Essex Partnership University
NHS Foundation Trust

Freedom of Information Request

Reference Number: EPUT.FOI.22.2483
Date Received: 20.04.2022

Information Requested:

A copy of all policies applicable to discharge at C and E centre mental health services

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Response:

Please see attached Trust wide policies which are applicable to the Specialist Mental Health Team (SMHT) & First Episode in Psychosis (FEIP) team of the C&E Centre;

- CG24 – Discharge and Transfer Clinical Guidelines
  - Appendix 1 - Admission to Hospital Letter
  - Appendix 2 – Leaving Letter
  - Appendix 3 – Temporary Transfer Form
  - Appendix 4 – MDT Clinical Handover Form
  - Appendix 5 – Self discharge against Medical Advice

- CLP30 – CPA Policy
- CLPG30 – CPA procedure.

Publication Scheme:

As part of the Freedom of Information Act all public organisations are required to proactively publish certain classes of information on a Publication Scheme. A publication scheme is a guide to the information that is held by the organisation. EPUT's Publication Scheme is located on its Website at the following link https://eput.nhs.uk

Essex Partnership University
NHS Foundation Trust

CPA POLICY

POLICY REFERENCE NUMBER:	CLP30
VERSION NUMBER:	1
REPLACES SEPT DOCUMENT	CPA & Non-CPA Policy CLP 30
REPLACES NEP DOCUMENT	CPA & Non-CPA Policy & Procedure CP10/CPA/08/16
KEY CHANGES FROM PREVIOUS VERSION	The Care Programme Approach (CPA) Policy and Procedure has been harmonised and reviewed following the merger of SEPT and NEP to ensure it is fit-for-purpose for the new organisation.
AUTHOR:	Linda Fisher (SEPT) Clinical Lead for Compliance Carol Larcombe (NEP) CPA Co-ordinator
CONSULTATION GROUPS:	AD's, Service Managers and Community Teams Community Quality and Safety Group Members Workforce Development Policy Group (North)
IMPLEMENTATION DATE:	1 July 2017
AMENDMENT DATE(S):	N/A
LAST REVIEW DATE:	N/A
NEXT REVIEW DATE:	May 2020
APPROVAL BY CLINICAL GOVERNANCE & QUALITY COMMITTEE:	26 May 2017
RATIFICATION BY QUALITY COMMITTEE:	15 June 2017
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POLICY SUMMARY

- This policy outlines the implementation of the Care Programme Approach (CPA) and Non-CPA for Essex Partnership University NHS Foundation Trust (EPUT). The policy must be applied together with other relevant legislation, and should be read in conjunction with the CPA Procedure which provides detailed reference for staff and advice regarding care under CPA and Non-CPA.
- The CPA is a process which describes the approach used in secondary mental health services to assess patients, develop a personalised care plan, manage risk, review and coordinate care to address patient needs.
- This policy applies to, and is mandatory for, all staff working within mental health services and learning disability provided by the Trust. It sets out the policy governing the operation/delivery of CPA & Non-CPA within the Trust.

- The commitment of the Trust and responsibility of all staff in everything we do is not to discriminate on any grounds. In drawing up this policy aspects of discrimination have been considered so that particular groups are not disadvantaged.

The Trust monitors the implementation of and compliance with this policy in the following ways:
Performance Standards, KPI's, Audit, Supervision, 1-1s and Trust wide CPA Steering Group.

Services	**Applicable**	**Comments**
Trustwide		
Essex MH&LD	✓	
CHS		

The Director responsible for monitoring and reviewing this policy is Executive Director of Corporate Governance & Strategy

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CPA POLICY

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CPA POLICY

1.0 INTRODUCTION

1.1 The Care Programme Approach was introduced by the Department of Health (DoH) in 1991 to provide a framework for effective mental health care to all patients and carers regardless of age, disability, race, ethnic origin, nationality, gender, gender reassignment, sexual orientation, marital status, religion, culture, belief, spirituality, pregnancy and maternity.

1.2 CPA is a framework for assessing, planning, implementing/delivering care, and then evaluating the effectiveness of that care/intervention.

1.3 The patient/carer is put at the centre of care planning and delivery. Comprehensive information is given to patients so they can make informed choices with regards to their care and treatment based on their diverse needs, strengths and preferences.

1.4 Values and principles of person-centred care include:

- Focussing on the individual and recovery.
- Assessing and planning the care for the person as a “whole”.
- Promoting and supporting self-care.
- Recognising the role and needs of carers.
- Services based on fulfilling therapeutic relationships and partnerships between the people involved.

1.5 The CPA process promotes safety, positive risk taking, and recovery/living well through a whole life focused approach and draws specifically on the Ten Essential Shared Capabilities (ESC**).**

1.6 The term ‘Patient’ will be used throughout this CPA Policy. This refers to service users, clients, residents.

2.0 SCOPE OF THE CARE PROGRAMME APPROACH

2.1 Following the initial assessment, service users will be placed on either CPA or Non-CPA. The decision to provide care under CPA or Non-CPA is a clinical decision.

- **CPA:** An individual deemed to have complex needs, a higher risk profile and/or requiring multi agency input should be placed on CPA.

- **Non-CPA:** An individual with more straightforward needs, one agency input or no problems with access to other agencies/support and lower risks should be placed on Non- CPA.

2.2 CPA or Non-CPA is applicable to all individuals (adults, older adults and younger people) receiving secondary mental health services in whatever setting that care is delivered. Therefore, throughout this policy, reference to the CPA framework includes the two levels (CPA & Non-CPA).

2.3 The following key groups will automatically be considered to require the support of CPA. Those:

- Who are admitted to a mental health hospital as an inpatient.
- Who have parenting responsibilities.
- Who have caring responsibilities.
- Who are unsettled in their accommodation.
- Who have a history of violence or self-harm.
- Who have known history of suicide attempts/ideations.
- Who have co-morbid drug and alcohol or physical health conditions.
- Who have complex physical, psychological and social needs.
- Who have learning disabilities.
- Who are accepted for treatment (as opposed to just assessment) by the Home Treatment Team.
- Who are under the care of the Early Intervention Team.
- Who are supported under S117 of the Mental Health Act.
- Who are subject to a Community Treatment Order (CTO) under the Mental Health Act.
- Who are under a Guardianship Order under the Mental Health Act (Section 7).
- Who are subject to safeguarding procedures.

3.0 CPA PROCESS

3.1 **Referral**

Referrals are received from a range of sources including GP's, local authority social services, the voluntary sector, probation services, police service, carers, family members, neighbours, other organisations, any other professionals (e.g. district nurse, pharmacist etc) and in some instances individuals user may self-refer.

3.2 **Components of CPA**

The main components of the CPA framework are:

- Assessing
- Risk assessing and planning
- Care planning (including crisis and contingency planning)
- Reviewing
- Co-ordinating care
- Transitions

3.3 **Assessment**

Those accepted for assessment will receive a comprehensive holistic assessment of their mental and physical health and social care needs (in line with the Care Act 2014) and this must always include an assessment of risk.

3.4 **Risk**

Risk assessment is an essential and on-going part of the CPA process and there must be a specific assessment of the level of risk posed to self and/or others using the Trust's approved risk assessment tool.

3.5 **Care Plan**

A care plan is intended to provide a shared understanding of care being provided for each individual. It is a written record outlining who is doing what, when and where, how and why, and must be written using language and terminology that the patient and their family or carer (if appropriate) are able to understand.

3.6 **Coordinating Care**

Care co-ordination is a clearly defined function which assures that the objectives and goals agreed with the individual are achieved through the effective delivery of care.

- The term Care Co-ordinator is used for those working with individuals supported by the CPA Process.

- The term Lead Professional is used for those working with individuals on Non-CPA.

3.7 **Review**

Review is the way we find out if the care plan is working, look at the progress the patient has made and the ways in which their needs may have changed. On review, consideration must be given to whether or not care should continue to be delivered under CPA.

3.8 **Transitions**

Individuals can experience any number of transitions during their contact with our service, such as discharge from services, transfer between services, or transfer of care to another provider.

3.9 **Carers**

Carers play an important role in the support required in helping to contribute to a person's recovery and wellbeing. Carers are entitled to a holistic assessment of their own needs in order to continue their caring role, even if the person they are caring for refuses support from the mental health service.

4.0 TRAINING

4.1 All staff who undertake the role of care co-ordinator will complete eLearning training every three years

5.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION

- Department of Health 1991, Care Programme Approach
- Department of Health 2008, Refocusing the Care Programme Approach
- Department of Health 1994, Ten Essential Shared Capabilities
- Mental Health Act 1983 (amended 2015)
- Mental Capacity Act 2005
- The Care Standards Handbook 2014 (Care Co-ordination Association)
- Care Act 2014

6.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

- Advance Decisions
- Carers Strategy
- Clinical Risk Assessment and Management
- Discharge Procedure
- Equality & Diversity Policy
- Information Governance Policy
- Records Management Policy
- Safeguarding Children & Adults Policy
- S117 Protocol
- 7 Day Follow up Policy
- Induction and Mandatory Training Policy and Procedure

END

Essex Partnership University
NHS Foundation Trust

CPA PROCEDURE

PROCEDURE REFERENCE NUMBER:	CLPG30
VERSION NUMBER:	1.6 (caveat text added)
KEY CHANGES FROM PREVIOUS VERSION	6 months extension (Nov21 – May 22) QC Dec 21 21/22 is considered a transitional year where NHSE and NHSI will be working with systems to implement the NHS National Community Mental Health Framework
AUTHOR:	Emma Strivens, Associate Director
CONSULTATION GROUPS:	AD's, Service Managers and Community Teams Community Quality and Safety Group Members Workforce Development Policy Group (North)
IMPLEMENTATION DATE:	1 July 2017
AMENDMENT DATE(S):	Dec 18 (Author)
LAST REVIEW DATE:	N/A
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APPROVAL BY CLINICAL GOVERNANCE & QUALITY SUB-COMMITTEE:	26 May 2017
RATIFICATION BY QUALITY COMMITTEE:	15 June 2017
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PROCEDURE SUMMARY

This Procedure provides guidance on the implementation of the CPA Policy for Essex Partnership University Foundation Trust (EPUT).

The main components of the CPA Framework outlined in this procedure are:

- Assessing
- Risk assessing and planning
- Care planning (including crisis and contingency planning)
- Co-ordinating care
- Reviewing
- Transitions

This procedure applies to, and is mandatory for, all staff working within mental health services and learning disability provided by the Trust. It sets out the procedures governing the operation/delivery of CPA & Non-CPA within the Trust.

The Trust monitors the implementation of and compliance with this procedure in the following ways:
Monitoring of implementation and compliance with this policy and associated procedural guideline will be undertaken by the Trust Safeguarding Group and the Mental Health and Safeguarding Sub-Committee.

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

CPA PROCEDURE

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CPA PROCEDURE

1.0 INTRODUCTION

1.1 This Procedure provides guidance on the implementation of the CPA Policy for Essex Partnership University Foundation Trust.

1.2 A **CPA INFORMATION LEAFLET** (See Appendix 1) should be given to all patients at the start of their journey.

2.0 COMPONENTS OF CPA

2.1 The main components of the CPA framework are:

- Assessing
- Risk assessing and planning
- Care planning (including crisis and contingency planning)
- Co-ordinating care
- Reviewing
- Transitions

3.0 ASSESSING

3.1 What is an Assessment?

The assessment is the starting point for all patient care. Those accepted for assessment will receive a comprehensive holistic assessment of their mental and physical health and social care needs (in line with the Care Act 2014) and this must always include an assessment of risk.

3.2 Who can undertake an Assessment?

All assessments are undertaken by a qualified clinician, including nurses, occupational therapists, social workers, psychologists and medical staff. On occasions, it may be appropriate to organise a joint assessment, for example where there are complexities and/or high risks.

3.3 Confidentiality

All those assessed (and those with parental responsibility for those young people seen in our service) must be informed at their initial assessment that information that is collected about them will be stored electronically and may need to be shared with other Trust staff, in particular the rest of the multi-

disciplinary team involved in providing care or service to them. They must be advised that all our staff are required to abide by a strict code of conduct on confidentiality.

3.4 **Purpose of an assessment**

The purpose of an assessment is to:

- Provide an initial assessment of needs and how they may be met (including identifying any S117 health or social care needs).
- Evaluate the individual's strengths.
- Identify their goals, aspirations and choices.
- Assess the level of risk and safety.
- Ascertain carer's involvement.
- Identify any safeguarding issues.
- Identify the need for specialist assessment, i.e. personality disorder, substance misuse, and where appropriate, refer to relevant service, agency or profession.
- Determine whether intervention from services is appropriate.
- Identify the person's need for CPA, Non-CPA or other care process that can support them.
- Establish an information base.

3.5 **The full assessment should take into account the following**:

Psychiatric & Psychological Functioning	**Personal Circumstances**
▪ Reason for referral	▪ Patients views on strengths & aims
▪ Presentation	▪ Personal circumstances
▪ Impact on daily life	▪ Family including Genogram
▪ Recent life event	▪ Caring responsibilities
▪ Precipitating factors	▪ Childcare issues
▪ Psychiatric history	▪ Relationship status
▪ Forensic history	▪ Religious & spiritual needs
▪ Pre-morbid personality	▪ Gender, sexuality, sexual orientation

▪ Significant life events	▪ Advance decision
▪ Team/Specific Assessment	▪ Statement of wishes
▪ Experience of violence & abuse	▪ Lasting Power of Attorney
▪ Family history	▪ Veteran (Armed Forces Covenant)
▪ Risks to individual or others	▪ Personalised budget
▪ Learning Disability	▪ Consent to seek or share information with other agencies
Social Functioning	**Physical Health Needs**
▪ Support network	▪ Physical health needs
▪ Housing status & needs	▪ Medical history
▪ Financial status & needs	▪ Allergies
▪ Carer & family involvement	▪ Accidents
▪ Involvement with other agencies	▪ Hospitalisation
▪ Advocacy needs	▪ Weight/Height/BMI
▪ Employment	▪ Smoking status
▪ Training & education	▪ Current Medications
▪ Leisure	▪ Disabilities
▪ Social function & social needs	
▪ Communication & cultural needs	

3.6 **Outcome Scale**

Outcome measures, as required by the service, must be completed at the point of assessment and at review.

3.7 **Assessment Outcome**

All assessments should conclude with the assessment outcome and a summary of what happens following the assessment. This could include advice, information and guidance given or the formulation and plan for what happens next. All assessments must be dated and include the name and designation of the assessor.

3.8 **Discharge back to the GP following Assessment**

If following the assessment, the person is deemed not to require any further intervention from our secondary mental health service; they should be discharged back to their GP with a copy of the assessment outcome and personalised advice, information and guidance on re-direction or signposting to other services if required.

4.0 RISK ASSESSING AND PLANNING

4.1 Assessing Risk

The assessment and management of risk provides the services the structure to anticipate and prepare for foreseeable dangerous behaviour, whether to self or others. Risk is dynamic and is constantly changing in response to circumstances, in particular treatment and management decisions are likely to influence the risks.

4.2 Risk Assessment Tool

The risk assessment must be carried out using the Trust's approved Risk Assessment tool.

4.3 Gathering Risk Information

Risk assessments must take into account all the available information from the patient, and other sources, such as the GP, carers, family members, forensic, other professionals and agencies that have knowledge of the individual. It is essential to seek information on the patient's past behaviour and any previous potential triggers for dangerous behaviour, and to consider the information in the context of the patient's present circumstances, as well as considering what previous strategies have worked.

4.4 **Risk Categories & Indicators**

Suicide	**Self-harm**
▪ Previous attempts	▪ Current/recent episodes of self-harm
▪ Threats	▪ Deliberate self-harm
▪ Opportunity	▪ History of self-harm
▪ Means	▪ Accidental harm
▪ Internet (access to information & suicide promoting groups)	▪ Alcohol/drug/substance misuse issues
▪ Expressed intent	▪ Food issues
▪ Plans	▪ Cutting
▪ Chronic suffering of persistent pain	▪ Binge drinking
▪ Recent diagnosis of life changing/threatening illness	▪ Degree of dependence/withdrawal problems
▪ Recent discharge from hospital	▪ Change in method
▪ Recent discharge from the services	▪ Increase in severity/Frequency
▪ Family history of successful or attempted suicide	▪ Deliberate promiscuous sexual behaviour
▪ Red Flag Alerts from Connecting with People / STORM Training	▪ Deliberate avoidance of prescribed meds or treatment
▪ Rational decision	
▪ Sleep disturbances	
Aggression & Violence	**Vulnerability & Neglect**
▪ Violence to others	▪ Inability to care for self
▪ Domestic violence	▪ Lack of carer support
▪ Access to potential victims	▪ Falls
▪ Specific threats made	▪ Cognitive impairment/confusion
▪ History of sexual assault	▪ Capacity issues
▪ Paranoid delusion	▪ Fire risk
▪ Verbal aggression	▪ Social isolation
▪ Escalation of threats	▪ Social media
▪ Response associated to withdrawal symptoms	▪ Recent discharge from hospital
▪ Aggressive behaviours whilst under the influence	▪ Impaired eyesight and/or hearing
▪ Predatory towards vulnerable individuals	▪ Physical ill health
▪ History of violence to family/staff/ other people & degree of harm caused	▪ Recent discharge from prison or the services
	▪ Lack of health education
	▪ Poverty or lack of resources
	▪ Recent bereavement

Safeguarding	Hazards
▪ Exploitation from others	▪ Environment
▪ Vulnerability to abuse	▪ Neighbourhood
▪ Bullying and harassment	▪ Unsafe buildings
▪ Domestic abuse	▪ Hoarding
▪ Risk of being radicalized	▪ Hazardous surroundings
▪ Financial abuse	▪ Unsafe buildings
▪ Institutional abuse	▪ Aggressive pets
▪ Sexual abuse	▪ Inadequate information on patient
▪ Physical abuse	▪ Location
▪ Female Genital Mutilation (FGM)	▪ Bad lighting
▪ Patient is carer of their own relatives	▪ No mobile phone network
▪ Patient is directly or indirectly providing support to a child	▪ Parking difficulties/issues
▪ Being cared for by carers with mental illness/addiction problems	▪ Other members of the household have aggressive/intimidating behaviour
Mental health history	**Personal**
▪ Previous admissions to hospital	▪ Age
▪ Previous risk taking behaviour	▪ Gender
▪ Detention under the Mental Health Act	▪ Social situation (for example Redundancy, Divorce)
	▪ Key life events
	▪ Relapse indicators
	▪ Triggers
	▪ Anniversary date of death of loved one (or pet)
	▪ Non-compliance with medication
	▪ Failure to attend appointments
	▪ Incidents involving the Criminal Justice system
	▪ Reluctance to engage with services
	▪ Substance misuse

4.5 Documenting Risks

All risks identified in the risk assessment and at every review must be clearly documented and evidenced in the patient's clinical record.

4.6 Planning & Sharing of Risks

All risks must be shared with all professionals involved with the patient. It is essential to record all considerations and risk plans and ensure that the relevant professionals are kept informed. All members of the multi-disciplinary team have a responsibility to consider risk and how these risks will be planned and managed. The outcome of the risk assessment must form the basis of a clear crisis and contingency plan.

4.7 Reviewing Risk

The assessment of risk is an essential and continuous ongoing part of the CPA process and must be considered on an individual basis. It is an essential mandatory requirement whenever a review takes place, or an individual's circumstances change (e.g. through admission to an inpatient unit or on transfer back to the community) to consider all the risk implications and how these will be planned and managed.

5.0 CARE PLANNING

5.1 Person-Centred Care

Person centred care planning is about listening to the patient and finding out what he/she wants and needs. It is about helping patients to think and plan what they want from their life now and in the future, and to enable friends, family & professionals to work together with the person to achieve these goals.

5.2 Jargon-free

In developing care plans in partnership with the patient and their family and/or carers, it is important that they must be created using language and terminology that the patient and their family or carer is able to understand.

5.3 Wellbeing and Recovery

The care plan is a record of the agreed care and treatment for the patient and should focus on their well-being and recovery.

5.4 Specialist Care Plans

When a range of services are identified in the overarching personalised care plan, each service, in partnership with the service user, must agree their specialist care plan which outlines the specific care a person, team or service will deliver. All those involved with specialist care plans must ensure that progress is communicated to the care coordinator/lead professional.

5.5 **What should be considered in the Care Plan?**

Consideration needs to be given to everything outlined in the table below.

Need	**Actions/Goals/Outcomes**
▪ Diverse needs and preferences	▪ Interventions
▪ Translation/interpretation requirements	▪ Contributions of all agencies involved (include their contact details)
▪ Specific needs arising from co-existing physical disability, sensory impairment, learning disability/autism	▪ Agreement of each professional or service to undertake their aspect of the care delivery
▪ Physical healthcare	▪ SMART goals
▪ Parenting or caring needs	▪ Patients actions necessary to achieve the agreed goals
▪ Specific needs arising from drug, alcohol or substance misuse	▪ Agree desired outcomes with patient and carer
▪ Consideration of self-directed support (SDS)/personalised budgets	▪ Arrangements for measuring and reviewing outcomes
▪ S117 Aftercare needs	▪ An estimated timescale by which the outcomes and goals will be achieved or reviewed
▪ Social, cultural or spiritual needs	▪ Date of next planned review
▪ Any unmet needs and service deficits	
▪ Easy read format care plans	
Risk, Contingency & Crisis	**Patient/Carers & Staff Involvement**
▪ Triggers & Relapse indicators	▪ Patients/carers responsibility to achieve the agreed goals
▪ Key events	▪ Patients comments
▪ Contingency plans	▪ Carers comments
▪ Advance decision & Statement of wishes	▪ Copy given to the patient
▪ Crisis contact details	▪ Copy given to the carer (where appropriate)
▪ Outline of who the patient best responds to in a crisis	▪ A note if the patient disagrees with the care plan and the reasons for the disagreement
▪ Crisis plans	▪ Dated and timed
▪ Contact Numbers to ring in a crisis	▪ A note if the patient does not wish to receive a copy
▪ Identified risks and safety issues	
▪ Things to take into account when a crisis happens (children, elderly relatives, animals etc.)	

5.6 **Copy of the Care Plan given to Patient**
A copy of the care plan must be offered to the patient, and made available to all those involved in the care plan. It is essential that practitioners maximise the extent to which the patient knows and understands their care plan and agrees with it. Any disagreements should be recorded.

5.7 **Care Plan for Patients on Non-CPA**
For those patients who are placed on Non-CPA, their care plan will often be in letter format (for example a copy of the letter from the consultant/clinician sent to their GP is copied directly to them).

5.8 **Copy of the Care Plan sent to GP**
The care plan must always be shared with the patient's GP.

6.0 CO-ORDINATING CARE

6.1 Co-ordinating care is a clearly defined function which assures that the objectives and goals agreed with the individual are achieved through the effective delivery of care by the appropriate agency or provider.

- The term Care Co-ordinator is used for those working with individuals supported by the CPA Process.
- The term Lead Professional is used for those working with individuals on Non-CPA.

6.2 **Who can co-ordinate?**
The role of the CPA care co-ordinator or Lead Professional will be allocated to the practitioner who, after consideration of the initial assessment, is best qualified to oversee and to support the care needs of the individual. Care co-ordinators will be qualified professionals who are employed by or seconded to EPUT.

6.3 The responsibilities of the care co-ordinator remain in place whatever the setting, especially during the period of inpatient treatment or when the patient is receiving intensive support from specialist services, such as community teams or residing in a residential home.

6.4 **Absence/Leave arrangements**
When a care coordinator/lead professional is on leave, arrangements must be made as to who will cover their absence.

6.5 **Co-ordinating Care – Main Responsibilities**
The main duties and responsibilities for the care co-ordinator are outlined in the table overleaf and have been divided into the following categories:

- Assessing
- Planning
- Co-ordinating
- Reviewing

Assessing	**Planning**
▪ Carry out a thorough assessment of the person's physical, social, emotional and psychological needs	▪ Agree goals with the patient
▪ Assess any immediate risk to the person or others	▪ Identify and agree actions and interventions
▪ Assess the impact on others in the household (particularly children)	▪ Develop risk management plans to support the individual's independence and daily living
▪ Ensure the identified carer has been informed of their rights to a Carer's Needs Assessment, and where relevant undergo this assessment	▪ Work with the person, their families and carers to identify measures to be taken to prevent a crisis developing and develop a **personal** crisis and contingency plan
	▪ Encourage the person to write an Advance Decision/Statement of Wish
Co-ordinating/Implementing	**Reviewing**
▪ Ensure regular contact is maintained to monitor the person's progress (whether at home/in hospital or prison) taking into account their needs & risks	▪ Review the effectiveness of the therapeutic interventions and recovery/ living well strategies with all involved
▪ Ensure the patient understands the care co-ordinator role and knows how to make contact and who to contact in their absence	▪ Review where there is deterioration in the patient's mental health or where problems may arise in the delivery of the care plan or if significant new risk factors are identified in the course of delivering the care plan
▪ Ensuring all those involved understand and are implementing their identified responsibilities	▪ Discuss the options for transfer of care or discharge
▪ Work with the patient & their families/ carers during times of crisis, ensuring crisis situations are responded to timely, effectively and safely	▪ Agree transfer/discharge plan and the arrangements including the support needs upon transfer/ discharge
▪ Arrange advocacy for those unable to represent their own interests	▪ Care plans are revised and updated after a review and re-issued to those involved
▪ Support patients on their caseload to have an annual health check	▪ Review of S117 needs at every review
▪ Work in collaboration with carers and ensure information, advice or signposting to services is given	

6.6 **Recording**

It is essential that information collected is recorded in line with legal and operational requirements.

7.0 REVIEWING

7.1 Review is the way we find out if the care plan is working, look at progress the patient has made and the ways in which their needs may have changed.

7.2 **Who attends the review?**

The level of complexity of each case will determine who needs to be present at the review. It may not be practical to have all those individuals involved in the care plan attend the review meeting, and it is essential that the patient's feelings and views are taken into account, as large meetings can be intimidating. In some cases, the review may consist of just the patient and the care co-ordinator. However, the care co-ordinator should ensure the views of others are represented.

7.3 **Where the review takes place?**

The patient's wishes about the location and timing of the review and the number of people attending should be respected wherever possible.

7.4 **How often does a review take place?**

All patients on CPA must have their care reviewed no less than once every six month, in response to any change and prior to any transition (e.g. discharge from hospital).

7.5 **The review process**

The review process is outlined in the table on the next page and has been divided into the following categories:

- Purpose of a review
- Preparation for a review
- During the review
- Outcome of the review

7.6 The table below outlines the review process

Purpose of Review	Preparation for Review
▪ Any person involved in the care plan, including the patient or carer, can ask for a review to be held at any time (if refused, this must be recorded in the patient's notes)	▪ Reviews should be prepared for in advance
▪ Ensure the patient's personal details are up-to-date and correct	▪ Respect the patient's wishes for the location and timing of the review and who attends the review
▪ Review the consent to share agreement	▪ Invite all those involved in the patient's care plan
▪ Discussion of any progress the person has made	▪ Where appropriate carers should be involved in the review
▪ Whether they continue to or now need the support of CPA, S117 aftercare, and/or a Community Treatment Order (CTO)	▪ Care co-ordinator/lead professional must ensure they obtain the views of those involved in the care plan who are unable to attend the review
▪ The extent to which the care plan (including crisis and contingency plan) needs amending	
▪ Reassessment of risk factors	
During the Review	**Outcome of Review**
▪ Record all present and apologies received	▪ Change the amount of support required
▪ Determine views of the patient, carer and professionals	▪ Move from or to CPA
▪ Decide upon the best plan of care and setting approximate timescales based on the above discussions	▪ Discharge from the service back to the GP or transfer to another system of care
▪ Consider whether someone continues to have S117 aftercare needs, or if they continue to require a CTO under the MHA & the impact of any user led document (such as an Advance Decision) has on the care plan	▪ Update the care plan, risk plan, crisis and contingency plan and draw up the modified care plan

▪ Any changes must be agreed by all parties and disagreements recorded	▪ Ensure everyone receives a copy of the updated care plan even if they were unable to attend the review

7.7 **Date of the Next Review**
At every review the date of the next review must be planned and appropriately recorded.

7.8 **Professionals Meetings**
It may be necessary on occasions to hold a multi-disciplinary professionals meeting to discuss and decide on the support and treatment of patients who may present with complex needs, high risks and probable non-concordance with their care plan, and where there maybe differences of opinion within the multi-disciplinary group.

8.0 TRANSITIONS

8.1 Individuals can experience any number of transitions during their contact with our service, such as discharge from the services, transfer between services, or transfer of care to another provider.

8.2 **Examples of transitions:**

- Admission to hospital
- Discharge to community from hospital
- Move to a residential home/nursing home
- Imprisonment or release from jail
- Change of geographical area
- Change of care co-ordinator
- Move from the child & adolescent service to the adult service
- Move from the adult service to the older adult service

8.3 **At the time of transfer it is essential that:**

- The process is co-ordinated by the care co-ordinator/lead professional
- The patient and all relevant members of the multi-disciplinary team are involved in the planning of any transition
- Handovers of care are clearly documented with transfers of responsibility agreed in a timely manner
- There are clear plans which have been agreed with all concerned
- Information is shared with all the relevant people

Inpatient transitions – communication

8.4 If it becomes necessary for the patient to have a period of inpatient care, the care co-ordinator will maintain contact with the patient throughout.

8.5 During the period of inpatient care, the care co-ordinator and the inpatient team will maintain open communication to facilitate full assessments of needs and appropriate plans of care.

8.6 The care co-ordinator will retain his/her responsibility for actively overseeing the patient's CPA care plan in close liaison with the inpatient team throughout the period of the inpatient stay.

8.7 **Care Planning for leaving inpatient care**
It is the responsibility of the care co-ordinator in conjunction with the inpatient team and others involved in the care package, to oversee all arrangements for transfer out of the inpatient setting into the community. At the time of leaving inpatient care, the patient must have a current and coherent care plan that includes any changes in need or circumstances and risk factors that were not considered or included in the previous care plan.

8.8 **Follow up arrangements when leaving inpatient care**

The care plan must include details of follow-up arrangements and these should be in line with the 7 day follow up policy.

8.9 **Change of care co-ordinator**
If a change of care co-ordinator/lead professional is necessary, either within the existing team or to another team within the Trust or outside the Trust, the current co-ordinator must arrange to hold a formal CPA review with the patient, any carers if applicable and the new co-ordinator. The care co-ordinator will not discharge the person from their caseload until the person has been accepted fully by the receiving professional/team/service.

8.10 **Transfer to residential homes/nursing homes/prisons**
When a patient is removed from their normal place of residence (e.g. they go into a prison, residential home, nursing home or children being placed into out-of-area foster care), it remains the responsibility of the care co-ordinator to review the quality and appropriateness of their care in accordance with Trust Policy. The care co-ordinator must always ensure that they remain in contact with the patient and ensure that reviews are still carried out in accordance with Trust policy.

8.11 **Change of geographical area**
The national Care Co-ordination Association (CCA) has outlined the procedure for the transfer of patients between Trusts and Local Authority Areas.

END

Essex Partnership University
NHS Foundation Trust

DISCHARGE AND TRANSFER CLINICAL GUIDELINES

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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.

Individual service areas will operate local procedures in accordance with the needs of their patients/service users/residents.

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

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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 7 days of discharge.

7.6 In addition to the above face to face follow up, a follow up telephone call must be made within 48 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

CG24 - APPENDIX 1

Trust Head Office
The Lodge
The Chase
Wickford Essex
SS11 7XX

Telephone:

Chair: Sheila Salmon
Chief Executive: Sally Morris

Dear…….

Admission to Hospital

You have been admitted to hospital so that you can be cared for closely and receive treatment to help you. We all hope that you will be able to be discharged as soon as possible. Your expected date of discharge is ……

During your stay, you will receive the highest standards of care until you are well enough to be discharged. If you have any questions about your care, or if you don't think that the standard of care is as high as it should be, then please discuss this with the ward manager, or, if you want someone outside the ward to look at something, then please contact the Patient Advice Service (PALS). A Hospital admission is intended to offer you treatment during the most difficult stage of your problems and we will work with you towards discharging you from the ward as soon as possible.

If you have any concerns about your discharge, please speak to your Named Nurse, Consultant or Care Co-ordinator as soon as possible, so that any problems can be dealt with sooner rather than later. If you have a housing problem (for instance with nowhere to go) it may be that you will be discharged to the local authority for Homeless Accommodation, but we will discuss this with you.

We will work closely with you, your family and the services which you might require to make certain that all arrangements are in place before you leave hospital. Any questions you or your family have will be discussed and if possible answered.

I repeat that it is not our plan to keep you in hospital as long as possible; we want you to become well enough to return to the community and that is what all the staff are working to.

Yours sincerely

Sally Morris
Chief Executive

CG24 - APPENDIX 2

Trust Head Office
The Lodge
The Chase
Wickford
Essex
SS11 7XX

Telephone:

Chair: Sheila Salmon
Chief Executive: Sally Morris

Dear

Leaving Hospital

We are pleased that your care and treatment has progressed and your assessment indicates that there is no longer any need for you to stay in hospital. As you know, we have been working to find a nursing or residential home for you. Unfortunately your preferred home does not currently have any places available.

We are anxious that you should not have to stay in hospital any longer than you need, and we have found a temporary place in another home, which is suitable for you. We appreciate that this may cause some difficulties in travelling for your visitors.

If you wish to discuss the contents of this letter, please speak to a member of the Ward Team, Care Coordinator or your Social Worker.

Yours sincerely,

Sally Morris
Chief Executive

TEMPORARY TRANSFER FORM

For use when sleep-over arranged within the Trust

(Not to be used for Trust patients Sectioned under the MHA)

Patient's name				
Ward/Unit	From			
	To			
Temporary transfer commenced	Date		Time	

1	The transferring ward/unit to arrange the transport to drop off and pick up their patient (8.00 pm to 8.00 am)?	Yes / No
2	Medication sent and clearly marked to cover prescribed night and morning medication? Ensure drug name on the foil if in blister packs, if possible	Yes / No
3	Medication card sent?	Yes / No
4	Notes included?	Yes / No
5	Special needs – please specify, e.g. sensitivities, disability, preferred language, dietary needs, etc.?	Yes / No
6	Care plan included?	Yes / No
7	Current risk assessment included?	Yes / No
8	Safeguarding concerns shared with the receiving team?	Yes/No/NA
9	Infection Risk (on Admission/Transfer) form ICPG1 Section 4 completed?	Yes / No
10	Sleep-over discussed and agreed with patient?	Yes / No
11	Has the patient been made aware of the receiving ward/unit's night routine?	Yes / No
12	Does the service user have an established sleep pattern?	Yes / No
	If response is 'no', please provide details of night sedation care plan	
13	State patient's current level of observation	

14	Relevant belongings assembled and listed?	Yes / No

15	**In the event of any queries, please contact -**			
	Name (printed)		Phone number	
16	**Person completing this form --**			
	Name (printed)			
	Signature		Designation	

ONLY COPIES OF RELEVANT INFORMATION SHOULD BE GIVEN TO RECEIVING EXTERNAL TRUSTS

CG24 - Appendix 4

MDT CLINICAL HANDOVER AT POINT OF TRANSFER FROM ONE WARD TO ANOTHER

From: Ward/Team		
To: Ward/Team		**Date:**
Name of person/persons completing this form		

	DETAILS
MDT Clinical Information • Patient's Name • Date of Admission • Reason for admission • Current MHA status • Details of any concerns in relation to the patient's Mental Capacity (i.e. consent, management of finances, accommodation)? Details of any recently completed assessments. • Details of any current safeguarding issues	

MDT CLINICAL HANDOVER AT POINT OF TRANSFER
FROM ONE WARD TO ANOTHER

	DETAILS
• Infection Control risk	
• Summary of current identified risks and risk management plans	
• Current Nursing Observation level and rationale	
• Summary of mental health presentation and diagnosis, physical presentation and identified conditions, medical treatment plan and level of engagement	
• Is MEWS card attached and completed?	
• Current medications to go with the patient. Check drug chart attached.	
• Current leave plan	
• Summary of nursing care plan, required interventions and interventions that may impact on staffing requirements i.e. Escorts	
• Details of any planned appointments.	

MDT CLINICAL HANDOVER AT POINT OF TRANSFER
FROM ONE WARD TO ANOTHER

• Contact details of involved family/carers and nature of agreement from patient as to who and when they are involved and level of clinical information to be shared. • Have family/carers been informed of transfer? • Name of patient's care coordinator and contact details • Patient's property – has all personal property been packed. Has Cash and Valuables stored in the ward and unit safes been removed and signed for in readiness for handing over to next ward. Has new Cash and Valuables forms been completed? • Are there Health Care Records which need to be securely transported with the patient, including Section papers. • Have Mental Health Administration being informed of transfer? • Has a Transport Risk assessment been completed? • Date and Time Transport has been arranged.	

Transferring Nurse
Print Name_____ Signature_____

Date:_____

Receiving Nurse
Print Name_____ Signature_____

Date:_____

Name **DOB** **NHS Number**

Essex Partnership University Foundation NHS Partnership Trust
Trust Head Office
The Lodge
The Chase Wickford
Essex SS11 7XX

Ward Tel:

Date:

SELF DISCHARGE AGAINST MEDICAL ADVICE

I ……hereby give notice that I am discharging *myself / my (*delete as appropriate)

……*write relationship where necessary.

(Staff must 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).

against the advice of Doctor ……....., who has explained the possible medical consequences of my decision which are as follows:

1…….

2…….

3…….

(Continue on separate sheet if necessary)

I accept full responsibility for my actions and absolve Essex Partnership University NHS Foundation Trust and its employees from all liability should the above consequences materialise.

I have been provided details if required for contact in crisis. I have/have not (*delete as appropriate) been provided with medications at discharge.

Patient's / relative's signature …….. Date ……

Address:

……

……

Witness: …… * write full name

I confirm that patient has mental capacity and I have explained to the patient the dangers that might arise out of *his/her decision to take *his/her own discharge.

* delete as appropriate

Date: …….. Signed: ……. (Medical / Practitioner)

Full name: …… (Medical / Practitioner)

1. Crisis contact details provided (* Yes / No) (* delete as appropriate)
2. Discharge medications * given / not given (* delete as appropriate)