Essex Partnership University
NHS Foundation Trust

DISCHARGE AND TRANSFER CLINICAL GUIDELINES

PROCEDURE NUMBER:	CG24
VERSION NUMBER:	2.7
REPLACES EPUT DOCUMENT	CG24
KEY CHANGES FROM PREVIOUS VERSION	Amended 7.5 (7 days to 72 hrs'; amended 7.6 (24 hours of discharge) 2.5 – 3 month extension 2.6 – 2 month extension 2.7 - Extension to July 23 & new author approved (Sarah Brazier) May 23
AUTHOR:	Sarah Brazier Advancing Clinical Practice Lead
CONSULTATION GROUPS:	Operational Service Leads
IMPLEMENTATION DATE:	1 July 2017
AMENDMENT DATE(S):	September 2017; August 2019 March 2020; July 2020; December 2020; Dec 21
LAST REVIEW DATE:	September 2019
NEXT REVIEW DATE:	September ~~December 2022~~ February 2023 July 2023
APPROVAL BY CLINICAL GOVERNANCE & QUALITY SUB-COMMITTEE:	September 2019
COPYRIGHT	© Essex Partnership University NHS Foundation Trust 2018-2022. All rights reserved. Not to be reproduced in whole or part without the permission of the copyright owner

CLINICAL GUIDELINE SUMMARY

These guidelines aim to provide a clear pathway for the transfer and discharge of all patients of Essex Partnership University NHS Foundation Trust (EPUT) from and within Mental Health, Learning Disability, Secure Services and Community Health Services, ensuring that a patient's transition between areas of EPUT services and transfer outside EPUT services is carried out timely, effectively and safely.

NB: The guidance encompasses the broad principles expected of EPUT staff in relation to the safe and effective transfer and discharge of care. Some guidance is specific to a service area; however there are general guidelines and instructions that apply to all services.

The Trust monitors the implementation of and compliance with this clinical guideline in the following ways:
Discharge and transfer of care are frequent and significant to patient's care. The team leader/manager will routinely monitor implementation and compliance with guideline. A component of management supervision must include the scrutiny of records documentation relating to the discharge and transfer process. All incidents or near misses, related to the discharge and/or transfer of patients should be reported via the Trust Risk Management reporting systems i.e. Datix. Monitoring of this policy will include data collected from any clinical incident reporting.

Services	Applicable	Comments
MH & LD	✓	With exception of Secure Services - refer to SSOP 4

The Director responsible for monitoring and reviewing this Clinical Guideline is the Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DISCHARGE AND TRANSFER CLINICAL GUIDELINES

CONTENTS

THIS IS AN INTERACTIVE CONTENTS PAGE; BY CLICKING ON THE TITLES BELOW YOU WILL BE TAKEN TO THE SECTION THAT YOU WANT

Appendices

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

DISCHARGE AND TRANSFER CLINICAL GUIDELINE

1.0 INTRODUCTION

1.1 The Trust's commitment to high quality care and patient safety is paramount and as such the purpose of this document is to provide clear guidance to staff, patients, relatives and carers when a person is transferred while in the care of Essex Partnership University NHS Foundation Trust (EPUT) services to another service such as an acute trust or, discharged from EPUT services completely.

1.2 When a person is admitted to an inpatient service it is good practice to consider individual discharge needs and a planned discharge date from the point of admission together with personalised care planning.

1.3 Transfer of care refers to patients who are transferred between service providers within EPUT and to other service providers.

1.4 Discharge refers to patients whose in-patient and/or community episode has been completed and they no longer require the interventions from EPUT services.

1.5 Throughout this document the term patient will be used throughout and relates to people who use Mental Health, Learning Disability and Community Health services, often referred to as either 'patients', 'service users', 'customers' or 'residents'.

2.0 SCOPE

2.1 These guidelines apply to all clinical staff involved in the discharge and transfer of patients in the care of EPUT. It should be noted that elements of the guidance are specific to all service areas, however there are local guidelines and instructions/operating procedures that apply to different services in accordance with commissioning agreements and local arrangements.

2.2 The guidelines identify the process and principles of managing the following:

- Discharge and transfer of care from EPUT services
- Transfer of care and treatment to another service within EPUT

2.3 These guidelines identify the steps that need to be taken within all areas of the Trust.

3.0 RESPONSIBILITIES

3.1 **The Trust Board** has overall responsibility for ensuring:

- That the principles of this guideline and other associated procedures are implemented across the organisation
- The availability for any necessary financial resources

3.2 **Directors and Senior Managers** are responsible for ensuring:

- That any clinical risk issues are addressed with relevant line managers
- The implementation of national guidance in relation to transfer and discharge
- Disseminating, implementing and monitoring this guideline within their services via clinical audit and supervision
- Ensuring that detailed local procedures are in place to manage discharge and transfer of patients
- Ensuring that EPUT policies and procedures are followed
- The procedures and principles detailed within this guideline are followed, to meet with all relevant guidance
- Staff receive appropriate and correct training
- The monitoring the implementation of this policy via clinical audit and supervision

3.3 **Ward Sisters/Charge Nurses/Team Leaders/Care Coordinators/Lead Professionals** will ensure:

- Appropriate systems are in place to assess and effectively manage clinical risk through discharge and transfer back into the community
- That appropriate discharge and transfer arrangements are in place and followed for all patients as set out with related procedural guidelines
- That employees undertaking discharge and transfer of patients complete the agreed records/documentation as set out within related procedural guidelines
- That all appropriate documentation accompanies the patient on discharge / transfer
- All appropriate information is provided to the patient on discharge / transfer
- Where discharge / transfer happens out of hours, arrangements are in place and followed for patients as set out within related procedural guidelines

3.4 **Individual staff** are responsible for ensuring that they:

- Adhere to all EPUT policies and guidelines
- Are familiar with these guidelines and associated documents and know where to locate them i.e. the intranet

4.0 PATIENT GROUP DEFINITIONS

4.1 **Adults**

This includes:

- People of Working Age and Older Adults Mental Health Services (inpatient and community)
- Learning Disability Services
- Secure Services
- Community Health Services

4.2 **Children**

This includes Young People aged 0-17:

- Mental health Services (inpatient and community)
- Learning Disability Services
- Community Health Services

5.0 GENERAL INSTRUCTIONS FOR TRANSFER (ALL SERVICES)

Staff in Secure Services should read this clinical guideline in conjunction with SSOP4.

5.1 Safe and effective transfer of care should be undertaken with minimal disruption and risk. All transfers will be planned and managed in a sensitive way ensuring all communication is clear to the patient, relative/carer, referrer and receiving service. The patient should be fully informed and if able to do so give agreement to the transfer prior to the transfer taking place. This must be documented in the patient's record. Where appropriate, it will be necessary to consult with those who have parental responsibility.

5.2 Following a decision to transfer a patient, the decision should be documented in the patient records with the rationale and decision to transfer. The transferring team/clinician must ascertain who will take medical responsibility and act as dedicated consultant/medical practitioner.

5.3 The patient will be identified as medically and mentally (where applicable) well/fit for transfer by the medical team with recognised authority to do this.

5.4 Within mental health services, if a patient is to be transferred from one community team to another, full agreement must be sought from both teams and the relevant consultants/medical practitioners. This decision must be planned with explicit dates for transfer to ensure continuation of care. This must be clearly documented within the patient's records and this principle must be applied to both planned and emergency transfers. For patients subject to the Mental Health Care Programme Approach (CPA) the requirements around safe and effective transfer of care as outlined in the Trust CPA Policy and the CPA handbook.

5.5 Where the transfer is from a ward to another ward the form 'MDT Clinical Handover At Point of Transfer from One Ward to Another' (Appendix 4) is completed by the Transferring Ward Staff and signed by the Receiving ward staff. This is to ensure that vital Clinical information has been shared at the point of transfer. Furthermore, the ward qualified staff must ensure that all medicines that have been individually dispensed for the patient must be sent to the new ward along with his other property. This should also include any

medication that had been brought into hospital by the patient on admission where appropriate (often medication will change following admission and unrequired medicines may have been destroyed on the ward with the patient's permission) (Refer to sections 9.8 and 9.9 of the Trust's procedures for the Safe and Secure Handling of Medicines).

5.6 The transferring team must ensure a risk assessment is completed prior to every patient transfer to determine the appropriate mode of transport required e.g. secure vehicle, ambulance, taxi. The risk assessment must include number of staff required for escort and band to effectively and safely carry out the role of escort. Staff are required to record in patient's notes that risk assessment has been done prior to transfer.

5.7 Adequate information from the transfer/transport risk assessment must be communicated to the transport provider so they can fulfil their duties under H&S legislation and ensure safety of all parties involved.

5.8 The transferring ward/community team must ensure that relevant health records (for example, section papers, engagement and observation records, medicine charts, etc.) relating to the patient are transferred with the patient. Other record, such as, the assessment, risk assessment, care plan, etc. should be on the electronic health record so that they are published into the Health Information Exchange Portal (HIE).

5.9 HIE is a portal which allows EPUT clinical staff to search for patient information from the North and/or South of the Trust. This information is read only and consists of key documents and a Patient Summary. Managers may request access for their staff by raising a job on the IT Helpdesk. A list of the documents being published is available on the intranet within the quick user guide.

5.10 Verbal and written communication between the ward, department or receiving team/service is necessary so that information may be shared regarding specific requirements: falls risk; mental health risks (including mental capacity); infections; any special equipment required and resuscitation status.

5.11 The staff member accepting the patient must ensure that they have all the necessary information to care for the patient safely and correctly.

5.12 If a patient has or is suspected of having an infection risk the receiving ward/department must be notified in advance of the transfer and the transferring staff member must complete the inter-healthcare infection control transfer form for all patients.

5.13 The time of transfer will be agreed with the receiving ward/team/department where possible avoiding out of hours transfers.

5.14 The patient's property will be checked and accounted for, returning any valuables which have been held in welfare for safe keeping.

5.15 In the majority of cases the decisions regarding the transfer of patients between wards in EPUT services will occur with the involvement of the ward MDT, the patient and those involved in their care. Patients will be provided with a nurse escort in line with their identified need to ensure that their transfer occurs safely.

5.16 Clinical information will be communicated to the receiving team, ensuring that the care transfer process is safe, effective, timely and maintains continuity of care for the patient.

5.17 The receiving team will also access patient's information on Mobius/Paris depending on geographical area of the patient.

5.18 If Mobius or Paris is not accessible due to geographical area, then the information will be accessed via HIE.

5.19 If patient information is not found on HIE, then staff should ring the ward or community team where the patient is coming from for information. This process should also be followed if the patient is coming from outside the Trust.

6.0 GENERAL INSTRUCTIONS FOR DISCHARGE (ALL SERVICES)

6.1 Discharge planning is a continuous process which should begin at the point of admission, ensuring that patients and their carers/relatives understand and are able to participate in care planning decisions. The process should continue until the patient is formally discharged from services.

6.2 The process of discharge planning should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the patient journey. It should involve the development and implementation of a plan to facilitate the discharge from EPUT services to an appropriate setting, and include the relevant onward community team/service, the patient, and their carers and relatives.

6.3 Discharge planning must include regular reviews to elicit any potential barriers to effective discharge e.g. housing etc., or deal with situations where it is not possible to return the patient to their own home. This must be identified as early as possible to ensure effective discharge planning can commence.

6.4 Where there are safeguarding concerns or a person is subject to a safeguarding investigation the patient should not be discharged or transferred without a review of the safeguarding issues and any discharge plans should reflect the safeguarding action plan where appropriate in accordance with the Trust Safeguarding Policy and Procedure.

6.5 With regard to secure services, restricted patients under Part 3 of the Mental Health Act 1983 will require Ministry of Justice approval before transfer or discharge (refer to Discharge of Patients from Secure Services Procedure).

6.6 The patient will be identified as medically and mentally (where applicable) well/fit for discharge by the medical team with recognised authority to do this. This decision must be clearly documented by the medical staff within the patient's records. In some cases patients may discharge themselves against medical advice and therefore the usual general instructions may not be possible.

6.7 The patient will be reviewed by their multi-disciplinary team prior to discharge and a formal discharge planning meeting recorded in the notes.

6.8 Unless the patient is discharged under the Zero Tolerance policy the patient and their carers/relatives/advocates must be fully informed and give agreement to the discharge prior to the discharge taking place. This must be documented in the patient's record. If relatives have not been able to be contacted the receiving ward/team (where appropriate) must be notified. If the person does not have capacity to make a decision regarding discharge then a capacity assessment must be completed and if they do not have capacity and do not have friends or relatives then an advocate can be requested.

6.9 The nurse in charge must ensure that all medication required have been dispensed and given to the patient. In addition staff must ensure any medication that had been brought into the ward by the patient on admission have been returned to the patient where appropriate. Planning for medication on discharge should begin sufficiently prior to the discharge date to allow all necessary medicines to be provided by the pharmacy. If the patient requires compliance aid to enable them to self-administer medicines safety and effectively at home, this will require additional time and liaison with other organisations about continued supply. Refer to Trust procedures for the Safe and Secure Handling of Medicines.

6.10 The patient's property will be checked and accounted for by ward staff, returning all property and any valuables which have been held for safe keeping and the required records completed.

6.11 The nurse in charge at the time of discharge must ensure discharge records are kept in line with local operational procedures.

6.12 On discharge a summary of the patient's admission, continuing treatment requirements/medications must be completed by medical staff and a copy forwarded to the GP within 24 hours of the patient leaving the ward, another copy given to the patient and a further copy should be within the electronic record of patient. A more detailed discharge letter must be sent to the GP within five working days of the patients discharge and a copy has to be in the patient electronic record too. Where a patient has indicated that they would like to receive copies of letters relating to them a copy will be provided to them. Refer to policy for copying letters to patients.

6.13 The nurse in charge will ensure ongoing services and equipment (where appropriate) are in place prior to the discharge.

6.14 The majority of patients will make their own transport arrangements, but the nurse in charge of the shift needs to check that this is the case and that the arrangements are appropriate. For some patients, particularly within older peoples services transport may need to be provided. Staff should refer to their local arrangements and refer where necessary the policy on the use of taxis.

7.0 TRANSFER BETWEEN MENTAL HEALTH INPATIENT AND COMMUNITY MENTAL HEALTH SERVICES

7.1 When a service user is transferred to a mental health inpatient setting and there is an existing care coordinator, the role of the care coordination remains within the community. During the inpatient episode, the key worker will work collaboratively with the existing care coordinator. Please refer to the CPA Policy and CPR Handbook for full details of the role of the care coordinator.

7.2 The care coordinator must work collaboratively with ward staff and the consultant psychiatrist to develop and agree the care plan, taking into account the needs of the service user and their family/carer's wishes. It is the responsibility of the care co-ordinator (in conjunction with the unit and others involved in the care package) to oversee all arrangements for discharge from inpatient care.

7.3 When planning discharge from inpatient services, the family of the person being discharged must routinely be contacted and informed unless there is an explicit instruction not to contact the family from the person being discharged. If this explicit instruction is given for the family not to be contacted, then the reasons for this must be fully explored with the patient and documented in their clinical notes.

7.4 Patients who have been discharged following a serious self-harm attempt and or where there is a heightened risk of suicide must have this follow up visit completed face to face within 48 hours of discharge from hospital. Such patients must not be discharged on a Friday unless the identified responsible community team is available to undertake the 48 hour follow and or unless an alternative team has accepted this responsibility to facilitate discharge such as the Home Treatment Team. This must be clearly recorded by the ward on the ward discharge list and in the patient's clinical record.

In secure services, in circumstances where a patient is remitted back to prison, the telephone call/face to face follow-up does not apply.

7.5 For all other service users discharged from the inpatient unit, a face to face follow up must be made within 72 hours of discharge.

7.6 In addition to the above face to face follow up, a follow up telephone call must be made within 24 hours of discharge by the ward manager or by a delegated clinical member of staff to all service users discharged.

7.7 Where a service user's episode of inpatient care has been discontinued following inappropriate behaviour e.g. use of alcohol or illegal substance whilst on the unit, the care co-coordinator should be informed at the earliest opportunity and prompt a review of care.

8.0 TRANSFERS FROM MENTAL HEALTH INPATIENT CARE IN THE ABSENCE OF THE SERVICE USER

8.1 On occasion a service user may be absent when they are 'discharged' from inpatient care e.g. in cases of not returning from leave or non-engagement or admitted to an acute hospital due to physical reasons. In this instance, a professional meeting should be held and an assessment of risks made. The outcome of the professional meeting and risk assessment should be relayed to the service user and documented clearly in the patient's notes. .

8.2 For patients who have a community care co-ordinator, the care coordinator is responsible for arranging appropriate follow up if the service user's whereabouts is known and every effort should be made to maintain contact and re-negotiate a new plan of care.

8.3 For more information on the management of patients who disengage please refer to refer to the Trust Disengagement or Non-concordance Clinical Guideline.

9.0 TRANSFERS BETWEEN COMMUNITY MENTAL HEALTH SERVICES

9.1 All transfers of care between EPUT community services must be carried out in accordance with CPA policy / procedures and any local protocols /operational policies.

9.2 **Transfer of Crisis Resolution & Home Treatment Team/Assessment/Care patients to community services:**

a) The community teams will be alerted by CRHT/Assessment / Care in cases of new individual to the service requiring further ongoing input from the appropriate community teams. This advance planning from both teams can allow time for appropriate and considered allocation of case coordinators from within the community teams.
b) CRHT/Assessment/Care identifies patient needs as early as possible during the treatment episode (while patients are RED or AMBER) and shares risks, patient/carer needs with community teams as appropriate, as part of anticipated CPA transfer.
c) To promote robust information sharing between CRHT/Assessment/Care and community services, CRHT/Assessment/Care would provide a clear written summary of patients' needs and after care plans on the agreed internal transfer template.
d) Community teams will allocate a care coordinator/key worker within the seven days following the summary provided to community teams. To ensure continuity of care, CRHT/Assessment/Care jointly with the appropriate community team would plan a face to face handover of care within the seven days of patient being graded to green on RAG rating.
e) It is anticipated that the community services would prioritise care coordinator allocation to CRHT/Assessment/Care to assist the CRHT/Assessment/Care to fulfil its function of rapidly taking on and discharging patients when home treatment is no longer indicated. In the event that timely allocation is not achieved the case must be escalated to both the CRHT/Assessment/Care and respective CMHT Manager.

f) In circumstance, where CRHT/Assessment/Care MDT views it may be appropriate to discharge straight back to GP – (e.g. Acute Stress Reaction completely resolved) and no significant risk history. In these cases, the MDT will record decision and rationale in the notes and transfer the care to GP/primary care without referring to First Response Team /Recovery & Well Being (Community Mental Health Team).

9.3 Transfer of patients from community services to home treatment:

a) Case coordinators in the community teams can alert CRHT/Assessment/Care staff of concerns about individuals (prior to crisis). When a crisis occurs, which the community team has not predicted, foreknowledge of concern helps the CRHT/Assessment/Care in their assessment and care planning.
b) In circumstances of patients requiring home treatment as an alternative to hospital admission the community team will request a joint review with CRHT/Assessment/Care. This joint visit is reassuring to service users, and allows the process of sharing key information in relation to risks treatment plan of the proposed home treatment. The CRHT/Assessment/Care will continue to provide intensive treatment until the resolution of immediate crisis. Following the resolution of crisis patient care would be transferred back to community teams via a joint face to face meeting involving the care coordinator/key worker and CRHT/Assessment/Care.
c) In circumstances where patients make contact with CRHT/Assessment/Care again next day or shortly following conclusion of home treatment and being closed to crisis care; the CRHT/Assessment/Care would liaise with the appropriate services, as identified at the time of discharge to share the patient's reasons for contact and request a prompt review from community teams as necessary.

10.0 AGE BASED TRANSFERS

10.1 The Care Plan, detailing a continuing clinical need takes precedence over acceptance criteria of the service. The person should be cared for in the most appropriate environment to meet their clinical needs including potential beneficial joint working between services. This is further reinforced in the Royal College of Psychiatrist Occasional Paper 82.

10.2 All reviews of care should involve a decision in relation to the appropriateness of the current care setting.

10.3 There may be occasions when it is deemed to be appropriate to continue working on a short term basis with a young person beyond the age they would normally be expected to transfer to an adult service. In such cases this should be agreed with the relevant Service Manager.

10.4 Generally persons with a diagnosis of progressive cognitive impairment will be transferred to the most suitable environment/ service to meet their clinical needs regardless of age.

10.5 Service users with a functional illness, who are receiving treatment from the services for adults of working age, will continue to be seen by the adult consultant and adult teams beyond the age of 65 unless there are agreed clinical reasons between Adult Mental Health Service and Older Adult Mental Health Service to transfer.

10.6 Service users should not be transferred between services whilst experiencing a crisis. It is in the service user's best interests to be cared for by those who are already working with the service user unless the environment is unsuitable.

11.0 TRANSFERS TO OTHER MENTAL HEALTH TRUSTS/PRIVATE FACILITIES

11.1 For patients subject to the Mental Health Care Programme Approach (CPA) the requirements around safe and effective transfer of care as outlined in the Trust CPA Policy and the CPA handbook section 15.0 must be followed.

11.2 For procedural guidance on transferring between inpatient units refer to local guidelines.

12.0 TRANSFER OF DETAINED SERVICE USERS AND THOSE SUBJECT TO SUPERVISED CTO's, GUARDIANSHIP OR CONDITIONAL DISCHARGE

12.1 Transfer of detained service users to services other than within EPUT should unless exceptional circumstances prevail be a planned event and occur during normal working hours (9-5). Transfer of any service user subject to Ministry of Justice conditions e.g. Section 37/41 must be authorised by the Ministry of Justice including transfer between wards, unless the warrant specifies a location e.g. Brockfield House, rather than a specific ward.

12.2 The Act makes provision for the transfer of detained service users between different hospitals, or into local authority guardianship (England), or across borders within the UK and Wales. The rules relating to transfers differ based on the Section a person is detained under. When a person is transferred under the Act the power and responsibility to detain them is transferred to the new hospital (or local authority in respect of guardianship). For further information refer the EPUT Policy for the administration of the Mental Health Act 1983 as amended by the Mental Health Act 2007.

12.3 The Act also provides the power to transfer a detained service user to countries outside the UK. This is used primarily to repatriate a service user who does not have the right to live or remain in the UK. The power authorises the legal transfer of the Service User (for example, in an aeroplane) to the receiving country. Once in the receiving country, it becomes that country's responsibility to apply its own legislation. Repatriation is usually organised by the UK Border Agency in conjunction with the Ministry of Justice if applicable.

12.4 Part VI of the Mental Health Act 1983 as amended by the Mental Health Act 2007 - Removal and Return of Patients within United Kingdom Etc. This part deals with the transfer between the United Kingdom jurisdictions and the Channel Islands or the Isle of Man of patients who are subject to certain compulsory powers. It ensures that the patients remain in legal custody whilst in transit and that they are liable to equivalent compulsory powers on their

arrival in the receiving jurisdiction. It also provides in Section 86, powers for moving mentally disordered patients who are neither British Citizens nor Commonwealth Citizens with the right of abode in the United Kingdom from hospitals in England and Wales to countries abroad. The procedure to be followed on the removal of a patient to England under this Part is set out in regulations 15 & 16 of the English Regulations and regulation 29 of the Welsh Regulations' Extract from Mental Health Act Manual - Richard Jones – 13th Edition Page 429 para.1-927

12.5 When transferring a service user to services user outside England or Wales or those services users subject to Community Treatment orders, Guardianship or Conditional Discharge advice regarding correct procedure **must** be sought from local Mental Health Act Administrator prior to the transfer.

13.0 EMERGENCY AND OUT OF HOURS TRANSFERS

13.1 It may be in the best interest of a service user to be transferred for urgent treatment without delay and proper arrangements and documentation cannot be developed or put in place. In these instances the following must be considered and any action taken in relation must be documented in clinical records:

- Arrangements regarding medication.
- Information for informing relatives , carers, care coordinator and any other external agencies that need to be informed.
- Information to be provided to service user if appropriate regarding arrangements for care.
- Any identified risk, including need for observation, escorts etc.
- Refer to paragraph 9.9 of CLPG13-MH Procedural Guidance for Safe & Secure Handling of Medicine in Mental Health services on transfer of medicines when a patient moves to another healthcare setting. Contact the on call pharmacist for advice if necessary.

13.2 If the service user is subject to detention in hospital under the Mental Health Act 1983 as amended by the Mental Health Act 2007, all decisions about their care must be made in light of Statement of Guiding Principles (Mental Health Act 1983 as amended by Mental Health Act 2007 s118) for further information refer to Code of Practice: Mental Health Act revised 2008.

13.3 For young people under the age of 18 presenting out of hours – requiring either a Community team response or inpatient admission please refer to the local CAMHS procedure.

14.0 TEMPORARY TRANSFERS (SLEEPOVERS)

14.1 When a service user needs to sleep over in other neighbouring units within the Trust to facilitate bed management the Temporary Transfer Form (Appendix 3) should be completed:

- Transfers after hours after 8:00pm should be avoided wherever possible.
- No Temporary transfer to take place after 11 pm, except in exceptional circumstances i.e. a result of evacuation etc.

14.2 The manager or nominated person requesting the temporary transfer should ensure that the receiving unit can meet the personal requirements of the service user, these may be related to ethnic, religious, gender/sexual orientation, physical disabilities, and/or language issues.

14.3 The reasons for the temporary transfer must be discussed with the patient and the outcome detailed in their clinical record.

15.0 DISPUTES

15.1 This guidance is dependent on the exercise of clinical judgement and good relationships between teams and agencies. It is expected that experienced clinicians/practitioners in both affected services (learning disability services if appropriate) will have early negotiation and a clear hand-over. Even so, there may be instances where agreement cannot be reached and differences remain unresolved, potentially to the detriment of the service user, a meeting to resolve the issue must be held within 15 days. Where this is the case:

- The relevant team leader/ward manager/service manager should inform their relevant Associate Director and Clinical Director
- The Associate Director and Clinical Director must consult with relevant managers and clinicians in an attempt to resolve the dispute.
- Disputes should be resolved quickly but if no resolution seems forthcoming, the Associate Director and Clinical Director will consult with the relevant Directors to resolve the matter.

15.2 Where there is a dispute between the two parties, for example over the operation of this protocol or a difference of opinion with regard to which service should take the lead role, the appropriate local Clinical Manager responsible for the relevant geographical area in EPUT and the relevant Community or Clinical Services manager for the receiving service will be responsible for liaising and reaching the swiftest possible resolution of the dispute after hearing all relevant views. An initial meeting must occur within 15 working days of any dispute and the dispute will be documented by the EPUT staff member and passed to the relevant service director. This should also be incident reported. It is vital that as little time as possible is spent in disputes that affect people using either Trust's services.

15.3 Should the dispute remain unresolved after this, the issue will be referred to the most appropriate Director in both organisations relevant to the nature of the dispute who shall endeavour to agree an appropriate resolution of the relevant dispute within an agreed time.

16.0 DISCHARGE FOLLOWING INITIAL ASSESSMENT OF A SERVICE USER WHO DOES NOT MEET THE CRITERIA FOR SECONDARY MENTAL HEALTH SERVICES (COMMUNITY)

16.1 If following an initial assessment, the service user is deemed not to require any further intervention from EPUT; they should be discharged back to the referrer/GP with a copy of the assessment outcome and advice on re-direction to other services if required.

In order to meet the requirements of the Care Act 2014, "in parallel with assessing a person's needs, local authorities (in this instance the Trust as carrying out these functions on the LA's behalf) must consider the benefits of approaches which delay or prevent the development of needs in individuals. This applies to both people with current needs that may be reduced or met through available universal services in the community and those who may otherwise require care and support in the future" (Care and Support statutory Guidance). This could involve directing people to community support groups, helping people to access universal services, helping service users identify their own support, helping to promote access to education, training etc. to maintain independence.

16.2 Where the assessor has identified that the service user has no eligible needs for social care, they MUST provide information and advice on what can be done to reduce or meet the identified needs (for example identifying a community support/resource) AND what can be done to prevent or delay the development of needs in the future. This information must be tailored to the needs of the individual with the aim of delaying deterioration and preventing future needs, and reflect the availability of local support.

17.0 DISCHARGE OF A SERVICE USER WHO DOES NOT MEET THE CRITERIA FOR SECONDARY MENTAL HEALTH SERVICES FOLLOWING INPATIENT / Crisis Resolution & Home Treatment Team / ASSESSMENT/CARE

17.1 It is the responsibility of the consultant, designated doctor or registered clinician (band 6 or above) to make a decision to discharge with no further follow up. In complex cases the clinician must consult with the wider multi- disciplinary team prior to making the decision.

17.2 The decision must be based on an up to date risk assessment and consideration given to the following;

- Have the risks increased?
- Is there a history of self-harm?
- Is there evidence of substances misuse?
- Is there evidence of enduring mental illness?
- Are there any safe guarding concerns?
- Are there any concerns regarding capacity?
- What support networks does the service user have access to?
- Is the service user registered with a GP?
- Is the service user aware as to how contact further help and advice?
- Is the service user subject to s117?

- Does the service user have any social care needs?

17.3 All conversations, actions and decisions made must be documented immediately in the clinical record.

17.4 The GP must be informed on the day of discharge and advised as to risk assessment and re referral process by the discharging clinician.

17.5 The service user and where appropriate relative /carer must be provided with written information as to how to access mental health services routinely and given crisis a card. They must also be given written advice and information regarding any social care needs.

18.0 DISCHARGE FROM EPUT MENTAL HEALTH COMMUNITY BASED TEAMS

18.1 The responsibilities of community based teams in discharge planning can be summarised into four key areas:

- Engaging in collaborative discharge planning at an early stage of treatment with the patient, their carer/s, internal and external stakeholders involved in the patient's treatment and care.
- Providing written and verbal treatment and medication related information for the patient being discharged and where appropriate their relative/carer
- Providing written and verbal treatment-related information for GPs and other service providers involved in the patients care.
- Providing timely communication with patients, carer/s, GPs and other key stakeholders

18.2 The care coordinator/lead professional for the clients care will follow the operational policy discharge process and must ensure:

- The decision is made at an MDT meeting and is clearly communicated and followed up in writing to the patient and/or carer as appropriate in advance, with clear details as to the rationale to ensure involvement
- Information is given regarding any ongoing care /follow up by other providers
- All risk assessments are up to date
- Information is given to the patient on how to make contact with services in the future if needs change

18.3 Patients who are subject to CPA and/or Section 117 being discharged to another Trust mental health service or other service the requirements of the Trust CPA Policy (MHA 21 for Section 117) must be met with the care coordinator ensuring that a joint handover meeting is arranged with the receiving team which includes the following:

- A review of the care plan and crisis and contingency plan
- Where appropriate the receiving professional/team/service must identify a new care coordinator as a matter of priority
- The decision to transfer or discharge from care must be communicated in writing to the patient, their carer/s as appropriate and the patient's GP

- Adequate time must be allowed to ensure accurate communication of all risks between care coordinators

19.0 DISCHARGE OF THE NON-ENGAGING SERVICE USER

19.1 Exceptionally, a service user may be absent when they are discharged from EPUT services e.g. as a result of non-engagement. A review should be held so that professionals can evidence the reason for that decision and facilitate any onward planning.

19.2 The decision to discharge in a service user's absence must be based on an up to date assessment of risk (as above) and only when all attempts have been made to re-engage the service user in treatment and re-negotiate a new plan of care.

19.3 For service users on Section 117 (aftercare) or Section 7 (Guardianship) of the Mental Health Act, the care co-ordinator, in consultation with the team, will instigate a formal review with all professionals involved. In the case of Section 7 (Guardianship) the appointed Responsible Clinician must authorise the discharge from EPUT services and notification of discharge must be made in writing to the Essex County Council nominated officer (currently the ECC Head of Mental Health Commissioning). Discharge from EPUT cannot occur whilst the service user remains subject to s117.

19.4 Where there are serious concerns regarding the safety of the patient, the public, liaison with the Police, the Probation Service, MAPPA, the PREVENT lead or other relevant agency may also be appropriate in certain circumstances.

19.5 The decision to discharge and written information as to how to access services for support and in a crisis must be relayed to the patient

19.6 The care coordinator / case worker is responsible for informing the GP and any other relevant parties. For more information refer to Guidance for Service users who Disengage with Mental Health Services (including non-compliance with treatment), Appointments procedure, Care Programme Approach and Mental Health Act Policies.

20.0 DISCHARGE FROM CPA

20.1 Within Mental Health/Learning Disability services, patients can only be discharged from CPA following a CPA Review. At no time should a patient under CPA be discharged from CPA purely on the grounds of disengagement. Full guidance should be followed in the CPA Policy and handbook.

21.0 INPATIENTS MENTAL HEALTH SERVICES

21.1 In mental health units where patients are detained under a section of the Mental Health Act (1983) the Responsible Clinician (R/C) will authorize the removal of the section and sign the appropriate Mental Health Act 1983 (amended by the Mental Health Act 2007) discharge form.

21.2 Prior to discharge there must be explicit plans in place to ensure on-going care.

21.3 Any team or service which is to provide the ongoing community care should where possible be present/or conference call to at/to the discharge meeting and the patients care co-ordinator identified prior to discharge.

NB: Patients without accommodation are not to be discharged at the weekends as these departments e.g. housing are not open to them for advice. Under no circumstances would children without accommodation be discharged without prior planning involving all relevant specialist services.

21.4 In certain instances on mental health wards it is acknowledged that there are occasions where informal patients may wish to leave at short notice, against the advice of the MDT and/or refuse further service involvement. This will be subject to assessment of the patient's mental and physical state, mental capacity safeguarding circumstances and the risks to self or others and risk of deterioration of physical health. In this circumstance the nurse in charge of the shift will:

- Ask the patient to remain on the ward until seen by a member of their medical team
- Where possible ask the patients responsible clinician (R/C) to see them prior to leaving the ward
- If the R/C is not available contact the junior or out of hours the duty doctor and request that they review the patient prior to them leaving the ward
- In the event that the patient refuses to remain on the ward for a medical review the nurse in charge should again contact the R/C, or out of hours duty doctor to discuss and determine whether the patient can be classed as on leave and should return to the ward the next working day to be seen by a member of the medical team.
- For patients who are felt to lack capacity to make the decision about leaving the inpatient services and/or the patient is suffering from a mental disorder to such a degree that it is necessary for their health or safety or for the protection of others for them to be immediately prevented from leaving the hospital, an assessment must be made for possible detention under the Mental Health Act 1983 (amended by the Mental Health Act 2007), in particular use by medical and nursing staff of the powers under sections 5(2) and 5(4) see Trust policy MHA 17 Application in respect of a patient. All relevant persons involved in the patients care will be notified of the fact that the patient has left inpatient services at short notice by the member of staff in charge of the ward at the time
- Where possible medication to take home will be obtained from pharmacy, determined by the nature of any risks presented by the patient. However **under no circumstances should ward stock medication be issued.**

21.5 The relevant community team must undertake a 7 day follow up. In addition the patient should be given crisis contact details of how to make contact with services in the future and asked to sign the Self Discharge against Medical Advice notification form (CG24 Appendix 5) prior to leaving the ward. Where it has been possible to obtain medication from pharmacy a copy of the discharge prescription form will be given to the patient.

21.6 Out of hours advice can be sought from the site officer, on-call manager and on-call consultant.

21.7 The following will be completed by the named nurse or their representative at the time of discharge as a minimum requirement;

- Ensure that the discharge plans are documented in the notes
- Record possible medical consequences of the patient's decision and that they have been explained to the patient.
- Ensure that if someone is discharging another individual they have parental responsibility for the child or they have Power of Attorney for health and welfare if the patient has no capacity. Also consider safeguarding in these circumstances.
- Notify the GP within 24 hours of the patient leaving the ward usually by means of faxing the patients discharge prescription form and posting the white copy with details which will include date of admission and discharge, medications on discharge and main diagnosis.
- Notify the relevant community team/service allocated Care Co-ordinator.
- Ensure that for those with a history of self-harm in the last three months, no more than 14 days medication is supplied.
- Ensure that a qualified nurse gives the patient their discharge medication. The nominated person must ensure that the patient understands the medication given, when it will be taken and when and how to obtain further prescriptions.
- Ensure the patient is given crisis/service contact numbers. All conversations, actions and decisions made must be documented immediately in the clinical notes.

For patients who are going to longer term residential and care home care, a handling strategy must be provided where challenging behaviour and risks are likely to be displayed.

22.0 HOME OF CHOICE LETTER

22.1 To ensure the involvement of patients and their carer's at the earliest opportunity two letters are available which address the following:

- Admission to Hospital – this letter should be given to all patients admitted into hospital and relatives/carers made aware. (Appendix 1)
- Home of Choice letter – this notification letter should be used where the patient may not be able to return home and needs a nursing, residential or alternative placement on discharge. (Appendix 2)

22.2 Where it has been agreed that a place in a residential or nursing home is required and confirmed that the patient has been assessed as eligible for such provision every effort must be made to involve the patient and their carer's in the decision and to place the patient in the home of their choice in the context of an environment that is suitable to meet their needs. This needs to be considered within the local authority purchasing guidance and the required process regarding identification of placements.

22.3 Once identified the individual patient must be assessed by the MDT to determine the type of home most suitable to meet their needs. They must be advised at this stage that their preferred choice may not be available and therefore alternatives will be identified in accordance with their needs. This may necessitate discharge to a temporary placement in an alternative home. In some instances there may be

restrictions as a result of individual circumstances; for example where a patient is restricted by law from an area of residence.

In some cases it may not possible to identify a place in the home of choice to coincide with the planned discharge date. The patient and their carers/relatives must be advised that a temporary /interim placement will be arranged until such time as the placement of choice comes available at which time arrangements will be made to transfer there as quickly as possible.

22.4 A discharge planning meeting will be convened during which a full discussion will take place with the patient and their relatives/carers as appropriate regarding the availability of their preferred home of choice and any alternative homes available. The patient must be reminded at this stage that if their home of choice is not available and or not likely to be available at the point of discharge, then a temporary place in another home suitable for them will be found.

22.5 The care co-ordinator/identified case worker may make the necessary approaches to both locate a placement and to the funding Authority's purchasing panel in order to secure funding for the preferred home.

22.6 A full explanation must be given to the individual and their relatives/carers (as appropriate) regarding the need for the temporary placement and followed up in writing.

22.7 A visit to any identified alternative homes will be arranged prior to discharge from hospital and any written information available will be given to the patient.

22.8 It is the responsibility of the designated care co-ordinator/case worker to monitor the patient's progress, liaise with the home of choice and inform the patient and their relatives/carers (as appropriate) when a place becomes available in the preferred home of choice.

22.9 It is expected that if the patient is discharged to a temporary placement that the review of such placements should occur weekly to ensure patients have their needs met as comprehensively and diligently as a resident on a permanent placement.

22.10 In the event that an individual patient refuses to accept an alternative home placement the matter must be referred to the relevant responsible manager for a review of the case. If the matter remains unresolved after this review the case will be referred to the respective Service Director.

23.0 SPECIFIC TRANSFER AND DISCHARGE ARRANGEMENTS

23.1 Other areas such as those providing community health services will have specific transfer and discharge guidelines as agreed with local Commissioning Care Groups. Additionally, Secure Services have bespoke procedures to ensure the safe transfer of care to mental health teams in the community.

24.0 MONITORING PROCESS

24.1 Discharge and transfer of care are frequent and significant events in in-patient and community settings. The team leader/manager will routinely monitor implementation and compliance with this guideline. A component of management supervision must include the scrutiny of records/documentation relating to the discharge and transfer process.

24.2 All incidents or near misses, related to the discharge and/or transfer of patients should be reported via the Trust Risk Management reporting systems i.e. Datix. Monitoring of this policy will include data collected from any clinical incident reporting.

25.0 TRAINING

25.1 There are no specific training needs in relation to this guideline, but staff must be familiar with its contents and the key points that the guideline covers. Awareness can be through a variety of means such as, local induction, team/one to one meetings/supervision; discussion during other awareness raising and training.

25.2 Staff must ensure that they are equipped with the skills and confidence to carry out risk assessment with patients which is an integral part of managing discharge and transfer the Trust has in place Mandatory practice requirements for staff to receive on-going training as set out within Procedural Guidelines for Procedure for the Assessment and Management of Clinical Risk.

END

Essex Partnership University
NHS Foundation Trust

POST DISCHARGE FOLLOW-UP PROCEDURE

PROCEDURE REFERENCE NUMBER:	CLPG49
VERSION NUMBER:	2
KEY CHANGES FROM PREVIOUS VERSION	Three year review; renamed; amended in response to learning from NHSE post discharge pilot and change to NHS Standard Contract; various amendments throughout
AUTHOR:	Sarah Brazier
CONSULTATION GROUPS:	Clinicians, Associate Directors, SMB & SMT Members, MH Operations
IMPLEMENTATION DATE:	April 2017
AMENDMENT DATE(S):	June 2020; August 2021
LAST REVIEW DATE:	August 2021
NEXT REVIEW DATE:	August 2024
APPROVAL BY CLINICAL GOVERNANCE AND QUALITY SUB-COMMITTEE	July 2021
RATIFICATION BY QUALITY COMMITTEE	August 2021
COPYRIGHT	2020
PROCEDURE SUMMARY	
The Trust monitors the implementation of compliance with this procedure in the following ways:	

Services	Applicable	Comments
Trustwide		
Essex MH&LD	✓	
CHS		

The Director responsible for monitoring and reviewing this procedure is Executive Chief Operating Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

POST DISCHARGE FOLLOW-UP PROCEDURE

CONTENTS

THIS IS AN INTERACTIVE CONTENTS PAGE, BY CLICKING ON THE TITLES BELOW YOU WILL BE TAKEN TO THE SECTION THAT YOU WANT.

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

POST DISCHARGE FOLLOW-UP PROCEDURE

Assurance Statement

These procedures are necessary to ensure that all service users are given, at the point of discharge, an allocated date for their post discharge follow-up in line with the Department of Health, Monitor requirements and best practice guidance.

1.0 PURPOSE

1.1 To specify Trust procedure for the post discharge follow up of all service users who are discharged from inpatient care.

1.2 To support the requirements of the National Confidential Inquiry Annual Report the Preventing Suicide in England 2012 on-going guidelines for safer management of those clients at risk.

2.0 BACKGROUND

2.1 One of the specific targets contained within "Saving Lives: - Our Healthier Nation" (DoH 1999) is to reduce the suicide rate by at least 10% by 2020/21. Health and Social Services are expected to play their full part in helping to achieve this, which is reflected in Standard 7 of the National Service Framework for Mental Health.

2.2 One of the particular requirements for preventing suicide among people suffering severe mental illness (SMI) is to ensure that follow up of those discharged from inpatient care is treated as a priority and that care plans include such follow up within one week of discharge.

2.3 This has been reinforced by more recent guidance in the 'Preventing Suicide in England' Feb 2015 which highlights the need to include suicide as an indicator within the Public Health Outcomes Framework will help to track National Progress against our overall objective to reduce the suicide rate.

2.4 The National Patient Safety Agency has published Preventing Suicide: A toolkit for mental health services, which introduces a set of standards for management and reduction of suicide following an inpatient episode, including telephone follow up from the inpatient setting (Standard 2) and a follow up visit within 48 hours of discharge from an inpatient setting which is specifically mentioned within the care plan where there is a heightened risk of suicide. Further guidance can be found in the Trust's Suicide Prevention Clinical Guideline (CG29).

2.5 Discharge from inpatient units to community settings can be a time of increased risk of self harm and suicide for service users, Recent findings from the National

Confidential Inquiry into Suicide and Safety in Mental Health[1] showed that most post-discharge deaths by suicide occurred in the first week after leaving inpatient care, with the highest frequency on the third day after discharge.

Based on this new evidence EPUT will complete face to face follow-up within 2-3 days post discharge for all people from inpatient care (not only those on CPA).

The earlier post discharge follow up follow has four main drivers:

- Reduce risk of suicide for high-risk service users immediately post discharge.
- Improve cross-pathway care coordination and discharge planning thereby reducing avoidable readmissions
- Reduced variation in practice in managing the transition from inpatient to a community service enabling improved communication and better linkages between teams.
- A better, safer experience for service users, families and carers.

The National Confidential Inquiry into Suicide and Safety in Mental Health report identifies key risk factors as:

1. Known self-harm or recent
2. Male
3. Aged over 40
4. Adverse life events
5. Comorbid psychiatric illness
6. Under CPA.
7. Isolation / living alone (43% live alone)
8. Economic adversity
9. Alcohol and drug misuse
10. Recent self-harm

2.6 National Suicide Prevention Strategy for England:

Published by the Department of Health in 2002 and expanded in 2017 this document sets out government strategy for achieving the above target in a coherent and co-ordinated manner. Goal 1 of the strategy is to reduce risk amongst key high-risk groups.

Preventing suicide in England: Fourth progress report of the cross- government outcomes strategy to save lives (Jan 2019) area for action 1 reiterates the necessity to reduce risk of suicide for high risk groups.

> *"People with severe mental illness remain at high risk of suicide, both while inpatient and in the community. Inpatients and people recently discharges from hospital and those who refuse treatment are highest risk"*

[1] The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: England, Northern Ireland, Scotland, Wales. October 2018. University of Manchester.

The National Confidential Inquiry identifies that improving care pathways between inpatient and community care and on hospital discharge can contribute to the reduction in suicide rates.

2.7 Application of These Procedures in Essex Partnership University NHS Foundation Trust:

These procedures apply to all Essex Partnership University NHS Foundation Trust's inpatient units when someone is discharged to a community setting. Essex Partnership University NHS Foundation Trust supports this action as part of its commitment to implement the National Suicide Prevention Strategy.

3.0 SCOPE

3.1 This Procedure applies to all Essex Partnership University NHS Foundation Trust's inpatient units including those admitted to Mental Health Assessment Units (MHAU) when someone is discharged to a community setting.

3.2 Community Drug and Alcohol Services will follow up any patient who was admitted to hospital with a dual diagnosis unless allocated a care coordinator within another Community Mental Health Team.

3.3 The Home Treatment Team will be responsible for completing the post discharge follow up within 48 or 72 Hours for any patient discharged from the MHAU.

3.4 Community Care Coordinator/Team will be responsible for ensuring post discharge follow up is completed within 48 or 72 Hours for patients discharged from treatment wards.

3.5 Child and Adolescent Mental Health Services (NELFT - EWMHS) will follow up patients discharged from the CAMHS inpatient units.

3.6 For patients discharged to Residential and Nursing Homes or known to be travelling out of area following discharge it is more likely that the agreed follow up will be by telephone contact within 72 Hours. However, this telephone call must be recorded within the clinical records and on the clinical information system.

3.7 For patients discharged to a General Hospital for medical treatment and or end of life care the respective Mental Health Liaison Team will be responsible for completing the 72 Hour up.

Exclusions

This requirement for 72 Hour follow-up includes the following exceptions:

- Patient who dies within 72 Hours of discharge
- Patients discharged to another NHS hospital for Psychiatric treatment

- Where legal precedence has forced the removal of a patient from the country
- Where a patient leaves the country within 72 Hours of discharge
- In secure services, in circumstances where a patient is remitted back to prison, the telephone call/face to face follow-up does not apply

3.8 Where a patient is admitted from "out of the catchment area" the in -patient named nurse will contact the identified responsible community team, following the telephone call an email will be sent to the identified responsible community team. This will be recorded both in the patient's clinical records and on the Trust Clinical Information System.

4.0 IMPLEMENTATION

4.1 Slot Management

Each identified responsible community team will be responsible for identifying the number of baseline slots (appointments for specific days) in accordance with the average number of discharges for their area where this system is in place.

For Early Intervention, CAMHS and Learning Disabilities teams pre- determined slots would not be appropriate due to the minimal number of discharges for these services.

In all cases Ward Teams will notify the appropriate community team of planned patient discharge to agree a post discharge follow up appointment and confirm the appointment details to the patient.

4.2 Specific Action (also see flow chart attached at Appendix 1):

4.2.1 All patients requiring either 72 hour or 48 hour follow up on discharge as detailed below in 4.2.3 must be identified during the discharge planning meeting by the ward MDT which will be recorded in the MDT minutes and also in the patient's clinical record.

4.2.2 The ward will ensure the daily ward discharge list clearly indicates which patients require 72 hour follow up and which require 48 hour follow up and notify the identified responsible community team responsible for undertaking the follow up when a patient is discharged. Wherever possible a day and time for follow up, will be agreed with the patient prior to discharge from the inpatient unit.

4.2.3 Patients who have been discharged following a serious self-harm attempt and or where there is a heightened risk of suicide must have this follow up visit completed face to face within 48 hours of discharge from hospital.

Where a community team are unable to complete a 48hour follow up post discharge on a weekend, care coordinator and ward MDT are to ensure home treatment teams have accepted responsibility to complete post discharge follow up.

This must be clearly recorded by the ward on the ward discharge list and in the patient's clinical record.

4.2.4 Team Managers are responsible for ensuring that patients are notified of the confirm the specific details of the appointment (time, venue and practitioner) prior to discharge.

For non-face to face contacts e.g. potential telephone contact in the case of individuals discharged to residential and or nursing homes confirmation regarding within what timescale and by which team contact will be made with the home must be given to the patient/carer on discharge.

4.2.5 There may be cases where an individual for 72 or 48 hour follow up either absconds or self-discharges. The general responsibility for providing follow up does not change in these cases, although the practicality of doing so may be more difficult. In these circumstances the following Trust policies and procedures would need to be implemented immediately:

a) Absent without leave (AWOL) procedures should be followed as appropriate and whilst acknowledging that CPA Care Plans may not be complete, there should nevertheless be efforts made by the in- patient clinical team to make contact and if sufficiently concerned for an individual's safety necessary request a police welfare check.

b) If the level of risk or degree of vulnerability is thought to be sufficiently high and the patient is informal. It may be appropriate to consider an assessment under the Mental Health Act.

4.2.6 For **all** patients (not only those on CPA) a face to face contact will be required via a pre-determined appointment with the identified responsible community team in an agreed location.

5.0 WARD PROCEDURE

5.1 During the patients episode of care, ward teams will work with the patient to develop a care plan that identifies barriers to discharge and the mitigation necessary to resolve these identified barriers to ensure a timely transfer of care from inpatient services. It is important that this discharge care planning process is carried out in partnership and supported by the patient's 'My Care My Recovery' document and those people identified as significant. The emphasis of

this care plan should focus on the safe transition of care for the patient and maintaining the individual's safety. Patient risk assessment, including risk of suicide should always be considered in the context of the patient being discharged from hospital

5.2 The ward staff will ensure the 48 / 72 hour post discharge follow-up is discussed in conjunction with the discharge date.

Patients will be discharged from inpatient services with the full detail of 48/72Hour post discharge follow-up provided by ward staff. To include: Name of person/team completing follow up appointment; date/time and location of appointment.

5.3 Where clinically indicated, face to face contact with the patient's proxy is acceptable e.g. for patients with organic illness such as dementia.

5.4 Wherever possible a face to face 48 / 72 hour follow up should be completed. However, where assessed as clinically appropriate and documented in discharge planning the patient may be contacted using appropriate technology such as AccuRx.

5.5 48 / 72 Hour post discharge follow up cannot be completed on the same date the patient discharge occurs. Clock Starts at Midnight on the day of discharge.

5.6 Mental Health Assessment Unit (MHAU)

5.6.1 The MHAU MDT are responsible for identifying which patients require 48 hour follow up (as detailed in 4.2.3) and highlighting these patients to community teams.

5.6.2 The MHAU will make telephone contact following discharge to review the patient post discharge risks within 24 hours of discharge. The details of this telephone review must be recorded in the patient's clinical record.

5.6.3 For patients discharged from the mental health assessment units, who are either open or have been referred to a Community Pathway Team, the MHAU must inform the appropriate identified Responsible Community Team/ Care-Coordinator of discharge in addition to the locality CRHT/Home First Team.

5.6.4 For all patients discharged from the mental health assessment units, the locality CRHT/ Home First team will complete the 48/ 72 hour follow-up.

5.7 Treatment Wards

5.7.1 The treatment ward MDT are responsible for identifying which patients require 48 hour follow up (as detailed in 4.2.3) and highlighting these patients to community teams.

5.7.2 The treatment ward will make telephone contact following discharge to review the patient post discharge risks within 24 hours of discharge. The details of this telephone review must be recorded in the patient's clinical record.

5.7.3 For patients discharged from treatment wards, who are either open or have been referred to a Community Pathway Team, the MHAU must inform the appropriate identified Responsible Community Team/Care-Coordinator of discharge.

Community Team/Care Coordinator will be responsible for ensuring 48 / 72 hour post discharge follow up is completed.

5.7.4 For Patients discharged from treatment wards who are open to CRHT/Home First to support earliest safe discharge, treatment wards must inform CRHT/Home First teams of plans for discharge. For these patients CRHT/Home First will be responsible for completing the 48 / 72 hour Post Discharge Follow up.

5.7.5 The completed daily ward discharge list must be sent by admin to the community teams using the agreed team email account.

5.7.6 Where a community team are unable to complete a 48hour follow up post discharge on a weekend, care coordinator and ward MDT are to ensure home treatment teams have accepted responsibility to complete post discharge follow up. Lack of community team presence should not prevent discharge and alternative follow up arrangements are to be agreed.

5.7.7 It is imperative that the ward obtains the correct patient demographic details and in the case of 'no fixed abodes' an agreed phone number and / or alternative address needs to be agreed and recorded.

5.7.8 For all 48 / 72 hour follow up appointments the ward is responsible for identifying the requirements for individual patients via the ward MDT.

5.7.9 Advance contact with identified Community Care Coordinators and Home treatment teams is required to enable participation in discharge planning.

5.7.10 MH Liaison Teams are to be notified of any patients to be discharged to a General Hospital for medical treatment/and or end of life care.

5.7.11 Wherever possible the date of the agreed 48 / 72 hour follow up appointment must be entered onto the discharge appointment card (see Appendix 2). A copy given to the patient (carer / relative as appropriate) upon leaving. A record of this must also be entered into the patient's clinical record.

5.7.12 The ward must contact the identified responsible community team responsible to ensure that discharge details are circulated to the appropriate worker. A copy of the completed daily ward discharge list must be sent by admin to the community teams via email to the agreed email account. This list must be complete and not contain any 'unknowns'. This list must also clearly identify those patients identified as requiring 48 hour follow up.

5.7.13 The ward staff will make telephone contact with the patient within the first 24 hours following discharge, and the outcome will be recorded in the patient's clinical record. If they have been unable to make contact they will discuss with the identified responsible community team wherever possible with the Care Co-ordinator allocated, if unavailable the respective community team's duty practitioner must be contacted and informed.

6.0 IDENTIFIED RESPONSIBLE COMMUNITY TEAM PROCEDURE

6.1 The Community Team Manager or nominated deputy is responsible for ensuring patients are contacted within 1 working day of discharge to confirm the time, venue and practitioners for the appointment. In the case of telephone contact ensuring it happens and is recorded in the patient's clinical records and on the clinical information system.

6.2 Patients who have been discharged following a serious self-harm attempt and or where there is a heightened risk of suicide must have this follow up visit completed face to face within 48 hours of discharge from hospital.

6.3 Where ward teams are unable to complete 24 hr post discharge telephone contact the ward manager is to be informed. The Ward Manager will be responsible for ensuring a risk assessment is undertaken and if necessary, arranging a physical check as required, e.g. a home visit and or a police welfare check and reporting outcomes back to the Bed Management Department to update the Trust follow up monitoring / assurance report. All actions and outcomes must be recorded in the patient's clinical record.

6.4 The Team Manager is responsible for ensuring confirmation is sent to the Bed Management Department regarding the outcome of all booked appointments on the list they receive to update the Trust follow up monitoring /assurance report

6.5 Team Managers are responsible for the post discharge follow up outcome lists and forwarding to the Bed Management Department.

6.6 Team Managers are responsible for ensuring the post discharge follow-up takes place through the agreed local procedures for cover during absence, should the care coordinator/allocated case worker be absent.

6.7 Where planned contact with a patient is not achieved then this must be immediately escalated for discussion with the responsible community teams MDT, and steps taken to ensure that the patient remains well. Staff should use

the Non-concordance and disengagement policy as a guide for the escalation steps which are required and record the failed contact on Datix so that the outcome of the patient contact can be effectively monitored.

6.8 Where clinically indicated, face to face contact with the patient's proxy is acceptable e.g. for patients with organic illness such as dementia.

6.9 Best practice indicates a further 7 day follow up be provided by the Care Coordinator/CRHT/ Home First Team.

7.0 COMMUNICATION

7.1 Appointments for follow up visits will be communicated to the patient in an appropriate format taking into account any communication difficulties they may have either through sensory disability or limited language understanding.

8.0 AUDIT / MONITORING

8.1 Compliance with post discharge follow up requirements will be reported upon regularly via the Trust's performance reporting framework.

8.2 It is imperative that the outcomes of the post discharge follow up are captured and recorded in a timely manner.

9.0 REFERENCE TO OTHER TRUST POLICIES/DOCUMENTATION

9.1 This policy shall be read in conjunction with the following Trust policies:

- CLP49: 7 Day Follow Up Policy
- CLP30: Care Programme Approach
- CLP28: Clinical Risk Assessment and Management
- CG29 : Clinical Guidelines on the Prevention of Suicide
- CG71: Self Harm Clinical Guideline
- CG77: Disengagement or Non Concordance Clinical Guideline
- F & C1 System Flow and Capacity Inpatient and Community Care Policy (North)

END