Cumbria Partnership NHS Foundation Trust

Transfer and Discharge of Patients within Mental Health Services and Learning Disability services in Cumbria Partnership NHS Foundation Trust

(Previous title in v2: Transfer and Discharge of Patients within and from Community Hospital/Step up Step Down Units, Mental Health and Learning Disability Services in Cumbria Partnership Foundation NHS Trust)

Reference	POL/001/033
Version	3
Date Ratified	7 August 2018
Next Review Date	May 2021
Accountable Director	Medical Director
Policy Author	Jill Archibald Acute Network Manager in collaboration with Mental health. Learning Disability and specialist service colleagues.

Please note that the Intranet / internet Policy web page version of this document is the only version that is maintained.

Any printed copies or copies held on any other web page should therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments.

Policy On A Page

SUMMARY & AIM

This policy provides a framework of safe and effective transfer and discharge of patients within the trust. The policy provides guidance for the transfer and discharge of patients from in-patient settings and within and from community based mental health services.

Transfer and discharge of patients between wards, teams and services whether within Cumbria Partnership NHS Foundation Trust (CPFT) or other service providers can be distressing for patients and is associated with an increase in risk factors in relation to Physical , Mental health and social wellbeing. Care that is well co-ordinated and actively collaborates with all stakeholders involved in the care transition can reduce and manage potential risk factors, ensuring that transfer and discharge between services is a seamless process for patients, and their families.

TARGET AUDIENCE:

This policy is applicable to all staff involved in the discharge and/ or transfer of patients from specialist, mental health and learning disability inpatient facilities and community based mental health, services within Cumbria Partnership NHS Foundation Trust.

TRAINING:

All managers and senior clinical staff will ensure that their teams are familiar with the content of the policy and are to ensure that the policy is followed.

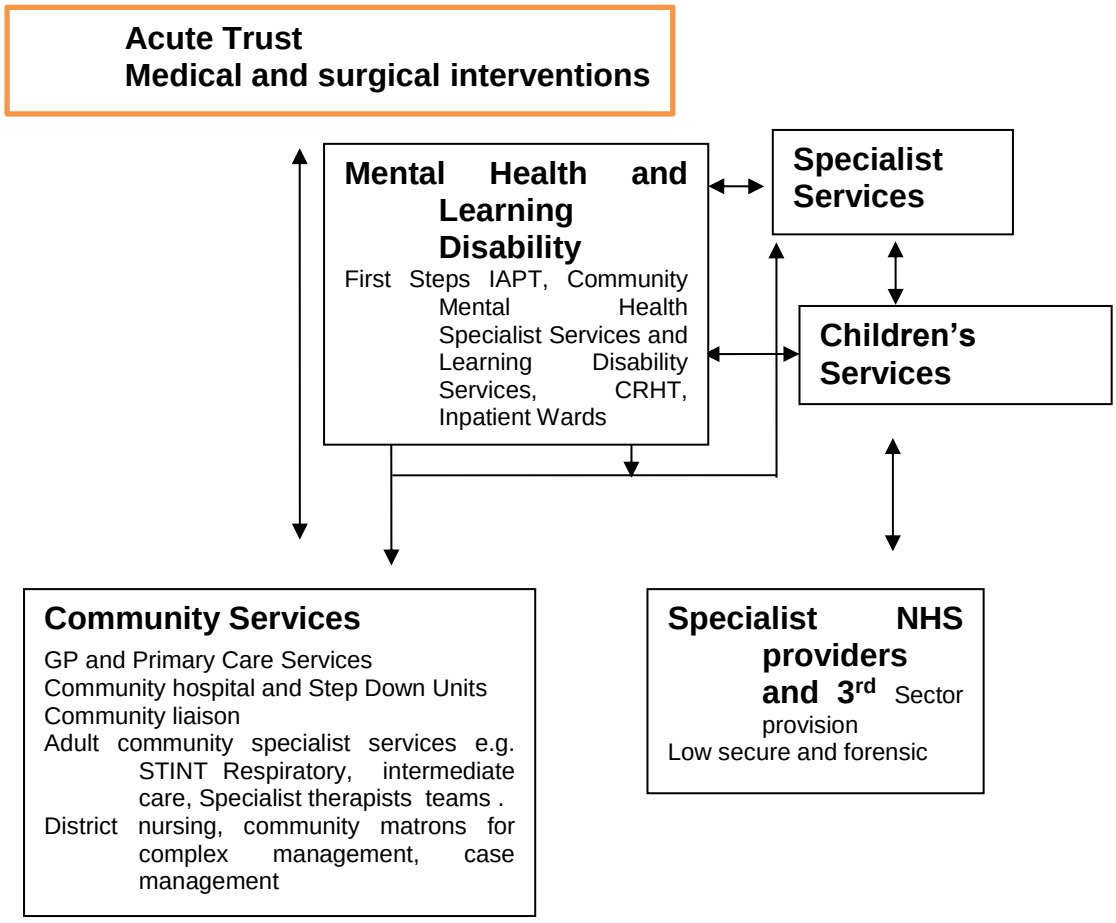
KEY REQUIREMENTS

- .Early communication with patient / families to understand the patient's support needs to facilitate timely admission, discharge and transfer.
- The expected date of discharge (EDD) will be identified within 72 hours of admission. This will be communicated to patients and their families/ representatives to support discharge planning.
- The discharge plan will clearly set out the criteria to be met for discharge.
- Patients identified as having care and support needs following discharge will, as part of their discharge plan, have referrals and assessments completed at appropriate points to ensure the EDD is not delayed.

TABLE OF CONTENTS

SUMMARY FLOWCHART

The following diagram illustrates the transitions that may be encountered by patients:



1. INTRODUCTION

Transfer and discharge of patients between wards, teams and services whether within Cumbria Partnership NHS Foundation Trust (CPFT) or other service providers can be distressing for patients and is associated with an increase in risk factors in relation to Physical , Mental health and social wellbeing. Care that is well co-ordinated and actively collaborates with all stakeholders involved in the care transition can reduce and manage potential risk factors, ensuring that transfer and discharge between services is a seamless process for patients, and their families. This policy will be read in conjunction with POL 001/001 Care Co-ordination Policy and the Cumbria multiagency approved Discharge and Home Choice policy CPCT/001/039.

CPFT provides services which meet the needs of people from Community health, mental health; learning disability and physical health perspectives. In addition CPFT provides care in in-patient and community settings delivered by primary care community services; secondary care community services both for physical and mental health, specialist providers such as psychotherapy and acquired brain injury and meets the life stage groups of children and young people, working age adults and older adults. Community services meet individual patient needs using a holistic approach drawing on necessary community specialisms.

2. PURPOSE

This policy provides a clear framework for staff of the operational, governance and risk management procedures which underpin the safe and efficient transfer and discharge of patients within mental health and learning disability services. In accordance with the duties outlined, staff are expected to make certain that the mental and physical well-being of patients is supported throughout the patient journey to ensure a safe, seamless transfer or discharge of a patient to the appropriate setting, based upon need.

3. POLICY DETAILS

3:1 TRANSFERS

This refers to patients who are transferred between service providers within CPFT. This will include the following categories of transfer.

3:1:1 IN-PATIENTS

Transfers that occur between wards within CPFT and may involve transfer within or across clinical networks and localities. This will also include transfers from adult units both Community and mental health to more specialist units dependant on individual clinical need.

In-patient Discharges: Refer to patients whose in-patient episode has been completed and their ongoing care needs will be delivered and monitored by community based services.

3.1.2. Community Based Services

Transfers that occur between community based services when an intervention has been completed and the ongoing needs of the patient will be met by another service within the pathway, for example Access and liaison service & Home Treatment completed initial assessment and intervention and transfers the care of the patient to the Community Mental Health Assessment & Recovery Team, or IAPT services delivering first level interventions, but requires secondary care involvement by CMHART.

Discharge from Service **-** refers to patients who no longer require the interventions from mental health and learning disability of CPFT. The patients care will be referred back to the patients GP.

.

3:2 CLINICAL PATHWAYS

A system of mental health and social care that a patient will enter dependent upon their presenting needs. These will broadly cover the following areas of need:-

- Psychosis: pathways related to schizophrenia and related diagnosis
- None Psychosis: will include anxiety, depressive and personality disorders
- Organic: will include dementia and learning disabilities
- AAP : Acute Admission Pathway (Adult Acute in-Patient Services) (Appendix 1)
- 72 Hour Pathway for service users in crisis (ALIS/HTT)
- FIRST STEP
- LEARNING DISABILITY
- MLL

Detained Patients

Patients who are being assessed and / or treated under the Mental Health Act (1983). Such patients will be managed in a suitable mental health facility.

3:3 TRANSFER OF PATIENTS WITHIN IN-PATIENT WARDS IN CPFT

There are two main reasons why patients may be transferred within the wards of CPFT;

- The clinical need/safety of the patient or others.

- Repatriation of the patient to a ward within their own locality within CPFT.

- Transfer of patients will be planned in advance and will not disrupt the patient's care-pathway. When planning and facilitating the transfer ward staff will undertake the following actions:

- Carers/relatives will be given contact details including telephone number and address of the new ward.

- Inform all members of the patients MDT including Care Coordinator within 24 hours.

- Ensure all clinical records including risk assessment and care/ treatment plans are up to date prior to actual transfer.

- The clinical records will accompany the patient. In some situations e.g. Mental health or a patient who has an acute physical deterioration a nurse will accompany the patient.

- Obtain transport and appropriate staffing to support the patient during the transfer based upon the updated risk assessment and care plan to meet the physical and mental health needs of the patient. (See appendix…2….)

- Ensure all the patients belongings are accounted for and transferred with the patient.

- Check the patient's prescription chart and ensure non-stock medicines are sent with the patient.

- If the patient has a known infection, clear information is required written and verbal to the referred unit. The appropriate Cumbria Partnership NHS Foundation trust Infection control Policy must be adhered to.

3:3:1 TRANSFER/DISCHARGE OF PATIENTS WITH KNOWN INFECTION

The prevention and management of infectious diseases is a high priority in all health care organisations. The transfer/discharge of patients known to have an infection can put both the patient and others at risk. Therefore infection control procedures will be included in all decision making for patients who have an infection.

- Before a Service User/Client with a known infection is considered for transfer the Infection Prevention Team will be contacted,

- Advice regarding necessary equipment, information and facilities required to care for the individual will need to be considered.

- Any transfer across the Trust of patients with a known infection will consider the risk this patient poses to others.

- On discussion with the Infection Prevention Control Team a risk assessment can be completed. Any additional resources required by the ward to which the Service User/Client is to be transferred (i.e. information, additional PPE/support) can be requested from the Infection Prevention Team at this time. This will ensure a safe transfer, minimising the risk of cross infection.

- It is the responsibility of the ward manager to monitor this.

- On the day of transfer the nurse in charge will take responsibility for ensuring the correct surveillance transfer document is sent to the receiving ward/facility (See Infection Control Policies). This will be supported by the infection prevention nurse and further monitored by the ward manager.

- Before the discharge/transfer of any Service User/Client with a known infection it is the ward manager's responsibility to inform the Infection Prevention Control Team.

- The Infection Prevention Control Team will risk assess the situation offer advice and guidance and contact the GP and carers as necessary and appropriate to the needs of the patient.

3:4 IN-PATIENT DISCHARGE PLANNING PROCEDURES

All patients will be discharged in a timely and effective manner and as soon as they are deemed well enough to no longer require in-patient treatment. All in-patient wards have a pathway which has been devised specific to their client group .

Discharge planning is a continuous process which begins on admission and continues until the patient is formally discharged from the ward.

- Planning for discharge will begin as soon as practicable following admission in order that a comprehensive treatment and discharge plan can be formulated; therefore discharge planning is a key component of the in-patient care plan.

- Mental health -Following admission the ward will notify the care-coordinator/community case manager immediately of the patient's admission if they do not already know.

- Following admission the ward will notify those community key workers involved in the patients care of admission. This allows the community services to have involvement in the AAP (Acute Admissions Pathway) Appendices 1, memory and later life and learning disabilities pathways. The community team will remain involved in the patients care and will support discharge back into the community.

- A care coordinator or case manager will facilitate safe discharge; he or she will be identified and agreed by the MDT. The identified care coordinator/case manager will have a key role to play within any in-patient episode of care; they will need to ensure the named nurse/ in- patient care team are fully aware of the service user's home/social situation and they will take the lead in reviewing the package of care/treatment and for the planning of safe discharge from hospital at earliest opportunity.

- All patients will have a review within 72 hours of admission in adult acute services.. This review will consider the reasons for admission, plan the treatment

to be provided and provisionally plan the patients discharge. This review process will elicit any potential barriers to effective discharge e.g. housing.

- A medical check will occur within 24 hours of admission. (refer to physical health policy and pro-forma for inpatient mental health units)

- Arrangements for discharge will be negotiated and agreed with everyone likely to be concerned with the patient's aftercare by the responsible multi- disciplinary team (MDT).

- The patient, their carer and/or family member, will also be fully involved, at the earliest opportunity, in all aspects of the discharge and aftercare plan, where appropriate and practicable. The patients and carer's right to confidentiality will always be considered. Patients and carers will be encouraged to give their permission for information to be shared (refer to Consent to Treatment Policy POL/001/010).

- Patients will be reviewed by their MDT prior to discharge and in complex discharges a formal discharge planning meeting will be recorded in RIO .

- It is best practice that when an NHS body gives notice of an individual's case to a Local Authority, they must take reasonable steps to ensure that an assessment for NHS continuing healthcare is considered in all cases where it appears that the patient may have a need for such care. This should be in consultation, as appropriate, with the relevant Local Authority.

- From the discharge meeting a formal discharge plan will be set. The discharge plan will include: Identification of the care coordinator/case manager and all other people involved in the care and treatment of the person after discharge; outcome of risk assessment and the strategies identified to manage any assessed risk; details of the community follow up to be provided including day services, day care, carers, education etc.

- Designated staff member on shift will be responsible for notifying the GP about a patient's discharge by email via EMIS or within 24 hours of the patient leaving the ward using the discharge proforma (Appendices 3). Details will include medication on discharge, care plan, care required in the community and crisis and contingency plan which will contain the risk management plan.

- On occasions the out of hours provider CHOC require, with the patients consent, information to alert them of special out of hours care required. A CHOC proforma should be completed by the GP or case manager/coordinator and emailed to CHOC.

- Where service users are detained under a section of the Mental Health Act (1983) the Consultant Psychiatrist who is the responsible medical officer will authorize the removal of the section and sign the appropriate Mental Health Act (1983) discharge form.

- A qualified nurse will give the patient their discharge medication and ensure that they understand the medication given, when it will be taken and when and how to obtain further prescriptions.

- The patient/carer/relative will make their own transport arrangements following discharge unless there is a clear reason for in-patient staff to book transport.

- The named nurse/designated Qualified Nurse on shift will record the date of discharge within RIO ,

- An allocated nurse will ensure that the discharge has been recorded onto RIO on the day of discharge.

- During the patient inpatient stay the named nurse and care coordinator/case manager will ensure that the patient is involved and aware of the discharge date and preparation that they are being discharged.

- Mental health learning disabilities patients will be given the following information/documentation; a copy of their discharge plan, community care plan and crisis/contingency plan, follow up care meetings. The discharge care plan will ensure that the patient has contact details for all professionals involved in their care, information when care support will start, when to expect professionals involved in their care/ continued treatment, follow-up appointments, details of any prescribed medication including drug information leaflets.

- All patients WILL be offered a discharge questionnaire prior to leaving the ward this will be documented in the RIO progression notes..

- Patients who are being discharged to no fixed abode/temporary accommodation will be given contact details for local housing and social services departments 7 days prior to discharge, who can help them to find short term accommodation.

- Patients from CPFT who are discharged/transferred to a mental health unit outside of Cumbria will continue to receive input from their care coordinator/case worker whilst they are out of locality. Further details can be found in the CPA policy.

- When patients are to be discharged to a destination out of area, the Care Coordinator / case manager must ensure and confirm care and professional community follow up is put into place prior to the patient discharge.

3:4:1 IN-PATIENT DISCHARGE DOCUMENTATION

There are a number of records which relate to the discharge process and which will be completed;

- Discharge planning will be documented in the patients care plan and a record of action taken in relation to discharge planning maintained in the clinical record

- Care coordinators/case managers will ensure there is a care-plan in place for community services and crisis and contingency planning on discharge. This is will be entered onto RIO

- For patients being discharged under Home Treatment or who require follow-up by the HTT they will have a crisis care plan which will be recorded on RIO. Patient will also receive a paper copy of the plan.

- Preliminary discharge summaries (Appendix 2) including details of medication and aftercare arrangements WILL be emailed to the patients General Practitioner within 24 hours.

- A full discharge letter will be typed and faxed to the patients GP by the medical secretary within 7 days.

3:4:2 UNPLANNED DISCHARGES

Discharge from the in-patient service may, in rare cases, take place before the planning process is complete. The two main circumstances leading to such unplanned discharges are:

- A decision by the service user to take discharge against the advice of the multi disciplinary care team. This will be subject to assessment of the patient's mental state, mental capacity and the risks to self or others. Patients who are detained under the Mental Health Act or a Deprivation of Liberty Safeguards cannot self-discharge from hospital.

- A decision by the in-patient team that the individual's behaviour is not consistent with continuing in-patient care. Indicators for such a course of action include substance abuse, aggressive behaviour, abuse and exploitation of fellow patients and/or staff in the absence of signs of acute mental disorder.

In the event of an unplanned discharge advice will be sought from the ward/service manager, senior clinician, GP involved in the patients care. Out of hours advice can be sought from the on-call manager and on-call consultant and out of hours provider CHOC.

The standards of discharge planning will still be adhered to where possible including –

- Arrangements made for post discharge follow-up by the HTT or care coordinator/Case manager.

- GP notified of the unplanned discharge as soon as possible.

- Notify other professionals involved in the patients care. e.g. District Nursing team, DART, Psychology, Social Services, and Probation etc.

- Provision of a discharge prescription if the patient is prescribed medication; where possible take home medicines will be obtained from the pharmacy. However if the patient is not willing to wait they can be issued with a FP10 prescription which they can take to a community pharmacy.

- The patient must sign a form to accept that he/ she is taking his own discharge against professional and medical advice.

- Full discharge summary sent to GP within 24 hours of the patients self- discharge.

- An electronic incident should be submitted for information and investigation.

3:5 SECTION 117 AFTERCARE

Patients who have been detained in hospital under certain sections of the Mental Health act will receive aftercare under section 117 of the MHA. Further details of the legislation can be found in the Trust Policy POL001/005/011 Mental Health Act Policy – 117 Aftercare. The main points relevant to this policy are outlined below;

- Section 117 of the MHA 1983 places a duty on Health and Social Services to provide aftercare services to users detained under certain sections of the Act: Section 3, 37 and transfer orders made under Sections 45A, 47 and 48.

- It is a requirement of Section 117 in Cumbria that both an adult social care practitioner and a health care coordinator are identified

- The Key worker under Section 117. Will be either the Care Co-ordinator or an adult social care worker depending on the primary presenting need.

- Patients subject to Section 117 will require a fully care plan describing their needs as per 117 prior to discharge from hospital , this wil need to be agreed jointly between Adult social care and the CMHART.

- The duties to provide aftercare lasts until both the Health and Social Services authorities are satisfied that the service user is no longer in need of such services.

- Section 117 issues and responsibilities will be clearly noted on the pre discharge care plan, along with the identity of designated Care Co-ordinator.

- The Care Co-ordinator or ASC practitioner is responsible for organising all S117 reviews, in accordance with this Policy.

- After discharge, the medical responsibility is shared between the GP and the Consultant Psychiatrist or other Approved Clinician.

- The service user will be identified as being on Section 117 by the completion of the relevant Care Co-ordination Section 117 document; similarly, discharge from Section 117 will be recorded on such documentation.

- The service user can refuse to accept the offer of aftercare services but this does not affect the continuation of the Section. Services are considered to fall under

- Section 117 where they are provided in order to meet the individual's mental health needs and to enable a service user to leave hospital and to minimise their chance of requiring further in-patient care.

3:6 DISCHARGE UNDER COMMUNITY TREATMENT ORDERS (CTO)

Some patients may be discharged from Hospital under Section 17 (A-G) Supervised Community Treatment (SCT) which is a community based section under the powers of a Community Treatment Order (CTO). It is initially for a period of up to 6 months and then renewable thereafter. It can be applied to patients who were initially detained on Section 3, 37, 47,48 or 45a (without restriction) and does not discharge but rather suspends those sections. Further details on the powers and process for completing a CTO can be found in the MHA policies and code of practice.
The main points relevant to this policy are summarised below;

- A CTO does not provide the power to treat a person with capacity against their will in the community.

- Responsibility for the application for a CTO is that of the Responsible Clinician (RC) (with supporting agreement of the Approved Mental Health Professional AMHP), however, this will be undertaken as part of the Care Programme Approach (CPA) process and the Care Co-ordinator identified and involved early in the planning stage prior to discharge from in-patient care and the commencement of the order.

- The responsibility for the pre-discharge planning process lies with the RC but actions in support of this process may be delegated as appropriate to other members of the care team.

- The pre-discharge planning will include consideration of Monitoring and supervision arrangements including, risk assessment, appropriateness of accommodation, the provision of Occupational Therapy and Day Service Activities, appropriate personal support, crisis support and intervention, cultural requirements, advocacy, welfare and financial needs, physical health care needs, carer and family support requirements

- This list is not exclusive, but will form the basis of any post discharge care plan for individual subject to a CTO.

- Monitoring of the provisions of the care plan is the responsibility of the Care Co-ordinator reporting progress against actions to the RC as part of the CPA Review process.

- Good practice requires that the Care Co-ordinator ensures that prior to the commencement of the CTO the person receives;

- A copy of the care plan including all aftercare arrangements and written confirmation of their first appointment post discharge from in-patient care.
- The names and contact details of the key members of the care team including the RC and the GP.
- Details of the crisis and or contingency plan including who to access ALIS/HTT services if appropriate.
- Details of their right to appeal to the Mental Health Review Tribunal (MHRT).
- Details of the arrangements for their appointment with the Second Opinion Approved Doctor (SOAD) service.

3:7 DISCHARGE OF CPFT IN-PATIENT TO AN IN-PATIENT WARD BY ANOTHER HEALTHCARE PROVIDER

For patients that are discharged from in-patient units from CPFT to another in-patient unit provided by another healthcare provider (including Residential and Nursing Home Accommodation) the principles and procedures related to the discharge planning procedures indicated in section 3:4 will be followed. The discharge will be planned in advance with care co-ordinators, the patient, their carer, their multidisciplinary team and their receiving service.

The patient's records will remain within CPFT and photocopies of relevant documentation, decided in consultation with the receiving team, will be made and handed over to the receiving team by the staff facilitating the discharge to the new service. This will include the following documents:

- Up to date risk assessment and management plan,
- Up to date care plan,
- Record of current medicines,
- Responsible clinician's letter detailing the presenting problem; history; reason for presentation; progress with treatment interventions and social history.
- Assessments undertaken and scores,
- Crisis and contingency plans.

3.7:1 Follow-up Post Discharge

The post discharge period can be a period of increased risk for some patients. This is evidenced in mental health care through the findings of the National Confidential Inquiry into Suicide and Homicide 2017, . In addition measures to achieve reduced risk of suicide are set out in the National Suicide Prevention Strategy for England and Preventing Suicide:

All Trusts in England are required to ensure all patients discharged from in-patient mental health wards receive a follow -up post discharge. This applies to transfers to acute/general hospitals, care homes, no fixed abode and to discharges out of area

The rationale behind the indicator is to reduce the overall rate of death by suicide through effective support arrangements for all those with mental ill health.

3.7.2 Mental Health In-Patient Discharges

All Trusts in England are required to ensure all patients discharged from in-patient mental health wards receive a follow -up post discharge. This applies to transfers to acute/general hospitals, care homes, no fixed abode and to discharges out of area The rationale behind the indicator is to reduce the overall rate of death by suicide through effective support arrangements for all those with mental ill health.

Best practice is for this appointment to occur within 48 hours. CPFT follow up care is face to face contact within 48 hours of discharge for all patients. If face to face contact is made within 48 hours, there is no need for a second contact within 7 days, unless required. If 48 hours falls on a weekend or Bank Holidays, ALIS/HTT will facilitate the contact in the absence of CMHART. However, the contact must be a successful contact with the client, not DNA, cancelled or by proxy. Post discharge follow-up is a key performance indicator which the Trust is required to monitor and formally declare compliance in accordance with Monitor requirements.

Discharges from CPFT mental health inpatient units are to be followed-up within 48 hours not just those on CPA. Inpatient specialties include 'Psychiatric Nursing', Psychology', 'Adult Mental Illness' and 'Old Age Psychiatry'. Where a patient has been discharged to prison or nursing home then contact should be made through the prison/nursing in-reach team.

- The following actions will be undertaken to provide post discharge follow up:
- The follow-up appointment will be made with the patient prior to their actual discharge from the ward.
- The follow-up appointment will be carried out by the patients community care – coordinator/case worker where possible. For patients who do not require ongoing input by secondary mental health services the ALIS/HTT provide the follow-up appointment post discharge.
- All follow-up appointments WILL be recorded as such on RIO within 24 hours of the appointment occurring.

3:7:3 EXCEPTIONS:

Post discharge follow-up is not required in the following circumstances:

- Where legal precedence has forced the removal of a patient from the country;
- Patients discharged to another NHS psychiatric inpatient ward;
- Patient discharge to home residence which is not in the country;
- Patient readmitted within 48 hours of discharge;
- Patient refused a 48 hour day follow up appointment;
- Patients discharged to alternative non NHS accommodation where RMN 24/7 cover and where the service providers have been involved in discharge planning meetings and aftercare arrangements.
- Patients where the discharge destination identifies that patient as having died
- Discharges from Learning Disability inpatient specialty

3:7:4 DISCHARGE & FOLLOW UP OF PATIENTS WHO ARE NOT FROM CPFT LOCALITIES

There are occasions when patients are admitted to wards in CPFT who are not from this locality. Where possible such patients will be repatriated to an in-patient unit in their own locality as soon as possible.

- Patients who are transferred to other NHS, community trust or in-patient mental health units outside of CPFT will not be subject to post discharge follow up.

- Where transfers of detained patients take place, the ward staff will ensure all relevant MHA documentation is sent to the new service in line with requirements of Mental Health Act and Code of Practice and with support from the MHLU as required.

When out of area patients are discharged from CPFT to return to their home address

Mental Health/ Learning Disabilities the follow-up appointment will be provided as follows;

- If the patient is known to secondary mental health services in their home locality they will be informed and involved in the discharge plan and be responsible for arranging after care.

- If the patient is not known to secondary services and the MDT do not believe this is indicated in-patient staff may notify the CRHT in the patient's home locality who will have responsibility for providing follow-up post discharge.
- If the patient is discharged to their home address without input from mental health services in their own area and it is not possible to arrange input from their local CRHT then CPFT ALIS/HTT will provide the follow-up appointment via telephone.
- Discharge summaries will be sent to the patient's GP.
- Upon discharge the patient will receive a copy of their Crisis and Contingency plan and a supply of their medication which will be determined by the nature of any risks presented by the patient.

3:8 DELAYED TRANSFERS OF CARE (DTOC)

A Delayed Transfer of Care (DTOC) refers to a patient being fit for discharge from an in-patient bed or transfer to another provider but the care package or placement required to enable discharge to take place is not in place therefore causing a delay. Fitness for discharge will relate to all of the following criteria

- A clinical decision has been made by the Responsible Clinician that the patient is ready for transfer AND
- A MDT decision has been made that the patient is ready for transfer AND
- The patient is safe to discharge/transfer

When a Delayed Transfer of Care occurs the reporting form will be completed and stored in RIO . A copy of the *Delayed Transfer of Care Guideline for Mental Health.* can be found in appendix 2.

3:9 TRANSFERS BETWEEN COMMUNITY BASED MENTAL HEALTH AND SPECIALIST SERVICES

Care coordinators will follow the Trust Policy PPOL/001/001 Care Co-ordination policy for transfer of patients to other service providers within CPFT. First step practitioners will follow their standard operating procedures.

3:9:1 Transfers from Children and Young People's Mental Health Services to Adult Mental Health Services

Care Co-ordinators for young people whose care is being transferred to adult mental health services will follow trust policy POL 001/011 Transition of Young People from CAMHS to Adult Services.

3:9:2 Transfers between Learning Disability Services to an Acute Trust

Care co-ordinators and /or ward based staff for people with a learning disability who require admission to an acute trust for medical or surgical assessment and treatment will follow trust Protocol CL/Protocol/000/000 Protocol for supporting people with learning disabilities to access Acute Services and joint care policy for patients with physical, mental and learning disability needs 001/032.

3:10 Discharges from Community Based Mental Health Services

3:10:1 CMHART

Patients being discharged from community based mental health services will be fully involved in decisions about their discharge and follow up care provision by other professionals where indicated. The care co-ordinator will hold a pre discharge meeting with all healthcare providers involved in the future care of the patient and this may involve GP, social care providers, primary healthcare staff; housing providers, probation services; carers or other providers of support. All patients being discharged from community based mental health services will receive the following interventions:

- Up to date GRIST risk assessment and management plan.
- Repeat of HONOS questionnaire.
- Discharge plan clearly detailing the interventions to be received and by which agency/provider, for example receiving medication from GP.
- Medication prescribed on discharge together with an assessment of medication concordance and interventions. Early warning signs of relapse and relapse prevention plan.
- Clear plan of how to refer back to services or receive additional support if required.

- Assessment of risks of non-engagement of services and management plans to address these.
- Contact details of professionals and providers involved in their ongoing care plan.

Care Coordinator responsibilities:

The care coordinator will follow the CMHART discharge process as part of the CMHART patient journey and in particular the care coordinator will:-

- Ensure all risk assessments are up to date.
- Enter all risk assessments, management plans and the care plan on RIO .
- Send discharge letter and risk assessment to GP and other care providers within 24 hours of discharge.

3:11 PATIENT NON-ENGAGEMENT FROM COMMUNITY BASED MENTAL HEALTH SERVICES

If a patient disengages, during treatment from a community based mental health service, discussions around risk and contact attempts should take place between care coordinator/Case manager and all relevant professionals involved in the care. When discharge is agreed a discharge summary should be completed by the care coordinator and copied to GP/relevant professionals and a letter of discharge sent to service user together with information on how to re-engage with the service.

4. TRAINING AND SUPPORT

Training on this Policy will be provided in accordance with the Trusts Training Needs Analysis and Learning and Development Policy (POL/001/051).

5. PROCESS FOR MONITORING COMPLIANCE

The process for monitoring compliance with the effectiveness of this policy is as follows:
The table below outlines the Trusts' monitoring arrangements for this policy/document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
What	How	Who	Where	How often
Handover of care is managed and monitored in accordance with this policy will include a)handover requirements between all care settings, to	a) Audit of a sample, of 10 transferred and discharged patients.	Network Managers/Quality and Safety Leads and team managers.	Senior network group	Annually

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
include both giving and receiving of information b) how handover is recorded c) Out of hours Transfers and discharges Discharge is managed and monitored in accordance with this policy to include: a) discharge requirements for all patients b) information to be given to the receiving healthcare professional c) information to be given to the patient when they are discharged d) how a patient's medicines are managed on discharge e) how the organisation records the information given in minimum requirements b) and c) f) out of hours discharge process				

Monitoring to include

- AAP audits
- DTOC monitoring and validation by partners
- Monitoring of incidents and complaints relating to discharges through governance meetings

Wherever the above monitoring has identified deficiencies, the following must be in place:

- Action plan

- Progress of action plan monitored by the *name of relevant committee* minutes
- Risks will be considered for inclusion in the appropriate risk registers

6. REFERENCES

NICE Guidance
Transition between inpatient mental health settings and community or care home settings (NG53)

Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27)

Transition between inpatient mental health settings and community or care home settings (QS159)

Transition between inpatient hospital settings and community or care home settings for adults with social care needs (QS136)

7. ASSOCIATED DOCUMENTATION:

Care Programme Approach Policy
Consent to Treatment Policy
Mental Health Act Policy – 117 Aftercare Learning and Development Policy
Delayed Transfer of Care
Care Co-Ordination Policy
Enter and Exit Policy
Operational Procedures for all Wards and Teams
Whole systems discharge policy
Transition of Young People from CAMHS to Adult Services.

8. DUTIES (ROLES & RESPONSIBILITIES):

8.1 Chief Executive / Trust Board Responsibilities:

The Chief Executive and Trust Board jointly have overall responsibility for the strategic and operational management of the Trust, including ensuring that Trust policies comply with all legal, statutory and good practice requirements.

8.2 Executive Director Responsibilities: Medical Director

All policies have a designated Executive Director and it is their responsibility to be involved in the development and sign off of the policies, this should ensure that Trust policies meet statutory legislation and guidance where appropriate. They must ensure the policies are kept up to date by the relevant author and approved at the appropriate committee.

8.3 Senior Managers

Senior Managers include network managers, service managers and on-call managers out of hours. They are responsible for ensuring all staff receive appropriate

training to support the implementation of this policy. They are responsible for ensuring the policy is implemented, for monitoring its implementation through receipt of KPI and/or audit reports and for ensuring through the accountability frameworks that appropriate action is taken when this policy is not adhered to. The on-call manager out of hours is responsible for providing where required support and guidance to in-patient staff in the event of emergency transfers and unplanned self-discharges.

8.4 Managers Responsibilities:

Ward and Team Managers

Ward managers, crisis team and community team managers will work closely to ensure the implementation of this policy is carried out such that all transfers and discharges from in-patient wards and carried out effectively.

- Ward managers will ensure all in-patient staff comply with this policy and complete the paperwork required to evidence effective transfers and discharge planning.

- ALIS & HTT managers will ensure the their team provide appropriate in- reach to in-patient wards to support effective bed management and proactively facilitate effective discharge such that the in-patient stay is minimised.

- Community team managers will ensure care-coordinators and case managers fulfil their duties in accordance with the CPA policy and/or the team operational policy and standards to ensure all patients have appropriate and effective discharge plans in place and community care plans to promote the patients continued recovery and reduced risk of future relapse.

- Inform the Mental Health Legislation Unit of all transfers of patients detained under the Mental Health Act.

8.5 Staff Responsibilities:

Care Coordinators

All patients subject to enhanced CPA will have a community based care-coordinator.
Responsibilities of the Care Co-ordinator are detailed in the Care Programme Approach Policy (POL/001/001). In relation to transfers and discharge planning from in-patient mental health units and community mental health teams, they will maintain a lead on the organisational processes of care, when a service user is admitted to hospital, and work with the named nurse to monitor the person's progress and facilitate development of plans for them leaving.

Community hospitals and Step Up Step down units will have a discharge co coordinator/ case manager or named nurse identified to facilitate discharge plans. Identified case managers i.e. Community Matrons or District nursing Sisters should be fully

involved with discharge planning for those with complex needs and long term conditions.

ALIS & HTT

ALIS & HTT have a vital role to play in relation to transfers and effective discharge planning. Specifically they will:

- Support the ward staff in making arrangements for the transfer of patients between wards. This may involve organising and confirming the availability of a bed on the designated ward and supporting arrangements for the physical transfer such as transport and staff escort.

- Contribute to devising discharge care plans for patients they are involved with supporting patients on home leave as part of the discharge plan.

- Support patients on facilitated early discharge which may include home treatment and intensive support to reduce the length of hospital admission.

- Carry out risk assessments for patients they are supporting.

- Carrying out 48 hour follow-up appointments.

In-patient Staff

In-patient staff, including nurses, medics and allied health professionals are responsible for ensuring patients are transferred in a safe and effective manner and which ensures continuity of the patients care. They will also ensure discharge planning occurs throughout the patient's in-patient admission whilst engaging with the relevant professionals to facilitate a timely and appropriate discharge from hospital. All in-patients on Mental Health Wards are automatically subject to enhanced CPA and the in-patient named nurse will act as the Care Co-ordinator where there is not one already in place.All Staff

All staff are responsible for ensuring that they:

- Are familiar with this policy and any associated procedural documents;
- Know where to locate them, i.e. Intranet;
- Keep up to date when any changes are made;
- Attend training or learning events necessary for the implementation of practice associated with this policy;
- Comply with the practices identified within this policy.

8.6 Approving Committee Responsibilities:

The Chair of the approving committee will ensure the policy approval is documented in the final section of the Policy Author Checklist. The committee will agree the approval of the final draft of the policy.

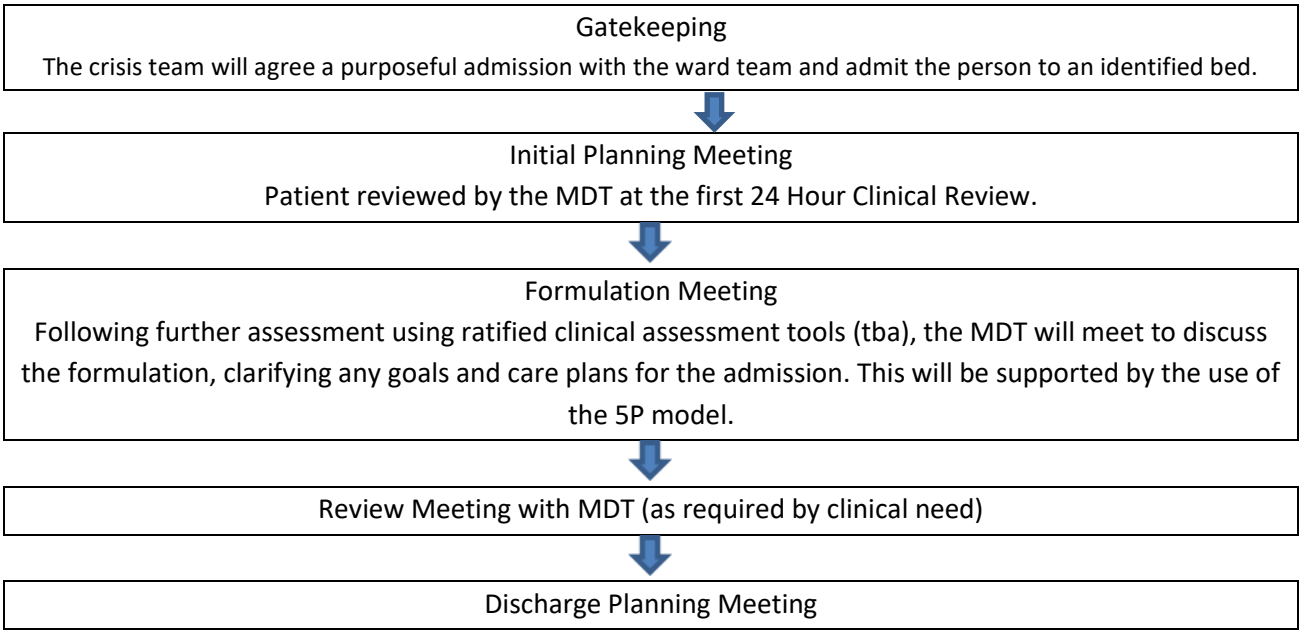
9. ABBREVIATIONS / DEFINITION OF TERMS USED

Keep lists in alphabetical order

ABBREVIATION	DEFINITION
AAP	Acute Admissions Pathway
ALIS	Access and Liaison Service
CMHART	Community Mental Health and Recovery Team
CPN	Community Psychiatric Nurse
DTOC	Delayed Transfer of Care
HTT	Home Treatment Team
LD	Learning Disability
MLL	Memory and Later Life

TERM USED	DEFINITION

APPENDIX 1 - AAP: ACUTE ADMISSION PATHWAY (ADULT ACUTE IN-PATIENT SERVICES):



Gatekeeping

The group agreed that a purposeful admission pathway should begin with the admitting entity, usually the crisis team, agreeing a purposeful and goal focussed rationale for admission. The group identified that “unable to guarantee the person’s safety” was a common rationale for admission, however we agreed that this is not a purposeful reason. An example of a purposeful rationale would be: “there is significant suicidal intent due to deterioration in mood, therefore the admission should be centred around establishing the person on medication and further monitor signs of depression for a period of 3-4 weeks”. This allows the inpatient team to start productively as opposed to having to identify the need once the person has been admitted. It will also allow the inpatient team to correctly populate any documentation for the Acute Admission Pathway. It is anticipated that this will encourage good working relations between inpatient and crisis at interface and increase patient flow.

Equally the above principles should apply when referring to PICU. The referrer, whether community or acute ward, should identify the need for a PICU bed and the aims of the admission to PICU.

Initial Planning Meeting

In attendance: nurse in charge, consultant, junior doctors, bed manager, ward manager, occupational therapist.

The daily meeting starting at 09:00 will be known as the Clinical Review Meeting and will be discussed later in this document. The first occasion a person is presented at the meeting will be classed as their 24 Hour Initial Planning Meeting and will be evidenced by

an agreed format to document the reasons for admission, associated risks, initial presentation on the ward, identification of any tasks, and allocation of the appropriate traffic light using an agreed system which will be used as a grading tool throughout the admission.

Formulation Meeting

In attendance: nurse in charge (preferably named nurse), consultant, care co-ordinator, occupational therapist, patient and family/carers (towards the end of the meeting).

Within 72 Hours of the person having been admitted, it is proposed that the nursing team have sufficient evidence regarding the person's mental state using agreed clinical tools (tba) and present the findings to the MDT. This forum allows the MDT to discuss the patients case using the 5P model of formulation. With regards to this model, the team felt that caution should be taken regarding the format and language used to give the patient and family/carers every chance of understanding of each domain. It was suggested that this may be another piece of work when devising the documentation for the AAP. This meeting should allow the patient and family to express any concerns that they may have to the MDT and support discussion to alleviate any anxieties. The outcome of the meeting should form the basis of the care plan with tasks to be fulfilled by each member, where appropriate, including the patient.

Review Meetings with MDT

The group felt that there are too many formal reviews for the patients on the wards, increasing their workload. As the plan is set in the Formulation Meeting and progress against this monitored through the Clinical Review Meeting, the group felt that the current system of weekly review should be replaced by a 1:1 consultation with the patient's RMO. This is also based on the feedback from patients who find MDT meetings extremely difficult, anxiety provoking, and obstructive when wanting to discuss personal information or symptoms.

Discharge Planning Meeting

Attendance: nurse in charge, consultant, junior doctor, occupational therapist, care coordinator, patient, family/carers.

This meeting takes place towards the end of an inpatient stay and reflect on the admission and progress which the person has made. It should also give the patient and the MDT an opportunity to negotiate the logistics of discharge such as discharge address and 48 hour follow up but also the aims for the post discharge care plan with emphasis on crisis management and relapse prevention.

Philosophy of Care

Discussion have taken place regarding the need to review the units' philosophy of care to reflect the purposeful admission and allow all external stakeholders the opportunity to understand the criteria for admission to an acute inpatient unit or a PICU.

24 Hour Clinical Review Meeting

This meeting currently exists within the current ways of working, however it has been named the 24 hour clinical review meeting in the interests of standardising it across all areas. All MDT members should be aware of the terms of reference for this meeting and its purpose to avoid it becoming a review meeting for certain patients. The purpose of the meeting is to provide the MDT with an update of the patient's presentation over the last 24 hours (or weekend for the Monday meeting). There should be a common sense approach taken to this and it is acceptable to ensure that the MDT is aware of incidents of note such as assaults on the unit or AWOL. Once electronic notes are available, there should be an emphasis on those not in meetings to familiarise themselves with a patient's presentation prior to going into the meeting. There is also an expectation that the nurse in charge of the meeting has prepared fully for the meeting and is aware of the previous day/s clinical entries.

With regards to efficiency of this meeting, the focus should be on the quality of the discussion rather than the time to avoid rushing and missing information. This reinforces the need for the team to be familiar with what should and should not be discussed at this meeting. If there is an urgent matter that requires discussing with the MDT, this should be facilitated and the person be allowed time to do so. The team may also consider identifying a blue light for this patient in these circumstances. Whilst timing of clinical conversations in this meeting should be considered by the whole MDT, the recording of times should be reserved for quality assurance or quality check.

The suggested allocated time for patient discussion is 2 minutes 30 seconds or 4 minutes for new admissions. With regards to current practices within the 09:00 MDT meeting, the initial readings were encouraging:

APPENDIX 2: MENTAL HEALTH INPATIENT DISCHARGE FORM

Mental Health Inpatient Discharge Form

NHS Number xxx xxx xxxx
RiO No: xxxxxxx

10 May 2018

DR xx xxxxx
FUSEHILL MEDICAL CENTRE
Fusehill Street
CARLISLE
CUMBRIA
CA1 2HE

WARD
Carleton Clinic
Cumwhinton Drive
Carlisle
Cumbria
CA1 3SX
01228 602000

PATIENT DETAILS

Patient Name: Mr Nic-Donotuse XXTESTPATIENTKATP **Patient DOB:** 18 Dec 1945
Patient Address: H S C I C, 1 Trevelyan Square, Leeds, West Yorkshire,
Patient phone number:

EPISODE DETAILS

Date of Admission: **Date of Discharge:** (No data)
Discharge Consultant:
Mental Health Act Status on Admission:

CLINICAL DETAILS

Diagnosis:

Clinical Summary

DNA CPR in place :

Actions Requested of GP

Other Actions

48 Hour follow up date -

48 Hour follow up clinician -

Care Co-ordinator -

Care Co-ordinator contact details -

Discharge Medication

Number of days medication to be dispensed

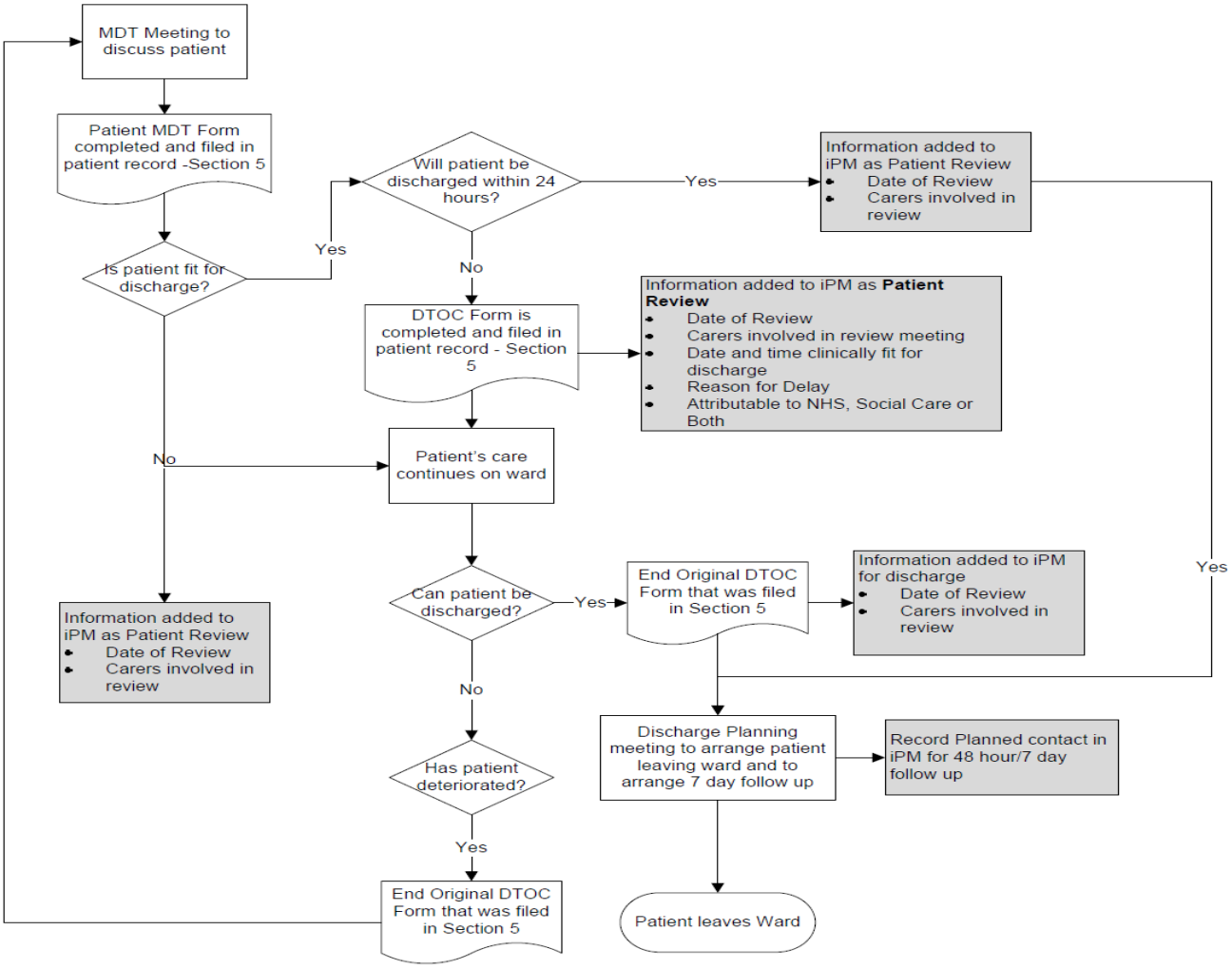
Medication Changes

Allergies and adverse reactions

Substance	Reaction Type	Reaction	Severity of Reaction
Unknown			

Transfer of Care Discharge Information Verified By:

APPENDIX 3 DTOC FLOW CHART



DOCUMENT CONTROL

Equality Impact Assessment Date	
Sub-Committee & Approval Date	*The policy has gone through LD, MLL, Acute and urgent and CMHART network governance meetings.* *Joint CPMG Ratified 7/8/18*

History of previous published versions of this document:

Version	Ratified Date	Review Date	Date Published	Disposal Date
V2		July 2017	4/7/2016	
V3	7/8/18	31/5/2021		

Statement of changes made from version

Version	Date	Section & Description
V2	Oct 2017	• Removal of community hospitals as I was informed that they would merge with the acute trusts discharge and transfer policy also refer to whole systems discharge policy. Previous policy title: Transfer and Discharge of Patients within and from Community Hospital/Step up Step Down Units, Mental Health and Learning Disability Services in Cumbria Partnership Foundation NHS Trust
	7/7/2018	• NICE Guidance added to References
		•

List of Stakeholders who have reviewed the document

Name	Job Title	Date
Jo Johnston	Senior CMHART network manager	OCT to May 2018
Andrea Greenwood	Senior Acute and Urgent network manager	Oct to May 2018
Peter Fairlamb	LD network manager	May 2018
Nina Hill	Senior specialist network manager	May 2018
All ward managers in Acute MH	Ward managers	Oct to May 2018
Jeannie Mark	MLL network manager	Oct to May 2018

David Storm	Senior network manager MLL	Oct to May 2018
Doug Maisey	Clinical director urgent care	July 2018
Community hospital network managers	Oct 2017 they stated that they would not form part of the policy as the have merged with the cute trust policies	Oct 2017
48 hour follow meetings	Review of follow up care in mental health	Finalised in April 2018
Discharge summary project		April 2018