Clinical Lead Survival Guide – Centralising out of hours care

For many smaller or district general hospitals, it is getting harder to deliver and staff on-site out of hours care: there are fewer SAS doctors; trainees with strict caps on hours and requirements for rest periods; it is often difficult to justify the costs and effort for staffing, space and equipment access for small numbers of out of hours attendees.

Many units are therefore seeking to transfer out of hours care to nearby or regional units, often large or teaching hospital units with more staff and trainees, better facilities and subspecialty expertise available and better access to beds, theatres and relevant specialties for areas such as trauma, paediatrics and infection.

It is important, if considering this, to ensure your pathways are compliant with the RCOphth guidance on urgent and emergency care[i] and standards for networks of care involving multiple providers[ii] if planning this move you must read these.

Here are some important tips and points to consider as you decide how to approach handing over out of hours work from a 'peripheral hospital' to a 'central hospital'.

1. Have as many historical facts and figures about activity as possible:
   - numbers of patients seen out of hours, times, diagnosis (if possible)
   - numbers of phone calls for advice from patients, GPs, optometrists, A&E and from ward doctors overnight
   - number of admissions
   - number of operations
   - numbers of children
   - numbers of those needing non-ophthalmic input (ENT, orthopaedics, maxilla-facial, paediatrics, physicians, neurologists etc)

2. What kind of commissioner contract does each unit work under – PBR (payment by results) is much more attractive to the hospital receiving the transfer of care as money follows the patient. On a block contract it can eat into the overall ophthalmic budget. However, the peripheral hospital will be saving substantially by not having staff on call (doctors and nurses) and will need to be prepared to recompense the central hospital for the additional work. Know how much the saving is and negotiate. Another option is to offer your staff to work on their rota reducing their staff costs or frequency of on-call.

3. Who will look after any inpatients at the peripheral hospital (ophthalmic and general)? Who will look after those who are unfit for transfer eg ITU patients?

4. Will the patients first be seen by the peripheral hospital main emergency department (ED) then referred on, or will all patients be directed straight to the central hospital? How will the notes be transferred?

5. Will the central on call team travel to the peripheral unit to see patients, or will the patients be transferred (second option strongly suggested as more practical, unless units very close, ophthalmic equipment and space available to visiting team and on call at central unit not onerous). Do not forget that visiting teams may have serious issues using electronic patient records and prescribing systems they have not access to or use infrequently.

6. In setting up an on-call service which does use doctors from other units, it is essential to have a full induction to familiarise doctors with the unit, agree management protocols (preferably with a handbook) and formalise handover procedures to the host doctors. This should also include pathways for arranging urgent follow up appointments in the local unit.

7. If peripheral hospital ED will first see patients, ensure there are clear simple protocols and triage guidelines for referral on to the central hospital and for those who can wait to return the next day or in a planned way to the peripheral hospital clinics. Involve main ED staff, consider teaching sessions, I care tonometers, camera to send images remotely to on call team via secure transfer. Empower the local ED staff to manage simple things definitively (corneal abrasions, infective conjunctivitis etc) so that they are confident to discharge them without bringing every patient back to see you the next day.

8. The management of inpatient referrals from other specialities to ophthalmology out of hours needs to be mapped for the peripheral units as well as the central host unit. A proforma handover sheet or referral sheet is useful for these patients. A mechanism for identifying the consultant responsible for the ophthalmic aspect of the patient's care needs to be clear to all teams involved in the patient care. In cases where the initial consultant involved during out of hours is different from the consultant who will be responsible in the long-term, a clear handover process needs to be in place.

9. What time will the peripheral unit hand over care, what time will they reopen, what will happen at weekends, bank holidays? Some hand over at 5, some at 9 or 10pm. Beware the official handover at 5pm creeping earlier and earlier – the central hospital will start to question the arrangement.

10. Ensure there is complete clarity about arrangements at the peripheral hospital to see patients in hours and ensure no inappropriate knee jerk ringing the central hospital in hours. Consider how the information/changes will be communicated to the public/rest of the hospital/main ED. Ensure patients are consulted during the discussions regarding the options under consideration.

11. Will the peripheral hospital consultants, SAS doctors or juniors take part in the central hospital on call rota? Again, do not underestimate the difficulties of working in an unfamiliar environment, with people you do not know and systems who are unfamiliar with or cannot access.

12. What are the arrangements for the peripheral hospital taking back in- and out-patients – transfer of information, who is responsible for the transport and costs?

13. A contact phone number at the peripheral unit (which is not an answering machine!) for urgent queries and issues in hours is essential, along with an e-mail address for details of transfer patients.

14. Before permanently agreeing the on-call transfer, arrange a pilot or trial period e.g. of 3 months, to identify unforeseen issues and ensure the guidelines are being followed. Decide and agree with the peripheral unit, what the consequences will be if the process is not being followed at that stage or in the future.

Involve the central hospital clinicians and management at an early stage. It will be in their interest to negotiate an acceptable arrangement, rather than have the peripheral hospital on call collapse without warning or start simply receiving patients without any suitable arrangements which is not acceptable.

Ensure that all arrangements are fully agreed, documented and where possibly underpinned with contracts or service level agreements. Keep a copy of these for when someone at the central hospital cannot remember this arrangement and refuses to accept a patient!

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[i] RCOphth standards and guidance for out of hour care https://www.rcophth.ac.uk/wp-content/uploads/2017/08/Emergency-eye-care-in-hospital-eye-units-and-secondary-care.pdf

[ii] RCOphth Commissioning standards 2018 https://www.rcophth.ac.uk/wp-content/uploads/2018/03/Commissioning-Standards.pdf