure that the skills are kept up to date; and that staff are aware of any new functions or changes to any aspect of the IHT electronic referral system.

The bed manager will receive alerts and messages related to patients transferring on the IHT system.

The designated managerial and clinical leads are responsible for monitoring the usage of the system for all appropriate referrals and monitoring performance of the Trust using the reporting function in the inter-hospital transfer electronic referral system (IHT system).

The table in Appendix 1 contains the key IHT contacts in each London trust and their responsibilities.

<table>
<thead>
<tr>
<th>User</th>
<th>Usage of system</th>
<th>Training point</th>
</tr>
</thead>
</table>
| 1. Doctors/ List coordinators (registrars/SHOs) | ● Input of clinical information  
❖ Transfer of patients | Hospital induction                                     |
| 2. Nurses/ secretaries              | ● User administration (user names and passwords)  
❖ Checking patients are discharged | Trust level training                                  |
| 3. Bed manager                     | ● Checking for upcoming referrals/ monitoring referral to transfer length of stay | Bed managers in both cardiology and cardiac surgery |
| 4. Service manager/ General manager| ● Performance management  
❖ Pathway monitoring and reporting  
❖ Downloads of patient level data | Special password                                     |

7.0 WAITING TIMES STANDARDS AND LENGTH OF STAY
The waiting time standards set out in this policy have been informed by pan-London and local agreements. The purpose of these standards is to ensure that patients within London have equal access to treatment and care across the whole of their in-patient pathway. Furthermore, by using standards that have been agreed as part of the LCVP, this policy aims to ensure that patients in all parts of London receive their treatment within similar time frames.

The system automatically calculates how long a patient has waited and system users are alerted on the inpatient waiting list page when a patient is about to ‘breach’ the waiting time.

All referrals must be made in real time, length of stay is based on input times.

The following time points will be used to measure the pathway from first admission to final discharge:

1. Admission
2. Referral
3. Transfer
4. Procedure
5. Discharge from receiving centre
6. Return requested
7. Returned
8. Final discharge

There will be occasions where a patient’s clinical condition is such that it may not be possible to deliver treatment within the time frames stated above. This may constitute a ‘Clinical Exception.’ For cardiac surgery, these pathways will have already been accounted for in the (10%) tolerance.

Pathways that exceed the waiting times/length of stay for non-clinical reasons will be counted as ‘breaches’ to the standards.

7.1 Non-Elective Cardiology
At least 90% of non-elective cardiology patients should be transferred and treated within the following time frames:

**Admission to Angiography +/- PCI**

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission to referral</td>
<td>24 hours (1 day)</td>
</tr>
<tr>
<td>Referral to transfer</td>
<td>48 hours (2 days)</td>
</tr>
<tr>
<td>Transfer to procedure</td>
<td>24 hours (1 day)</td>
</tr>
<tr>
<td>Procedure to discharge</td>
<td>24 hours (1 day)</td>
</tr>
<tr>
<td>Total length of pathway from admission to discharge</td>
<td>(120 hours) 5 days</td>
</tr>
<tr>
<td>Admission to procedure</td>
<td>96 hours (4 days)</td>
</tr>
<tr>
<td>Aspiration (in line with LCVP model of care)</td>
<td>72 hours (3 Days)</td>
</tr>
</tbody>
</table>

Patients who require further non-elective surgery after their angiography +/- PCI should be referred within 5 days of admission, as per section 7.3.
7.2 Non-Elective Electrophysiology
At least 90% of patients requiring non-elective electrophysiology should be transferred, treated and discharged within the following time frames:

Admission to Electrophysiology procedure

<table>
<thead>
<tr>
<th></th>
<th>Permanent Pacing</th>
<th>EPS/ Ablation</th>
<th>ICD or CRT PPM or CRT ICD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission to Referral (days)</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Referral to transfer (days)</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Transfer to Discharge (days)</td>
<td>2</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Total length of pathway from admission to discharge (days)</td>
<td>8</td>
<td>14</td>
<td>21</td>
</tr>
</tbody>
</table>

Where it is not possible to transfer a patient for electrophysiology within 72 hours of admission, owing to the complex/unclear nature of the patient’s clinical condition, the patients should be transferred within 96 hours of the decision to refer for the EP procedure.

7.3 Non-Elective Cardiac Surgery – Coronary Artery Bypass (CABG)
At least 90% of patients requiring urgent first time CABG should be transferred, treated and discharged within the following time frames (as specified in all commissioned cardiac surgery service specifications):

Admission at referring centre to discharge from surgical receiving centre

| | |
|--------------------------|------------------|------------------|
| Admission to referral for surgery (including admission to angiography +/- PCI within 4 days) | 5 days |
| Referral to transfer to receiving centre | 5 days |
| Transfer to discharge from receiving centre or referring hospital | 11 Days |
| Total length of pathway from admission to discharge (including angiography +/- PCI) | 21 Days |

(For patients admitted directly to the surgical centres and who require urgent first time CABG, their total length of pathway must also be no longer than 21 days)

7.4 Non-Elective Cardiac Surgery – CQUIN 2013/14
There is a national CQUIN which states that patients that are an in-patient (with or without transfer) requiring Cardiac Surgery are to have the procedure within 7 days of acceptance to treat by cardiac surgeon.

All referrals made using the London IHT electronic referral system should be made in line with the waiting time standards outlined above, also available in Appendix 4. All referring and receiving units will be expected to meet these waiting time standards for patients in their care.
8.0 REFERRAL PROCESS

All inter-hospital transfer non-elective cardiology and cardiac surgery referrals must be made using the London IHT electronic referral system. This will facilitate the timely and appropriate management of patient care across the whole of the inpatient pathway.

Referrals should only be made by or under the supervision of staff that are suitably trained.

All relevant fields (following minimum criteria) within the electronic referral form must be completed, with sufficient information in the ‘free text’ sections to allow fully supported clinical decision making.

The minimum data set and mandatory fields are detailed in Appendix 2.

8.1 Investigations and Standard Work up Criteria

All transfer patients must undergo clinical investigations in line with agreed London-wide criteria, in order to ensure consistency in the assessment of patients requiring non-elective care.

The London clinical investigations and standardised work up criteria for the referral of cardiology and cardiac surgery patients are detailed in Appendix 3.

8.2 Availability of Results

A clear, clinical rationale should be given for any investigations requested in addition to the Network-wide standard work up criteria. Such requests must be undertaken as a priority and the results of these investigations made available to the requesting clinician in a timely fashion.

8.3 Referral Acceptance Criteria

In the case of cardiac surgery, information provided by the Referring hospital is reviewed by the cardiothoracic surgeons at the Receiving centre pending review of the patient; the referral may be accepted or rejected for further surgical transfer and review. Confirmation of acceptance should be received from the Receiving centre before transfer arrangements are made. Furthermore, patients and their carers must be kept up to date at all times of their care plan, including an explanation of the decision-making process that determines whether or not the patient will proceed to surgery. The possibility of having their cardiac surgery referral going to a pooled list which may result in a patients going to a receiving centre different from where they were initially referred to if they have not yet been accepted within 5 days of referral, needs to be discussed. Patients and their carers can also exercise patient choice to not be included in the pooled list and potentially have a longer length of stay by going to the centre they were initially referred to.

In the case of cardiology referrals, information provided by the Referring hospital is reviewed by the appropriate clinician at the Receiving centre pending review of the patient; and the referral may be accepted or rejected. Confirmation of acceptance should be received from the Receiving centre before transfer arrangements are made. Furthermore, patients and their carers must be kept up to date at all times of their care plan, including an explanation of the decision-making process that determines their care.
8.4 Multi-disciplinary Team (MDT) Assessment

In line with the National Confidential enquiry into patient outcome and death (NCEPOD) Report into coronary artery bypass surgery, each unit undertaking coronary artery bypass grafting should hold regular pre-operative MDT meetings to discuss appropriate cases. Core membership should be agreed and a regular audit of attendance should be performed.

While MDT meetings should be held on a frequent basis (at least weekly), it is recognised that the volume of CABG and PCI is significant and that to discuss every case at an MDT meeting would be very time consuming. Nevertheless, where cases are not straightforward, either due to the nature of the coronary artery disease, a new condition diagnosed based on the reports or results of tests, or the patient’s co morbid conditions, these cases would benefit from the structured input of a well-constituted multidisciplinary team. To avoid unnecessary delay, MD discussions can still take place outside of the formal weekly meetings.

The role of multidisciplinary case planning and decision-making in the management of patients should be clearly documented in a policy.

8.5 Operator-specific Referrals

Referrals should be made to the department, rather than to a specific, named interventional cardiologist or surgeon. Referrals made to named clinicians should be the exception rather than the rule.

Although referrals may be made in discussion between Referring and Receiving centre operators, all relevant data must be entered onto the web-based transfer system for the referral to be complete and accepted by the Receiving centre. Consideration needs to be given to the waiting times and operator availability.

8.6 Referrals for Non-Elective Cardiac Surgery

If a cardiac surgery referral request is not acted upon (i.e. the patient transferred) within 5 days, the referral will be automatically go onto a pooled list available to the other London receiving hospitals. Patient choice of provider is not applicable for urgent cases. The intended receiving hospital will still have primary responsibility to accept the patient if the patient is not accepted by another hospital, once the patient is on the pooled list.

8.7 Putting Referral Requests on Hold

If a patient has become clinically unfit for the procedure and has remained so for more than 48 hours, the referring team (in coordination with the receiving hospital) may need to consider withdrawing the referral or putting the referral ‘on hold’ on the web-based transfer system, until the patient becomes clinically fit for the procedure. If a referral has been withdrawn and a patient needs to be re-referred, then the normal referral process should be followed.

A request can also be put on hold as a result of patient choice.

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7 Death following a first time, coronary artery bypass graft: The heart of the matter (NCEPOD, 2008)
9.0 TRANSFER PROCESS

9.1 Fitness for Transfer
A patient should be deemed ‘fit for transfer’ when:

*Patients who are clinically fit for the investigation/procedure and in who all work up relevant to the intended procedure has been completed and where receipt of all relevant documentation and other evidence of work up has been confirmed by the receiving centre. Only a receiving clinician has the authority to accept or declare a patient fit for transfer.*

Circumstances which may affect the procedure, including factors affecting preparation and post-intervention aftercare, must be highlighted in the free text section of the electronic referral form. Examples of such circumstances include but are not limited to:

Need for ECG Monitoring - *If patients require ECG monitoring (for non-PCI related reasons) and are deemed by the referring medical team to need ECG monitoring on the day of transfer, this must be highlighted on the referral form in order that appropriate care environments can be identified for these patients.*

Need for other close Nursing and Medical Monitoring - *If a patient requires close nursing and medical monitoring this must be highlighted on the referral form.*

9.2 Changes to Patient Status
It is not uncommon for a patient’s clinical condition to deteriorate while awaiting transfer. This may be due to newly acquired infection, cardiac instability or other clinical reason.

The IHT electronic referral system must be used as a live communication tool. It is the responsibility of the referring hospital to update the IHT electronic referral system with details of any reasons that may result in the patient being no longer fit for transfer on the date or time originally planned. Updates should be communicated to the receiving centre via the IHT system if the patient suddenly becomes unfit for transfer to ensure that the receiving centre is routinely kept appraised of the patient’s transfer status. It is the responsibility of the receiving centre to regularly review the system for any such changes to the patient’s status. The message facility should be used for all communication between referring and receiving centres pertaining to the patient status.

If the patient’s condition has deteriorated for longer than 48 hours and is such that transfer is no longer possible, the patient’s pathway should be put ‘on hold’ on the web-based transfer system by the referring hospital. This will allow the receiving centre to offer the slot to another patient who is clinically fit for transfer and will facilitate effective bed management.

The ‘hold’ should be removed or the referral re-activated on the web-based transfer system by the referring hospital as soon as the patient becomes clinically fit for transfer.
9.3 Capacity Management
The receiving centre must notify the referring hospital at the earliest opportunity of any significant issues relating to bed availability. This should be dealt with according to London quality standard 8.6.

Cancellations on the day are not acceptable except in the event of unforeseen circumstances.

In the case of treat and transfer patients: a patient transferred to the receiving centre for angiography +/- PCI, may return to the referring hospital by the evening of the same day. The bed on the referring ward must therefore be kept for the patient to return post procedure. In the case of a diagnostic angiogram having been performed only, the patient should be able to return to the original ward. If the patient has proceeded to a PCI the referring hospital is responsible for identifying a suitable recovery environment upon return. In most cases this will be the Coronary Care Unit of the referring hospital.

All treat and return patients should be indicated in the referral so that patients can be returned without entering the ‘request-to-return’ process on the IHT system.

9.4 Transfer Arrangements
The patient should be transferred when;

- They are deemed clinically ‘fit for transfer’ (unless critical transfer).
- The receiving centre has confirmed bed availability on the day of transfer.
- Appropriate transport arrangements have been made according to the patient’s condition and in line with Patient Transport Service policy, including an assessment of the needs of an escort.
  - If there is a fully equipped ambulance and paramedic crew it is not essential to send a nurse escort – however arrangements should be made for the handover of the patient and subsequent return of medical equipment.
- Appropriate copies of the patient’s current admission should accompany the patient.
- Where possible, x-rays and electronic images (e.g. angiogram films) should be transferred using web-based systems. If not possible, hard copies should accompany the patient.
- A complete handover should also accompany the patient - a copy of referral form and nursing transfer summary should accompany the patient. Details of the patient’s social needs post discharge (where applicable) and contacts of local intermediate care/social services should also accompany the patient.
- A verbal handover should be made in person or via the telephone if an escort is not in attendance.
- A complete list of the patient’s property and valuables is documented and handed over according to trust policy.
- Unless a critical transfer, all patient journeys should be made within daylight hours and Out of hours transfers should be avoided (unless weekend and bank holiday working is in place at the receiving centre).

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8Quality and Safety Programme inter-hospital transfers – Adults (February 2013), London Health Programmes
Prior to transfer, the referring unit will confirm whether the patient will be referred and discharged from the receiving centre or whether they will be referred to the receiving centre and returning to the referring unit.

10.0 DISCHARGE PLANNING AND PROCESS

10.1 Return and Discharge Planning
Effective discharge planning is a key component of providing an effective and efficient service. In particular, acute hospitals are expected to have developed an initial care plan (within 24 hours of a patient’s admission) that includes an estimated date of transfer or discharge which has been discussed with the patient and their carers.

The referring centres should engage in identifying any social needs, so that coordination with intermediate care and/or social services can be achieved much earlier in the patient’s pathway.

Bed managers in the referring and receiving centres must ensure the patient’s effective discharge planning and coordinate efforts to ensure early and effective care planning and good patient experience along the whole of the care pathway. This is of particular importance in being able to identify any social needs, so that coordination with intermediate care and/or social services can be achieved much earlier in the patient’s pathway.

Information regarding a patient’s social needs must be recorded in the patient’s notes (including contact details and initial care package where applicable) by the referring hospital so that the receiving centre can facilitate discharge post procedure (with the exception of day case procedures).

The receiving centre is responsible for developing a care plan that includes informing the patient and relatives of an expected discharge date.
11.0 RETURNING PROCESS

11.1 Return to the Referring hospital
Not all referring hospitals in London have a catheter lab and perform angiography and/or PCI. As such, patients referred for these procedures may be discharged back to the referring hospital when their condition warrants on going medical management, critical care and/or preparation for cardiac surgery.

Close coordination between the receiving and the referring hospitals is required to ensure timely return back to the care of the referring clinicians using the return request on the IHT system.

Escalation procedures should be instigated where repatriation does not occur in line with local protocols.

11.2 Return Request
In the case of a return of patient that was previously due for discharge from the receiving centre, a return request must be made at the earliest opportunity. The referral must clearly identify the rationale for repatriating the patient back to the referring hospital.

The Receiving hospital has to send a ‘return request’. The Referring hospital has to respond by ‘Return plan agreed’ OR ‘Return plan not agreed’, and ‘Return’ the transfer when the patient arrives.

11.3 ‘Accept’
The referring hospital must accept/reject the request on the same day of receiving the request. Where the request has been accepted, the bed manager at the referring hospital must make appropriate arrangements to accept and receive the patient back to their care.

11.4 Returned
Where a patient is returned back to the referring hospital for on-going medical management, the patient should be transferred to the referring hospital medical ward rather than the cardiac CCU.

11.5 Discharge
If a patient is returned/repatriated to the DGH, a picking list of reasons will be asked:
- Treat and Return - Cardiac related
- Non-cardiac related - Neuro rehab tests required
- Longer recovery (elderly & frail) - Social reasons
- Other

All the cardiac related reasons (social reasons, longer recovery –elderly and frail, other – cardiac related) related to the patient’s episode of care, will be included in the LOS reports. All the non-cardiac reasons will be included as part of the ‘Reasons for return’ in the performance reports.
12.0 DISCHARGE DESTINATION
There are several places a patient may be discharged to following angiography +/- PCI, electrophysiology or cardiac surgery. These include:

12.1 Step-down facility/intermediate care
The patient may require on-going care in a step-down or intermediate care facility. Close coordination with such facilities is essential and transfers to these facilities should be made in accordance with local acceptance criteria and protocols.

It is the responsibility of the referring hospital to ensure that contact details and acceptance criteria of local intermediate care facilities are passed on to the receiving centre.

It is the responsibility of the receiving Centre to coordinate discharge to an intermediate care facility where no clinical involvement of the referring hospital is required.

12.2 Home
Patients discharged home from the receiving centre should have a discharge letter sent to the GP and cc to the referring trust clinician in accordance with contractual requirements.

Follow up arrangements should be specified and first follow up should be at the location they have had their procedure wherever possible.

12.3 Death
All patient deaths occurring either pre-operatively, during the procedure, or post-operatively, should be recorded on the web-based transfer system as soon as possible. The date and estimated time of death should be recorded and, where relevant, the transfer should be ‘closed’ on the web-based transfer system. These records should be made in addition to individual hospital policies and procedures relating to deaths occurring while the patient is in the care of the NHS.

12.4 End of cardiac episode and/or non cardiac reasons
When the patient reaches the end of their cardiac pathway they will follow the same return procedure to discharge.

12.5 Cardiac Rehabilitation
All ACS patients who are eligible for cardiac rehabilitation should be referred to a cardiac rehab programme on discharge. Phase 1 rehabilitation is the responsibility of the receiving centre performing the revascularisation. The rest is the responsibility of the referring hospital. Cardiac rehab referrals should include a discharge summary and the British Association of Cardiac Rehabilitation database minimum dataset should be completed in order to facilitate the transfer of care.
13.0 MONITORING ARRANGEMENTS

Robust monitoring of the numbers of patients waiting and length of time that they have waited is essential to the successful operation of this policy.

The data reports generated within the IHT system will be reported by each of the hospitals into the Cardiac Strategic Clinical Leadership Group (SCLG) on a quarterly basis, for ongoing performance monitoring.

The Receiving Centre will:
- Monitor all referrals received and update the system with the progress of those referrals until their discharge or return to the referring hospital.
- Liaise with other Trusts outside London in instances where ‘cross referral’ transfers show significant delays to patient pathways.
- Ensure complete and accurate data entry into the IHT system for better quality reporting and monitoring, good governance and patient experience.
- Download reports to monitor and improve their waiting times (referral to transfer; transfer to discharge; transfer to return to referring hospital) and share them with the SCLG on a quarterly basis.

The Referring Hospital will:
- Ensure that all required information, reports and test results are submitted within the specified timeframe, and where there is a variant, record and date it on the IHT web base system.
- Update patient’s status daily or if the patient suddenly becomes unfit for transfer.
- Ensure complete and accurate data entry into the IHT system for better quality reporting and monitoring, good governance and patient experience.
- Download reports to monitor and improve their waiting times (admit to refer; transfer to discharge; return to discharge) and share them with the SCLG on a quarterly basis.

The Specialised Commissioners will:
- Monitor the waiting times for cardiac surgery and performance of hospitals through the SCLG, against CQUIN targets outlined in contracts.

The Commissioning Support Units will:
- Ensure that the hospitals perform in line with the performance targets in the above mentioned section 7.0.
- The CSUs are responsible for monitoring waiting times as a marker of quality. The NHS Operating Framework 2012/13 identifies a requirement to reduce delayed transfers of care and improve the patient experience.

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14.0 ESCALATION PROCESS
Collaboration between Lead Consultants, General or Service Managers from all the London trusts is paramount when unexpected events occur and escalation processes have been initiated. Instances where the escalation process may be evoked include:

- Closure of facilities
- Critical incidences
- Should the system fail, the Teleologic system should be contacted (details below)
- The Teleologic contract (copy of existing)
  - Should ensure that contingency plans are instigated in the event of database system failure
  - Should advise and inform referring hospitals of alternative receiving centres within existing cardiac patients’ choice arrangements.
  - Will monitor and produce a monthly report on all escalated cases.

14.1 Escalation Process Roles and Responsibilities
Should the need to evoke the escalation process arise please follow local protocols and procedures agreed at Trust board level according to London quality standard 10.

The roles and responsibilities of all stakeholders to ensure a robust process are outlined below:

14.1.1 Receiving Centre
- Nominate a named person to proactively identify suitable patients that would potentially breach the set target.
- Nominate a named person to contact the relevant referring hospital to discuss and agree the need to escalate the patient(s).
- Discuss with the agreed alternative external sector Trust the need to transfer patient(s), which should include dates, time, transport, discharge, repatriation, and after care. The details of the discussion above and contact details of the alternative centre MUST be conveyed to the referring General or Service Manager.

14.1.2 Referring Centre
- Ensure that appropriate information is given to the patient to enable an informed decision.
- Explain the potential risk(s) (if any) of the transfer or refusal to transfer and continue to wait for the treatment at the receiving centre.
- Collate relevant patient’s records to be copied and sent with the patient.
- Arrange transport for transfer of the patient.

10 Quality and Safety Programme inter-hospital transfers – Adults (February 2013), London Health Programmes
## Appendices

### APPENDIX 1 – Key contacts

Teleologic support team email: support@teleologic.co.uk phone: 01603 765737

<table>
<thead>
<tr>
<th>Sector</th>
<th>Organisation by Site</th>
<th>Role</th>
<th>IHT Lead</th>
<th>Service Manager</th>
<th>Bed Manager</th>
<th>Cardiology Coordinator</th>
<th>Cardiac Surgery Coordinator</th>
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<tr>
<td>North East London</td>
<td>BHRT (King Georges)</td>
<td>Referring</td>
<td>Jane Hustler Medicine Divisional Manager</td>
<td>Jane Hustler Medicine Divisional Manager</td>
<td>Cathy Dunne Cardiology Matron</td>
<td>Cathy Dunne Cardiology Matron</td>
<td>Cathy Dunne Cardiology Matron</td>
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<td><a href="mailto:Catherine.dunne@bhrhospitals.nhs.uk">Catherine.dunne@bhrhospitals.nhs.uk</a></td>
<td><a href="mailto:Catherine.dunne@bhrhospitals.nhs.uk">Catherine.dunne@bhrhospitals.nhs.uk</a></td>
<td><a href="mailto:Catherine.dunne@bhrhospitals.nhs.uk">Catherine.dunne@bhrhospitals.nhs.uk</a></td>
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<td><a href="mailto:Catherine.dunne@bhrhospitals.nhs.uk">Catherine.dunne@bhrhospitals.nhs.uk</a></td>
<td><a href="mailto:Catherine.dunne@bhrhospitals.nhs.uk">Catherine.dunne@bhrhospitals.nhs.uk</a></td>
<td><a href="mailto:Catherine.dunne@bhrhospitals.nhs.uk">Catherine.dunne@bhrhospitals.nhs.uk</a></td>
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<tr>
<td></td>
<td>BLT (Chest)</td>
<td>Receiving</td>
<td>Mike Allison Cardiology service manager <a href="mailto:Mike.allison@bartshealth.nhs.uk">Mike.allison@bartshealth.nhs.uk</a></td>
<td>Mike Allison Cardiology service manager <a href="mailto:Mike.allison@bartshealth.nhs.uk">Mike.allison@bartshealth.nhs.uk</a></td>
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<td>Mike Allison Cardiology service manager <a href="mailto:Mike.allison@bartshealth.nhs.uk">Mike.allison@bartshealth.nhs.uk</a></td>
<td>Kay St Louis Cardiac surgery coordinator <a href="mailto:Kay.stlouis@bartshealth.nhs.uk">Kay.stlouis@bartshealth.nhs.uk</a></td>
</tr>
<tr>
<td></td>
<td>BLT (Newham)</td>
<td>Referring</td>
<td>Mike Allison Cardiology service manager <a href="mailto:Mike.allison@bartshealth.nhs.uk">Mike.allison@bartshealth.nhs.uk</a></td>
<td>Mike Allison Cardiology service manager <a href="mailto:Mike.allison@bartshealth.nhs.uk">Mike.allison@bartshealth.nhs.uk</a></td>
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<td>Mike Allison Cardiology service manager <a href="mailto:Mike.allison@bartshealth.nhs.uk">Mike.allison@bartshealth.nhs.uk</a></td>
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<td>Mike Allison Cardiology service manager <a href="mailto:Mike.allison@bartshealth.nhs.uk">Mike.allison@bartshealth.nhs.uk</a></td>
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<td></td>
<td>Homerton Hospital</td>
<td>Referring</td>
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<tr>
<td></td>
<td>North Central London</td>
<td>Receiving</td>
<td>Karen Aston General Manager, Cardiology <a href="mailto:karen.aston@uclh.nhs.uk">karen.aston@uclh.nhs.uk</a></td>
<td>Karen Aston General Manager, Cardiology <a href="mailto:karen.aston@uclh.nhs.uk">karen.aston@uclh.nhs.uk</a></td>
<td>Karen Aston General Manager, Cardiology <a href="mailto:karen.aston@uclh.nhs.uk">karen.aston@uclh.nhs.uk</a></td>
<td>Rachel Hire Cardiology co-ordinator <a href="mailto:rachel.hire@uclh.nhs.uk">rachel.hire@uclh.nhs.uk</a></td>
<td>on call registrar and/or Shane Cashin Cardiothoracic general manager <a href="mailto:shane.cashin@uclh.nhs.uk">shane.cashin@uclh.nhs.uk</a></td>
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<td>Royal Free Hospital</td>
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<td>Navneet Bhangal Operations Manager - Cardiology &amp; Critical Care <a href="mailto:navneet.bhangal@nhs.net">navneet.bhangal@nhs.net</a></td>
<td>Ed Savill Service Manager <a href="mailto:edward.savill@nhs.net">edward.savill@nhs.net</a></td>
<td>Par Andersson Head of the bed and site team <a href="mailto:p.andersson@nhs.net">p.andersson@nhs.net</a></td>
<td>Karen Slater CNS Heart Attack service <a href="mailto:karen.slater5@nhs.net">karen.slater5@nhs.net</a></td>
<td>Menene Endaya Cath Lab lead nurse <a href="mailto:menene.endaya@nhs.net">menene.endaya@nhs.net</a></td>
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<td>Barnet and Chase Farm Hospitals</td>
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<td>Ethna Doyle Cardiology Matron <a href="mailto:ethna.doyle@nhs.net">ethna.doyle@nhs.net</a> Ceri Dominy Senior sister <a href="mailto:ceri.dominy@nhs.net">ceri.dominy@nhs.net</a></td>
<td>Juliet Shavin Business Manager <a href="mailto:juliet.shavin@nhs.net">juliet.shavin@nhs.net</a> Emily Smith Assistant Business Manager <a href="mailto:emilysmith2@nhs.net">emilysmith2@nhs.net</a></td>
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<td>Referring/Cath lab co-ordination: 0208 887 4610 / 4618</td>
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<td><a href="mailto:Tom.crake@nhs.net">Tom.crake@nhs.net</a></td>
<td>Hagar Cole <a href="mailto:hagar.cole@nhs.net">hagar.cole@nhs.net</a> 0208 887 2000 bleep 153/323 for SHO</td>
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<td>Mercedita Ollano Sr Phillipa Wright-Vassel Gloria Haire <a href="mailto:gloria.haire@nhs.net">gloria.haire@nhs.net</a> 0207 288 3528</td>
<td><a href="mailto:Kathriona.mccann@nhs.net">Kathriona.mccann@nhs.net</a></td>
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<td>Leah Gonzales Matron 0207 288 5485</td>
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<td>Referring</td>
<td>Iqbal Malik <a href="mailto:iqbal.malik@imperial.nhs.uk">iqbal.malik@imperial.nhs.uk</a></td>
<td>Graham Lomax <a href="mailto:graham.lomax@imperial.nhs.uk">graham.lomax@imperial.nhs.uk</a></td>
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<td>Irene Arenillas Data Manager <a href="mailto:irene.arenillas@imperial.nhs.uk">irene.arenillas@imperial.nhs.uk</a></td>
<td>Anne Marie Tiernan Cardiac Case Manager <a href="mailto:Annemarie.tiernan@imperial.nhs.uk">Annemarie.tiernan@imperial.nhs.uk</a></td>
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<th><a href="mailto:Iqbal.malik@imperial.nhs.uk">Iqbal.malik@imperial.nhs.uk</a></th>
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For Imperial (Charing Cross) and Imperial (Hammersmith), the Referring and Receiving roles are both held by Iqbal Malik. For RBH (Harefield), the Receiving role is held by Lucy Davies, and for NWLH (Northwick Park), the Receiving role is held by Rachel Butler.
<table>
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</table>
|              | NWLH (Central Middlesex) | Referring | Rachel Butler  
Matron for Cardiology  
Rachelbutler2@nhs.net | Rachel Butler  
Matron for Cardiology  
Rachelbutler2@nhs.net | Rachel Butler  
Matron for Cardiology  
Rachelbutler2@nhs.net | Rachel Butler  
Matron for Cardiology  
Rachelbutler2@nhs.net |                        |
|              | Chelsea and Westminster | Referring | Julian Collinson  
Consultant Cardiologist  
julian.collinson@chelwest.nhs.uk |                        | Cas Shotter  
Nurse Manager  
Cas.Shotter@wmuh.nhs.uk |                        |                        |
|              | West Middlesex       | Referring | Raffi Kaprielian  
Consultant Cardiologist  
Raffi.Kaprielian@wmuh.nhs.uk |                        | Rosita Charitou  
Ward Manager  
rosita.charitou@eht.nhs.uk |                        |                        |
|              | Ealing               | Referring | Sarah Noonan  
Acting General Manager  
Sarah.Noonan@eht.nhs.uk |                        |                        | Rosita Charitou  
Ward Manager  
rosita.charitou@eht.nhs.uk |                        |
|              | Hillingdon           | Referring | Richard Grocott-Mason  
Consultant Cardiologist  
richard.grocottmason@thh.nhs.uk |                        |                        |                        |                        |
|              | South East London    | Receiving | John Egan  
Service Manager – Cardiac Surgery  
john.egan@gstt.nhs.uk | John Egan  
Service Manager – Cardiac Surgery  
john.egan@gstt.nhs.uk | Site Nurse Practitioner  
Bleep 0400 | Julie Keoghan  
Cardiology Waiting List Manager  
Julie.keoghan@gstt.nhs.uk  
020 7188 1079 |                        |
<p>|              | Guy’s and St Thomas’ Hospital |            |                                |                                |                                |                                |                        |</p>
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<td>King’s College Hospital</td>
<td>Receiving</td>
<td>Olaf Wendell Consultant Cardiothoracic Surgeon <a href="mailto:olaf.wendler@nhs.net">olaf.wendler@nhs.net</a></td>
<td></td>
<td></td>
<td>Inga Salter Administrator – Cardiac Admissions <a href="mailto:inga.salter@nhs.net">inga.salter@nhs.net</a> 020 3299 4054</td>
<td>Imelda Shannon Matron Cardiology <a href="mailto:imelda.shannon@nhs.net">imelda.shannon@nhs.net</a> 020 3299 1135</td>
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<tr>
<td></td>
<td>SLHT (Queen Elizabeth)</td>
<td>Referring</td>
<td>Bal Wasan Consultant Cardiologist <a href="mailto:b.wasan@nhs.net">b.wasan@nhs.net</a></td>
<td></td>
<td></td>
<td>Charlie Carter ACS Nurse/Lead Cardiac Audit <a href="mailto:ccarter@nhs.net">ccarter@nhs.net</a> 020 8836 5574</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SLHT (Princess Royal)</td>
<td>Referring</td>
<td>Ed Langford Consultant Cardiologist <a href="mailto:ed.langford@nhs.net">ed.langford@nhs.net</a></td>
<td></td>
<td></td>
<td>Krisia Stevens Nurse Manager <a href="mailto:krisia.stevens@nhs.net">krisia.stevens@nhs.net</a> tel:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SLHT (Queen Mary’s Sidcup)</td>
<td>Referring</td>
<td>Ed Langford Consultant Cardiologist <a href="mailto:ed.langford@nhs.net">ed.langford@nhs.net</a></td>
<td></td>
<td></td>
<td>Charlie Carter ACS Nurse/ Lead Cardiac Audit <a href="mailto:ccarter@nhs.net">ccarter@nhs.net</a> 020 8836 5574</td>
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</tr>
<tr>
<td></td>
<td>University Hospital Lewisham</td>
<td>Referring</td>
<td>Mary Idowu Business Manager - Cardiology mary.idowu @nhs.net</td>
<td></td>
<td></td>
<td>Kate Grasma ACS Nurse/ CR nurse <a href="mailto:kate.gramsma@nhs.net">kate.gramsma@nhs.net</a> 0208 333 3081</td>
<td></td>
</tr>
<tr>
<td>Sect by Site</td>
<td>Organisation</td>
<td>Role</td>
<td>IHT Lead</td>
<td>Service Manager</td>
<td>Bed Manager</td>
<td>Cardiology Coordinator</td>
<td>Cardiac Surgery Coordinator</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
| South West London | St George’s Hospital | Receiving | Nick Bunce  
Consultant Cardiologist  
Nick.Bunce@stgeorges.nhs.uk | Alison Watson  
Cardiac Surgery Service Manager  
Alison.watson@stgeorges.nhs.uk |  | Nora Kerenyi  
Cardiothoracic nurse practitioner  
Nora.Kerenyi@stgeorges.nhs.uk  
020 8672 1255 ext: 6730 | Nora Kerenyi  
Cardiothoracic nurse practitioner  
Nora.Kerenyi@stgeorges.nhs.uk  
020 8672 1255 ext: 6730 |
|             | Croydon University Healthcare | Referring | Asif Qasim  
Consultant Cardiologist  
asif@g-cardio.net |  |  |  |
|             | Epsom and St Helier Trust (St. Helier Hospital) | Referring | Richard Bogle  
Consultant Cardiologist  
richard.bogle@esth.nhs.uk |  |  |  |
|             | Kingston Hospital Trust | Referring | Sarah Williams  
Head of Cardiology  
sarah.williams@kingstonhospital.nhs.uk |  |  | Lin Edmonds  
Secretary  
lin.edmonds@kingstonhospital.nhs.uk  
020 8546 7711 ext: 2894/5 |  |
<table>
<thead>
<tr>
<th>ROLE</th>
<th>RESPONSIBILITIES</th>
</tr>
</thead>
</table>
| IHT Lead Role                             | • It is the responsibility of designated managerial and clinical leads at each Trust to determine the most appropriate individual or group of individuals who input clinical data and make referrals using the IHT system and to nominate an IHT co-ordinator for the Trust.  
• Use the reports to inform the hospital on their performance.                                                                                                                                                                                                                       |
| Service Manager                           | • Performance management of the service.  
• Download patient level data for pathway monitoring and reporting to identify bottle-necks and use these to inform service improvements.                                                                                                                                                                                                                      |
| Bed Manager                               | • Checking for upcoming referrals/ monitoring referral to transfer length of stay.  
• Proactively manage bed occupancy to identify & maintain bed availability for all patients especially those marked ‘treat and return’                                                                                                                                                                                                                           |
| General                                   | • Ensure completeness and accuracy of data entry on the IHT system where possible  
• Arrange for training of new staff during their induction; ensuring that the skills are kept up to date; and that staff are aware of any new functions or changes to any aspect of the electronic referral system.                                                                                                                                                                          |
| Receiving unit                            | • Proactively identify suitable patients that would potentially breach the set target  
• Contact the relevant referring unit to discuss and agree the need to escalate the patient(s).  
• Discuss with the agreed alternative external sector Trust the need to transfer patient(s), which should include dates, time, transport, discharge, repatriation, and after care. The details of the discussion above and contact details of the alternative centre MUST be conveyed to the referring General or Service Manager.                                                                 |
| Referring unit                            | • Ensure that appropriate information is given to the patient to enable an informed decision.  
• Explain the potential risk(s) (if any) of the transfer or refusal to transfer and continue to wait for the treatment at the receiving/tertiary centre.  
• Collate relevant patient’s records to be copied and sent with the patient.  
• Arrange transport for transfer of the patient.                                                                                                                                                                                                                                          |
APPENDIX 2 - Mandatory Minimum Data set

<table>
<thead>
<tr>
<th>Demographic / Clinical Data</th>
<th>Mandatory fields or Mandatory dependent on answer to previous question</th>
</tr>
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<tbody>
<tr>
<td>Patient</td>
<td>Referring Hospital</td>
</tr>
<tr>
<td>Hospital Number</td>
<td>Referrer</td>
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<tr>
<td>NHS Number Status verified/not-known</td>
<td>Bleep/ Contact no.</td>
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<td>Hospital</td>
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<tr>
<td>Address</td>
<td>Consultant Name</td>
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<td>Postcode</td>
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<td>Language</td>
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<td>GP Surname</td>
<td>Date stopped</td>
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<tr>
<td>Practice Address</td>
<td>Varicose veins***</td>
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</table>

* Mandatory for surgery patients **Mandatory for surgery and pt is 75+ or has any of the following in medical history screen: TIA, Carotid Bruit, LMS Stenosis, *** For CABG requests Previous CVascular Surgery **** Mandatory for Valve surgery
APPENDIX 3 - Non-elective cardiac surgery work up criteria

Once a patient is identified as in need of surgery, the following agreed work-up investigations should be undertaken when appropriate.

- All relevant tests should be carried out without delay.
- Some tests may be completed once the referral has been made.
- All results must be made available to the receiving centre, ideally electronically.
- The information should be included on the electronic inter-hospital transfer referral forms where relevant.

1. LUNG FUNCTION TESTS:
   Saturations on air <90%
   Current smoker >20 cigarettes/day
   Uncontrolled pulmonary disease:
   - Moderate-severe asthma
   - Previous lung surgery
   - COPD

2. CAROTID DOPPLER:
   All symptomatic patients (history of TIA or previous stroke)
   Patients with carotid bruits
   Patients with significant left main stem stenosis (greater than 70%)
   Patients with severe peripheral vascular disease

3. ECHOCARDIOGRAM:
   Patients with NO left ventriculogram with LHC
   Patients with additional murmurs, even if LV gram done.

4. DENTAL CHECK UP:
   All patients who are referred for valve surgery

5. CORONARY ANGIOGRAM:
   All patients who are referred for valve surgery if over 40 years old.

6. BLOOD TESTS (THE DAY BEFORE TRANSFER):
   To include FBC, clotting screen, renal function, and liver function
   DO NOT INCLUDE CRP unless specifically requested.

7. CHEST X-RAY:
   All patients referred for surgery.

8. MEDICATIONS:
   Clopidogrel to be **continued** unless specified by the surgeon.
   Aspirin to be continued unless specified by the surgeon.
   ACE inhibitors and Angiotensin II Receptor blockers to be discontinued three days pre-operatively.
   Warfarin to be discontinued 4 days pre-operatively and covered with low molecular weight heparin as necessary.

**PLEASE NOTE:** All non-elective inter-hospital transfer patients must be referred on the electronic system. It is understood personal communication between a referring and surgical centre may still be required, but should only be held in **addition** to the electronic referral.
1. Patient admitted to referring hospital via self presentation or LAS, or already in hospital as inpatient

2. Investigations undertaken to aid treatment plan decision making

3. Referring hospital send request of patient referral to receiving unit for cardiac procedure

4. Referral reviewed by receiving unit and accepted or rejected. Requests for additional investigations may be made, or recommendations for alternative treatment plans

5. Additional investigations undertaken in preparation for intervention

6. Patient deemed clinically fit for transfer

7. Patient transferred to receiving unit

8. Patient undergoes further investigations if required at receiving unit

9. Patient undergoes procedure. Procedure recorded on IHT system

10. Does the patient need further intervention in this pathway?

   - No
     - 10.i Patient discharged home. Receiving unit record this on IHT system

   - Yes
     - 10.ii Patient repatriated to referring hospital. When discharged, referring hospital record this on the IHT system
     - 10.iii Patient wait at receiving unit before awaiting further cardiac intervention (e.g. surgery)
     - 10.iv Patient returned to referring hospital before awaiting further cardiac intervention (e.g. surgery)
APPENDIX 4 - Waiting Times Standards/ Length of Stay

Non-Elective Cardiology
At least 90% of ACS patients should be transferred, treated and discharge within the following timeframes

- Admission to Referral – 1 Day
- Referral to Procedure (Angio ?Proceed) – 2 Days
- Referral to Procedure (EP) – 2 Days
- Admission to completion of procedure – 3 Days

Total LOS i.e. Admission to Discharge – 5 days

Non-Elective Cardiac Surgery (CABG, and Combined CABG plus Valve Surgery)
The LCVP Model of Care for Cardiac Surgery state that: ‘the total length of stay for patients needing urgent CABG should not exceed 21 days’.
The audit standard is that 90% of patients should reach this target

- Admission to referral (including Angiogram) – 5 Days
- Referral to Transfer – 5 Days
- Transfer to Discharge from receiving centre – 11 Days

In order to provide equity of access to all cardiac surgical patients in the sector, the timeframes above should apply to all patients requiring cardiac surgical intervention (not limited to CABG).

Admission to Electrophysiology procedure
At least 90% of patients requiring non-elective electrophysiology should be transferred, treated and discharged within the following time frames

<table>
<thead>
<tr>
<th></th>
<th>Permanent Pacing</th>
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<th>ICD or CRT PPM or CRT ICD</th>
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<tr>
<td>Admission to Referral</td>
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<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Referral to transfer</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Transfer to Discharge</td>
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<td>7</td>
<td>11</td>
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<tr>
<td>Total length of pathway</td>
<td>8</td>
<td>14</td>
<td>21</td>
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<tr>
<td>from admission to</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>discharge (days)</td>
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