

Transfer and Discharge Protocol

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1.0	October 2011	Peter Sheils – NHSLA Consultant	Final	This protocol meets the requirement for the NHSLA risk management standards relating to the transfer and discharge of patients.
2.0	October 2012	Launa Rolf	Final	Update: This protocol meets the requirement for the NHSLA risk management standards (level 3) relating to the transfer and discharge. Changes made include the introduction of an internal transfer form for in patient mental health services and directions that relevant documentation offered / given to the patient must be recorded within the patient's notes.
2.1	November 2013	Peter Sheils – Corporate Projects Manager	Final	Incorporates more detailed guidance regarding mental health service users returning to ELFT MH inpatient care from local acute hospitals and contains an additional appendix: Appendix 2 - Inter-agency Agreement: Agreement Regarding Arrangements for Mental Health Inpatient Service Users Who Require Planned Care in a Local Acute Hospital

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Executive Summary

Transfer and Discharge of mental health patients brings specific risks and issues that require careful consideration and planning in order to minimise and manage risks effectively and ensure continuity of care.

General principles relating to communication, planning and implementation of care apply to both transfer and discharge of care happening across a wide variety of care settings. Specific considerations may be required depending upon the setting from which a patient's care is transferred or discharged to and from and may vary depending upon the patient group.

Procedures and interventions described in this protocol will also be found in more detail and specific related documents. This protocol aims to provide an overarching approach to the variety of transfers and discharge that happen routinely within mental health services.

1 Introduction

- 1.1 Transfer and discharge are inevitable aspects of a patient's experience of mental health care. However, it is recognised that transfer and discharge can be difficult and distressing for patients and can also present risks to their recovery and care if not managed with consideration and sensitivity.
- 1.2 The development of specialist teams and services within the mental health system has meant that patients are now more likely to undergo a number of transfers between services and this can cause uncertainty and anxiety as well discontinuity of care. Transfers may take place between inpatient and community services; involve specialist teams as well as transfer or discharge to care settings outside the Trust. Transfer of care may be made more difficult if prompted by deterioration in a person's mental health. Although discharge from a service is usually prompted by an improvement in a person's mental health some, like discharge from an inpatient unit, may still take place at a difficult time. Other forms of discharge, like that from secondary to primary care, may result in a reduction in the level of care that people receive. Discharge from secondary care mental health services raises important questions for patients and carers about how they can access services again should the need arise.
- 1.3 Failure in communication between staff in different services can increase the difficulty experienced by patients in response to transfer and discharge and also compromise the safety and quality of care. It is well recognised that patients' vulnerability is increased following discharge from services and that levels of suicide are higher in the period immediately following discharge from inpatient mental health care (NICE 2011).

In order to ensure a smooth and safe transition between various services, it is important to set out clear arrangements in terms of the process together with information requirements.

2 Purpose

The purpose of this protocol is to ensure that appropriate arrangements are in place when those receiving care and treatment from the Trust are either transferred between services that the Trust provides or are discharged from the Trust which may involve the transfer of care elsewhere. It aims to draw attention to the potential risks involved in transfer and discharge and to emphasise the need for adequate planning in order that those risks are minimised and that continuity of care is provided.

3 Duties

3.1 The Trust Board

The Trust Board has a responsibility to ensure there is a framework in place to promote the effective management of the problems and risks associated with the transfer and discharge of patients.

3.2 Directorate Management

The Borough/Specialist Service and Clinical Directors are responsible for ensuring that all operational managers are aware of this protocol, understand its requirements and support its implementation with relevant staff.

3.3 Clinical Team Managers

Are responsible for ensuring their clinical staff have a good working knowledge of this protocol and that the principles and standards within it are adhered to by their clinical staff.

Team managers should have good clinical systems in place for effectively managing the transfer and discharge of patients and support adherence to this protocol.

3.4 Clinical Staff

Clinical staff have a responsibility to ensure they have a good working knowledge of the principles and standards contained within this protocol and that they comply with the requirements of this and associated policies with regards to the transfer and discharge of patients.

4 Principles of Transfer and Discharge

4.1 Where transfer or discharge is being considered, the service user's level of need should be assessed and referrals made to other services in a timely manner. This will include social care and physical health needs.

4.2 Assessment and planning associated with transfer or discharge should always incorporate thorough risk assessment and planning. Consideration should be given as to the risks involved in escorting patients as part of a transfer and the necessary level of skill mix required.

4.3 It is important that patients are involved in the planning and decision-making about the transfer or discharge of their care and that this should take account of any preferences the service user may have.

4.4 Patients should be given adequate notice, where possible, about transfer and discharge arrangements and given clear information about support options available following transfer or discharge, in order that joint and informed choices can be made.

4.5 Patients and carers should be provided with clear information about how they can access the service again, if arrangements following transfer or discharge do not work out or things deteriorate.

4.6 Patients and carers should have clear information provided about the referral pathways and processes for any services they are being discharged from or transferred to (this should include information about possible waiting times, assessment process, intervention type, time-scale of intervention).

4.7 It should be acknowledged with patients, that discharges and transfers are often an anxiety provoking time. Patients should be provided with support through this process, having the opportunities to discuss concerns as well as other issues. Withdrawal or ending of treatment and transition from one service to another may evoke strong emotions and reactions and staff should ensure that such changes are discussed carefully with the service user beforehand and are structured and phased.

4.8 Family and carers should have the opportunity (with the agreement of the service user) to be involved in the planning of transfers or discharge, where possible.

4.9 Involved family and carers should be notified before the service user is transferred or discharged.

4.10 Planning with regards to transfer and discharge should be fully and accurately documented in order that all parties relevant to the transfer or discharge can clearly understand the arrangements and refer to these when needed.

4.11 Clinical staff should engage with and communicate effectively and timely with others involved in the transfer and discharge process. This will include Trust staff, staff from other agencies i.e. social care or NHS bodies, patients, their family and/or carers.

Key information should be given to those who become responsible for treatment and care following transfer or discharge.

- 4.12 In many circumstances, transfer and discharge will follow similar procedures and general principles will apply to each activity.

5 Transfer

- 5.1 Transfers may occur internally to the Trust, for example in the case of patients being discharged from inpatient care to a community team (or vice versa) or when someone moves from the Trust's adult services to the mental health care of older people. Each clinical team may have its own specific requirements in addition to the requirements contained within this protocol, for the transfer both in and out of its patients depending upon the patient group.

- 5.2 Adult Mental Health to Mental Health Care of Older People (MHCOP)
This type of transfer should follow the general principles and requirements described in this protocol and also adhere to the principles and guidance in the Protocol for the Transfer of Care from Adult Services to Older Adult Services.

- 5.2.1 Transfer will only be completed when all relevant CPA care planning and risk assessment; section 117 aftercare documentation and relevant electronic records/databases have been updated to reflect the transfer of care to Older Adult services. The relevant information should be disseminated to partner agencies, i.e. GPs.

- 5.2.3 On rare occasions a request maybe made to transfer a service user from an adult ward onto an older adult ward. The decision to do this should be based on clinical need and be discussed with the appropriate senior nurse and consultant looking at a risk/benefit analysis. Medical responsibility for the period of stay on an older adult ward should be agreed from the outset and communicated to the ward staff.

- 5.2.3 Disagreement about transfers that cannot be resolved between the two teams should be referred to the Clinical Director for Older Adults and the Clinical Director for Adults to assist in arbitration.

- 5.3 CAMHS to Community Adult Mental Health
Staff involved in the transition of patients from CAMHS to adult mental health services should adhere to the procedures laid down in the Policy for Transition from Child and Adolescent Mental Health Services to Adult Mental Health Services. In most but not all cases, the transfer will be that of open cases which will involve long-term collaborative planning but more urgent transfers may be necessary particularly following admission around a patient's eighteenth birthday.

- 5.4 Specialist Addiction Services to other internal services
It is important that any transfers from Specialist Addiction Services to any other services incorporate communication of the following key pieces of information:

- Specific details of the prescription (what, how much, who's prescribing, list of side effect monitoring such as the frequency and type of side effect)
- Who is responsible for monitoring side effects, the date of expiry of current prescription, dispensing and administration requirements, and the pharmacy attended (with phone number of pharmacy).
- Significant therapeutic blind alleys recently explored (e.g. non-response to hep C treatment, failed detoxification/rehab, on much higher dose of methadone which made no difference to injecting, failed benzodiazepine detoxification 6 months ago)
- Discharges/transfers to be accompanied by a copy of the most recent medical review.

- The latest physical health screening info as part of the transfer / discharge

5.5 Adult Mental Health/MHCOP to Psychiatric Intensive Care Units (PICU)

Patients assessed as requiring a PICU bed should be placed in the PICU in their own Locality. If no PICU bed is available, one will be sought within the Trust in another Locality. When full, all PICUs should endeavour to identify a service user who could be safely moved to an Acute Ward to create a bed if another service user is in greater need of the PICU bed. In such circumstances multi-disciplinary risk assessment must be carried out and documented in the relevant progress notes by the PICU Consultant or nominated deputy. Only if there is no PICU bed available in the Trust may an out-of-Trust placement may be sought as per Section 6.12 of the Admission and Discharge Policy.

5.6 Internal Inpatient Transfers

An existing stable patient may be transferred temporarily to another ward to enable their home ward to admit a new patient. When the patient is moved for one night, and returns to their home ward during day, this is considered a sleep-over (see Section 6.7 of the Admission and Discharge Policy). When it is agreed between the wards that a patient will stay for a longer set period of time, this will be considered a transfer.

- 5.6.1 The trust has an agreed transfer papers for all patients when they are transferred between wards on the same site or between inpatient sites within the Trust. The action of completing this form must be recorded within the patients notes and /or on RiO.

5.7 Inpatient to Trust Community Services

For detailed guidance on discharge from inpatient to community care within the Trust which for the purpose of this protocol is considered a transfer, refer to Sections 8-10 of the Admission and Discharge Policy.

- 5.7.1 To facilitate the transfer of specialist care, a joint review should take place between the teams involved, particularly important if the service user is on CPA and considered at significant risk. If, for transfers out of area, where distance/practicality precludes this, there should be full discussion by telephone and information provided.

- 5.7.2 Transfers should not take place unless there has been agreement or acknowledgement from the receiving care team to prevent people “slipping through the net”.

5.8 Forensic Inpatient to Community

The majority of in-patients are discharged to the community with support and supervision from forensic services. Others are appropriately transferred back to prison after assessment or treatment is completed. The service operates a prison in-reach team that was developed, in part, to support appropriate remissions to prison.

5.9 Transfers to and from Acute Hospital

The planning of all transfers to and from an acute hospital should incorporate detailed planning of both mental and physical health care needs and treatment and a detailed plan of care should always accompany the patient and a verbal handover provided at the point of handing over the patient to the receiving care providers.

The statutory obligations of the Mental Health Act must be considered where transfers occur with those who continue to be detained. Sections 17 and 19 of the Mental Health Act make provisions for the need for care requiring short and long-term transfer. Patients subject to a restriction order should only be transferred with authorisation from the Secretary of State unless the transfer is for the purpose of urgent medical assessment and treatment (refer to the Ministry of Justice’s Leave of Absence for Patients Subject to Restrictions - Guidance for Responsible Clinicians).

- 5.9.1 For patient transfers to and from the local acute hospital providers, Homerton University Hospital NHS Foundation Trust and Barts Health NHS Trust, refer to Appendix 2 – the Inter-agency Agreement (Agreement Regarding Arrangements for Mental Health Inpatient Service Users Who Require Planned Care in a Local Acute Hospital)
- 5.9.2 For return transfers from local acute hospitals, the procedures within Section 9 of the Interagency Transfer should be followed:

MENTAL HEALTH SERVICE USERS RETURNING TO ELFT INPATIENT CARE FROM A LOCAL ACUTE HOSPITAL:

- The reason for the initial transfer to the Local Acute Hospital should be fully resolved prior to transfer back to ELFT. If the condition is not fully resolved or stabilised and requires on-going care, a detailed pre-transfer discussion needs to take place.
- The Duty Senior Nurse (DSN) should be the first point of contact for the acute hospital, in order to discuss and make proper arrangements for the patient’s care to be transferred back to ELFT. Contact details for the Duty Senior Nurse for each ELFT site are as follows:

Inpatient Unit	Area of Care Covered by the DSN	Contact Details
City and Hackney	Adult acute and mental health care of older people	07534-214074
Newham	Adult acute and mental health care of older people	07816-972297
Tower Hamlets	Adult acute and mental health care of older people	07811-453637
Forensics	John Howard Centre	07572-154890
	Wolfson House	07908-805006
Coburn Unit	Child and adolescent mental health	07929-206630

- Depending upon the complexity of the case, the Consultant Psychiatrist or Senior Duty Doctor on call and a nurse will assess the planning needs relating to the service user’s transfer of care back to ELFT.
- If a patient is still being actively treated then there needs to be a clear management and crisis plan which should include what to look out for and what should be done for on-going care and in case of an emergency.
- A medical and nursing discharge summary should be sent to ELFT wards.
- The discharge summary should be in the form of a transfer summary highlighting any on-going care that may be required
- The transfer summary should include detailed description of any wound care, clinical observations or other management required
- Infection control risks should be clearly reported and any management plan.
- Breach of the above conditions should be reported as a clinical incident via Datix electronic incident reporting system and liaison with the relevant acute trust should be incorporated into the incident management and investigation arrangements.

5.10 Documentation to accompany the patient on transfer

As a minimum the following records should accompany any internal or external transfer:

- Assessment of current health & social care needs
- Up to date clinical risk assessment
- Up to date care plan which includes crisis & contingency arrangements
- Current/ongoing medication
- Legal status and CPA level as applicable
- For those detained under the Mental Health Act, relevant section papers for long-term transfer under Section 19.

5.11 Out of hours transfer arrangements

Transfer of patients out of hours is sometimes necessary but where possible transfer should happen during normal office hours. Any out of hours transfers should pay special regards to safe escort arrangements, prior risk assessment and adequate supporting documentation to accompany the transfer.

5.12 Infection Control

When planning transfers, discharges or re-admission of any suspected or confirmed infectious service user, advice must be sought from the Infection Control Nurse and Physical Healthcare Lead to ensure that risks of cross infection are assessed and minimised.

5.13 Physical Health

All transfers should include assessment and planning of patients' physical health care to ensure that physical health care is continued and consistent following transfer. Full written information regarding physical health care should be provided at the point of transfer and where possible a verbal handover to the receiving service or team. Planning should take account of any special physical health care needs that may require additional planning on the part of receiving team or service.

6 Discharge

6.1 For the purpose of this protocol and guidance, discharge will refer to the two main activities that involve a transfer of a patient's care from inpatient to community services (Trust and external) and discharge from Trust care.

6.2 Discharge from Inpatient care

The discharge process for all patients should begin at the point of admission and in the majority of cases is planned, following a multi-disciplinary care planning/review meeting actively incorporating the views of patients, their family and carers and any voluntary or independent sector agencies providing care or support to the service user. Exceptions to this may occur when discharge is at short notice or is against medical advice.

6.2.1 Where a patient is under CPA a written care plan specifying aftercare arrangements should be produced which incorporates crisis and contingency arrangements in accordance with the Trust's Admission and Discharge Policy and the Care Programme Approach Policy.

6.2.2 Patients should be offered a copy of their CPA care plan and give consent as to whom else may have a copy. The relevant section of the CPA Care Plan should be ticked to indicate that the patient has been offered/given a copy of their discharge CPA Care Plan. If a patient does not receive care under CPA then discharge notification should be offered to the patient. All relevant documentation offered / given to the patient must be recorded within the patient's notes.

- 6.2.3 The statutory obligations of the Mental Health Act must be considered where appropriate i.e. if the service user has been detained on a treatment section, the PCT and local authority's obligation to provide aftercare under Section 117 applies.
- 6.2.4 All patients discharged from adult acute inpatient wards on CPA should be followed up by a mental health professional within 7 days of discharge. Such follow up may be face to face or by phone.
- 6.2.5 Staff must comply with the Trust's Medicines Policy in respect of discharge medication and the information that should be given to patients when they are discharged.
- 6.3 Discharges from the Trust
In the majority of cases, discharge from the Trust is planned following a care planning review involving multidisciplinary discussion and actively incorporating the views of patients, their family and carers and any voluntary or independent sector agencies providing care or support to the service user. Exceptions to this may occur if the service user disengages or moves away unexpectedly.
- 6.3.1 The statutory obligations of the Mental Health Act must be considered where appropriate, for example if Section 117 (aftercare).
- 6.3.2 Appropriate discharge information including medication needs should be provided to GPs or other agencies that may be providing any ongoing care to patients. A final care plan should be produced and with the service user's agreement, circulated appropriately indicating that discharge has taken place.

7 Implementation, Monitoring and Review

- 7.1 Clinical staff should be made aware of the requirements of this policy and associated policies, procedures and guidance by their line managers. All related policies and guidance should be readily available to staff via the Trust's website and or intranet site. This protocol will be reviewed every three years unless it is deemed necessary to do so sooner. Details of how implementation of the protocol will be monitored are in section 7.2 below.

7.2 Monitoring

NHSLA Standard	Name	Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements	Actions on recommendations and leads	Change in practice and lessons to be shared
Transfer and Discharge Policy (MH)								
CHN Transfer and Discharge Policy								
4.9	Clinical Handover of Care	Handover requirements between all care settings, to include both giving and receiving of information	Deputy Director of Nursing	Health care records audit	annual	The Deputy Director of Nursing receives the audit report	The Deputy Director of Nursing will formulate action points and timescales for each Directorate where there is evidence of non-compliance within two weeks of the audit	The Clinical Effectiveness Sub Committee will receive and discuss the report and monitor the action plan within six weeks of the audit
		How handover is recorded						
		Out of hours handover process						

8 Associated Documentation

- 8.1 Admission and Discharge Policy
- 8.2 Policy for Transition from Child and Adolescent Mental Health Services to Adult Mental Health Services
- 8.3 Care Programme Approach Policy
- 8.4 Protocol for the Transfer of Care from Adult Services to Older Adult Services
- 8.5 Leave of Absence for Patients Subject to Restrictions - Guidance for Responsible Clinicians

9 References

- 9.1 NICE (2011) Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services. NICE Draft Clinical Guideline. London: NICE

10 Appendices

- 10.1 Internal Transfer Checklist
- 10.2 Patient Transfer Agreement

Internal Transfer Checklist

Name of patient _____

Wards FROM _____ TO _____

Handover FROM nurse _____ TO nurse _____

Handover FROM Dr _____ TO Dr _____

Information to be handed over	Tick if provided	List information provided	If not provided, why not & action to be taken
Diagnosis			
Risk assessment and management plan			
Care plans			
CPA details (latest CPA form)			
Physical Health needs (diagnoses, monitoring)			
Medication (including allergies, side effects and sensitivities)			
Medication compliance history			
Legal status and current leave status			
Level of Observations		Level of observations	
Allocation of Primary Nurse	Primary nurse on old ward		Allocated primary nurse on receiving ward

Signature of staff accepting transfer (receiving ward)

Date

Inter-agency Agreement

Agreement Regarding Arrangements for Mental Health Inpatient Service Users Who Require Planned Care in a Local Acute Hospital

1 BASIC PRINCIPLES

- 1.1 Patients should receive physical and mental health care in the most appropriate setting.
- 1.2 Disruption to patient's continuity of care should be kept to a minimum.
- 1.3 Risk assessments and management decisions should be undertaken in consideration of inpatient service user's physical and mental health care needs.
- 1.4 This policy relates to planned transfer of care. Where there is an emergency or life-threatening situation involving a service user within an inpatient mental health service, the expectation is that 999 services will be contacted. This may lead to an emergency admission to the Local Acute Hospital via the Accident and Emergency Department. A service user's return to inpatient mental health services from the local acute hospital following such an emergency admission would be covered by this agreement.

2 PURPOSE OF THE AGREEMENT

- 2.1 The purpose of this agreement is to clarify the protocol, roles and responsibilities for transferring East London NHS Foundation trust inpatient service users to and from local acute hospitals.

3 ROLES AND RESPONSIBILITIES

- 3.1 It must be absolutely clear at all times who is responsible for the case of an inpatient service user, both in terms of their physical and mental health. As a general rule, when a patient is physically located within the ELFT, they are the responsibility of ELFT; and when a service user is physically on-site at the local acute hospital they are the responsibility of the local acute hospital. There is an expectation of joint working and liaison between the two services.
- 3.2 In some cases, it may be necessary to make specific joint care arrangements to ensure comprehensive packages of care are provided for individual service users. For example, an agreement that ELFT continues to support a service user's mental health needs whilst they are in the local acute hospital OR the Local Acute Hospital continues to remain responsible for a patient's physical health care needs once the patient returns to an inpatient mental health setting. Where this is the case, joint care plans must be in writing and agreed between clinical staff from both physical and mental health services.
- 3.3 Any financial implications for such agreements will be handled on a case-by-case basis. The provision of joint care should not be delayed due to physical and mental health care services not being able to agree responsibility for funding.

- 3.4 In the unlikely event that there is a dispute regarding the terms of this agreement, the matter will be swiftly escalated to the most appropriate clinical and service managers or the most senior nurse on site out of hours.
- 3.5 Advice on the issues raised within this policy may be sought at any point from the Lead Nurse for Infection Control and Physical Healthcare at ELFT.

4 TRANSFER ARRANGEMENTS

- 4.1 Sufficient clinical information to allow the patient to be adequately cared for and an up-to-date risk assessment .infection risk assessment and care plan must accompany the patient at all times.
- 4.2 The Pan East London Information Sharing Protocol should be adhered to at all times.
- 4.3 All transfers will take place at a time mutually convenient to both services. This may be required on Saturdays and Sundays as well as week days. The date and times for transfers will be agreed depending on medical and nursing staff's availability to review the patient on arrival to the ward.
- 4.4 ELFT will provide escort where required when a service user is moving between mental health and the local acute hospital.
- 4.5 For a mental health service user not requiring on-going mental health special nursing observation, the mental health service will provide this initially on the transfer, allowing a full handover of care to be given. (It is expected that this would take no more than two hours).
- 4.6 For mental health service users who currently, or are likely to require mental health special nursing observation, agreement and arrangements will be made on a case-by-case basis. The expectation is that these negotiations will happen prior to the planned transfer of care, however, in no circumstance should this discussion become a barrier to appropriate care. Any financial implications for such agreements will be agreed on a case-by-case basis. The provision of joint care should not be delayed due to physical and mental health care services not being able to agree responsibility for funding. To facilitate transfer, if the move is required and HUHFT is unable to locate specific bank or agency staff to support the patients care needs the default position will be provision of mental health specific care by ELFT for at least the 1st shift.

5 CONTINUITY OF CARE

- 5.1 It is expected ELFT staff will ensure that they remain informed regarding the service user's progress during their episode of care at the local acute hospital. Visits from ELFT clinicians ensure continuity of contact and care for the service user, whilst they are at the local acute hospital. Any changes to the patient's mental health care whilst they are at the local acute hospital will be discussed and made jointly.

6 MONITORING PATIENTS PLACED OFF THE WARD

- 6.1 Patients moved to the local acute hospital should be discharged from PAS, but retained on Mental Health Link. However, they should be kept on their home ward's nominal roll (in practice, this means keeping the patient "on the board"). **No discharge summary is needed if, at the time of transfer, it is expected that the patient will return to mental health services.** The patient's bed on the ELFT ward should be considered vacant and may be used by another service user requiring admission. However, it would be expected that a bed would be made available within 24hrs of the patient being fit to return from the local acute hospital.

6.2 In all circumstances, the GP must be informed that the patient's care has been transferred.

7 PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT 1983

7.1 If a patient is to leave the place in which they are liable to be detained, appropriate legal authority must first be established and Mental Health Act Administration should be informed at the earliest opportunity.

7.2 Section 17 of the Mental Health Act

If the patient is to go to another hospital and it is planned for he/she to return, the most appropriate authority will probably be found in section 17 – 'Leave of Absence'.

7.2.1 Only the patient's Responsible Clinician can authorise leave under section 17 so this power cannot be delegated to anyone else. In the absence of the regular Responsible Clinician where no covering arrangements are in place, the Responsible Clinician is the on-call Consultant Psychiatrist.

7.2.2 Authorisation should be evidenced by the Responsible Clinician immediately completing the Trust's Section 17 form. If this is not practicable, the person receiving the authorisation should document the authorisation details in the patient's clinical notes and the Responsible Clinician should complete the form at the earliest opportunity.

7.2.3 The Responsible Clinician can attach conditions to the authorisation setting out for instance, where the patient should be and who has custody of the patient during conveyance to hospital and subsequent to arrival.

7.2.4 The appropriateness of leave and the conditions attached to it should be kept under regular review by the Responsible Clinician.

7.3 Section 19 of the Mental Health Act

If the patient's move to another hospital is likely to be permanent or for a prolonged period of time, then as long as the receiving hospital is in agreement, consideration should be given to transferring the authority to detain.

7.31 Section 19 and Regulations 7 & 11 (see below) set out the mechanism by which this can happen; a member of Mental Health Act Administration staff or any other member of staff at Band 6 or above who has attended a training session where section 19 was covered should complete Part 1 of Form H4. The receiving hospital should complete Part 2 upon the patient's arrival.

7.32 It is important to establish if a non-mental health hospital has the appropriate measures in place to become the detaining authority; for instance it is highly unlikely that they will have any Approved Clinicians that can become the patient's Responsible Clinician unless an appropriate local service level agreement with a Mental Health Trust is in place.

7.4 Patients subject to special restrictions

Any decision to authorise leave or transfer authority to detain must be preceded by consent from the Secretary of State (currently the Secretary of State for Justice). This includes patients subject to the provisions of the following sections 37/41, 44, 45A, 47/49, 48/49. This also applies to those patients who were detained (prior to 31st March 2005) under section 5 (with restrictions) of the Criminal Procedure (Insanity) Act 1964 as amended by the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991.

7.5 Once the patient has moved to the receiving hospital, the Secretary of State should be informed and then again should the patient return.

7.6 **Emergencies**

In cases of extreme emergency where a delay in securing the appropriate legal authorisation would put the patient's life at risk or cause them to experience serious suffering, movement of the patient to another hospital should go ahead and the legal procedures undertaken at the earliest opportunity. In the case of patients subject to special restrictions, the Ministry of justice should be contacted immediately.

8 **THINGS TO CONSIDER WHEN MOVING A PATIENT BETWEEN TRUSTS**

- 8.1 All patients moving within and between inpatient sites must be escorted by a member of nursing staff. ELFT will provide escort where required when a service user is moving between mental health and the local acute hospital.
- 8.2 The patient must be consulted and their views taken into account before they moved between services. Every effort should be made to respect the patient's preferences.
- 8.3 The patient's carer(s) must be informed of any relocation of the patient by a senior member of the nursing or medical staff.
- 8.4 The patient's care plan and sufficient clinical information to allow the patient to be adequately cared for must accompany the patient at all times, including an indication of their risk to themselves and others.

9 **MENTAL HEALTH SERVICE USERS RETURNING TO ELFT INPATIENT CARE FROM LOCAL ACUTE HOSPITAL:**

- 9.1 The reason for the initial transfer to the Local Acute Hospital should be fully resolved prior to transfer back to ELFT. If the condition is not fully resolved or stabilised and requires on-going care, a detailed pre-transfer discussion needs to take place.
- 9.2 The Duty Senior Nurse (DSN) should be the first point of contact for the acute hospital, in order to discuss and make proper arrangements for the patient's care to be transferred back to ELFT. Contact details for the Duty Senior Nurse for each ELFT site are as follows:

Inpatient Unit	Area of Care Covered by the DSN	Contact Details
City and Hackney	Adult acute and mental health care of older people	07534-214074
Newham	Adult acute and mental health care of older people	07816-972297
Tower Hamlets	Adult acute and mental health care of older people	07811-453637
Forensics	John Howard Centre	07572-154890
	Wolfson House	07908-805006
Coburn Unit	Child and adolescent mental health	07929-206630


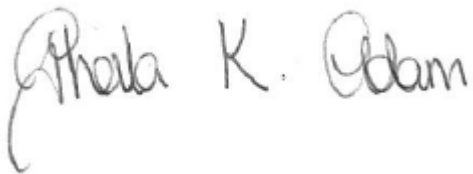
- 9.3 Depending upon the complexity of the case, the Consultant Psychiatrist or Senior Duty Doctor on call and a nurse will assess the planning needs relating to the service user's transfer of care back to ELFT.
- 9.4 If a patient is still being actively treated then there needs to be a clear management and crisis plan which should include what to look out for and what should be done for on-going care and in case of an emergency.
- 9.5 A medical and nursing discharge summary should be sent to ELFT wards.

- 9.6 The discharge summary should be in the form of a transfer summary highlighting any on-going care that may be required
- 9.7 The transfer summary should include detailed description of any wound care, clinical observations or other management required
- 9.8 Infection control risks should be clearly reported and any management plan.
- 9.10 Breach of the above conditions should be reported as a clinical incident via Datix electronic incident reporting system and liaison with the relevant acute trust should be incorporated into the incident management and investigation arrangements.

10 Further Guidance

- Mental Health Act Code of Practice – chapters 11, 21 and 30.13 to 30.23
- Mental Health Hospital, Guardianship and Treatment)(England) Regulations 2008
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice

Agreed by:

		
Signed above on behalf of East London NHS Foundation Trust		
PRINT NAME: Professor Jonathan Warren	TITLE: Director of Nursing	DATE: 15th October 2013
		
Signed above on behalf of Homerton Hospital University NHS Foundation Trust		
PRINT NAME: Sheila K. Adam	TITLE: Chief Nurse	DATE: 11 th November 2013
		
Signed above on behalf of Barts Health NHS Trust		
PRINT NAME: Tracey Carter	TITLE: Deputy Chief Nurse	DATE: 15 th October 2013