Transfer and Discharge Policy

This policy explains the process for transfers from community to inpatient and service user discharge to other organisations

Version:	**5**
Executive Lead:	**Exec Director Quality and Safety**
Lead Author:	**Head of Practice Governance**
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Target Audience:
This policy must be understood by all Trust employees involved in the transfer and discharge process.

Preface - concerning the Trust Policy Management System (PMS)

P1 - Version Control History:

Below notes the current and previous Version details

Version	Date of Issue	Author	Status	Comment
V4.2	1st May 2015	Head of Practice Governance	Superseded	Updated to include Care Act 2014
V5	14th July 2015	Head of Practice Governance	Current	Full review

P2 - Relevant Standards:

a) **Equality and RESPECT:** The Trust operates a policy of fairness and RESPECT in relation to the treatment and care of service users and carers; and support for staff.

b) **Care Act 2014**

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P3 - The 2012 Policy Management System and the Policy Format:

- **Policy Template** is the essential format for most Policies. It contains all that staff need to know to carry out their duties in the area covered by the Policy.
- **Operational Policies Template** provides the format to describe our services ,how they work and who can access them
- **Care Pathways Template** is at the moment in draft and only for the use of the Pathways Team as they are adapting the design on a working basis.
- **Guidance Template** is a sub-section of the Policy to guide Staff and provide specific details of a particular area. An over-arching Policy can contain several Guidance's which will need to go back to the Approval Group annually

Symbols used in Policies:

RULE **=internally agreed, that this is a rule & must be done the way described**

STANDARD **= a national standard which we must comply with, so must be followed**

Managers must bring all relevant policies to the attention of their staff, where possible, viewing and discussing the contents so that the team is aware of what they need to do.

Individual staff/students/learners are responsible for implementing the requirements appropriate to their role, through reading the Policy and demonstrating to their manager that they understand the key points.

All Trust Policies will change to these formats as Policies are reviewed every 3 years, or when national Policy or legislation or other change prompts a review. All expired & superseded documents are retained & archived and are accessible through the Compliance and Risk Facilitator Policies@hpft.nhs.uk

All current Policies can be found on the Trust Policy Website via the Green Button or http://trustspace/InformationCentre/TrustPolicies/default.aspx

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PART 1 – Preliminary Issues:

1. **Flow Chart** – Transfer of Service Users from Community Services to Inpatient Services

Transfer of Service Users from Community Services to Inpatient Services

Admission will be via Crisis Assessment Treatment Team, for all patients being transferred from Community Services.

If admission is under Mental Health Act, MHA procedures and documentation are followed.

Transfer information from Community to Inpatient includes:

- Needs agreement
- Updated risk assessment
- Last care plan
- Updated psychiatric assessment by the referring medical officer
- Advance decision (if appropriate)
- Other supporting Information from referral sources (if available) e.g. referral form, discharge summaries from other providers, GP information, Accident and Emergency Department notes, care plan/transfer summaries, SAP assessment, CATT short admission form.

Service user/carer kept informed and given information regarding the inpatient unit.

Transfer of Service Users from Inpatient Services to Community Services

Transfer of information from Inpatient to Community includes:

- Identified as a Delayed Transfer of care and reported as such
- Updated needs agreement which includes current mental health assessment
- Care plan /discharge plan
- Updated risk assessment
- Transfer letter to GP
- Date of 7 day follow-up contact refer to section 5.4

The service user and carer, as appropriate, is provided with verbal and written information which includes, contact details for their care co-ordinator, medication and on-going treatment, follow-up arrangements and date of first contact and access to the relevant community team including emergency help line. The service user is given a copy of the discharge care plan.

2. Summary

Hertfordshire Partnership University NHS Foundation Trust (HPFT) is committed to ensuring that service users using Trust services are prepared for and have a planned transfer or discharge from an episode of care and treatment between HPFT services or between HPFT and other partners or agencies.

This policy applies to all service users being discharged or transferred from services provided by the HPFT. For services provided by Norfolk Specialist Learning Disabilities Services, additional local procedures are followed.

This policy provides national guidance on identifying and reporting delayed transfers of care.

This policy does not include specific discharge and transfer requirements as required by the Mental Health Act and its Code of Practice 2008 which is covered in the Trust Mental Health Act policies and the Mental Capacity Act.

It takes into account the requirements of the Care Programme Approach (CPA), and the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness report Safety First and subsequent reports and the NHSLA standards for clinical care. The Trust Social Care Funded Placements policy sets out the requirements for social care funded beds commissioned for Hertfordshire residents.

The Trust works within the agreed joint protocols with Hertfordshire County Council Health and Community Services, reflecting the statutory duties under the Care Act (2014) to assess eligibility for social care according to the new framework.

The discharge or transfer from Trust services is part of a service user's journey towards recovery. The purpose of this document is to ensure that: the discharge or transfer is in partnership with the service user, their carers, partners and relatives; is carried out within the care planning process; is based on risk assessment; engages with the care programme approach or Single Assessment Process as appropriate; provides risk management support and good continuity of mental health/learning disability care within aftercare arrangements.

Transfer of information is based on the electronic record where possible; if not paper copies must be supplied.

The appendices deal with a wider range of issues related to transfer of responsibilities and include detail on managing delayed transfers of care and guidelines on referral to tertiary providers.

3. Purpose

This is an overview of the discharge and transfer procedures and is to be read in association with the operational policies of the specific services and the Delivery of Care (formerly Care Co-ordination) Policy.

Trust staff involved with the discharge or transfer of service users must be familiar with the procedures set out in this document and additional local service procedures initially on induction and then as Trust procedures change. Members of staff should also be aware of the operational procedures of the services with whom they will work in partnership. The individual's annual appraisal and personal development plan will highlight any additional requirements.

Standards are also contained in the following related policies:

- Clinical Risk Assessment and Management
- Delivery of Care (formerly Care Co-ordination)policy
- Social Care Funded Placements Policy
- Safeguarding Children
- Safeguarding Adults
- Mental Health Act policies
- Mental Capacity Act and Deprivation of Liberty Safeguards
- Equality and Diversity

4. Definitions

STANDARD

Transfer
Transfer is the movement of a patient/service user from one service to another. When a service user needs more intensive care and treatment they are **transferred** from a community team to an in-patient team. When the service user has completed their treatment they are then transferred from the in-patient setting back to the community team.

Discharge
Discharge takes place when a service user:
a) Moves out of the area into another Trust and ceases to receive services from the Trust or
b) Their needs no longer require care and treatment from the Trust and they are discharged back to the GP.

The delayed transfer of care definition guidance from Department of Health is available at Appendix 2.

Service User Groups Definitions

In-patients
When a service user is admitted to an HPFT hospital ward for 24 hour care and treatment for a period of time to receive treatment for mental health or a cognitive impairment

Community
When a service user receives care and treatment from Trust community workers whilst living in their own home or other non-hospital accommodation

Adult
Someone that has reached their 18th birthday is considered an adult and will receive services from adult community and in-patients services.

Adolescent
Is someone under the age of 18 who receives care and treatment in both community and in-patient settings specific to adolescents.

5. Duties and Responsibilities

RULE

Responsibilities of CPA care co-ordinator

- The care co-ordinator will arrange a face to face follow up appointment as the first contact with the service user within 7 days of transfer (or 48 hours).
- This meeting will be agreed with the service user prior to transfer from the inpatient unit. Details of the follow up meeting must be recorded in the care record.
- The risk assessment must be updated after the follow up appointment and the care plan amended.
- The care co-ordinator must feedback the outcome of the follow up appointment at the multi-disciplinary team meeting.

The Multidisciplinary Team (MDT)

This refers to all the staff involved in the management of patient's/service users care from admission to discharge. The MDT must ensure that the patient/service user is the focus of care and their carers are involved in discharge planning.

6. Service User Information and Communication

Good communication and clear explanation from all staff to service users and carers is required throughout the process in order to ensure a satisfactory outcome.

Transfer planning involves the service user, the health and social care team and as appropriate other health/social care professionals and agencies e.g. voluntary organisations and housing, partners, parents/relatives/carers/advocates and the referrer. All professionals involved should be made aware of the transfer arrangements. This includes crucially Social Services Children Schools and Families teams when they are involved in a case.

When a service user is transferred to another service within HPFT, information on the service should be provided by the referring team to the service user, relatives and carers. The members of staff giving the information must check that it has been understood. Written information on services is available from the Trust website.

The receiving team should be told by the referring team what information has been given to the service user.

When a service user is identified as experiencing a delayed transfer of care all plans should address minimising the length of the delay and ensure they have an appropriate, effective and timely planned discharge. The Trust as part of the Monitor national requirement to meet the Operating Framework 2015/16 must ensure that delayed transfers of care are minimised to ≤7.5% of admission days. This is essential to achieve as this makes up one of the key Monitor mental health indicators.

When transferred from inpatient services to community services the service user and carer, as appropriate, are provided with verbal and written information which includes, contact details for their care co-ordinator, medication and ongoing treatment, follow-up arrangements, date of first contact and access to the relevant community team including emergency help line. The service user is given a copy of the discharge care plan.

The information provided should meet the communication needs of the service user and their relative/carers, e.g. people with physical, sensory or learning disabilities or people who do not speak or read English. The Trust guidance on communicating with service users from diverse communities provides guidance on communication needs and the procedure on accessing the interpreting service.

Where there are specific cultural/religious practices which may affect compliance with treatment, the service user should be given the opportunity to discuss and agree adjustments or alternatives to enable treatment to go ahead.

Service users, their carers and relatives should be asked for their permission to be contacted about any quality monitoring being carried out by the Trust e.g. satisfaction surveys asking for their experience of using the service.

7. Transfers

7.1 Community to Community Transfers

- Responsibility for all clinical care – depot administration, follow up in outpatients – should be delivered locally by the team that is local to the patient's address

- Responsibility for CPA care coordination or contact person should be agreed on an individual case by case basis. In general, this should be delivered locally by the team that is local to the patient's address, if the patient will stay in the local area for a time period of three months or more. In cases where a patient is temporarily resident, even if for three months or more, agreement should be reached on which service is best placed to care co-ordinate the case, giving consideration to patient and carer wishes.
- The process for transfer of care will be that the team making referral will do so by brief written referral to new team, highlighting reference to the up to date needs agreement, risk assessment and care plan on the EPR. Formal transfer should take place within a review meeting. Transfer should be completed within 6 weeks of initial referral to the new team.
- Those who move between one community team and another in the Trust for whatever reason only require the reduced version of a review meeting – where the essential parties are the current and future care co-ordinators, the service user and where appropriate the carer
- Budgetary responsibility for a placement is not a barrier to transfer. Finance can be contacted to arrange transfer of budget to the team local to the placement to support transfer of care.
- Any disputes that cannot be resolved team to team should be raised to the relevant Service Line Lead and Medical Lead for assistance.

7.2 Transfer from Inpatient Units to Community Services

RULE

- Transfer planning commences at the beginning of the in-patient episode and is addressed within the care plan formulated at weekly ward/clinical reviews and confirmed and agreed within CPA meetings.
- Consultant Psychiatrists must always be informed and directly involved in clinical decisions for service users who express delusional beliefs or suicidal ideation that may involve and pose a risk to children. Where the service user is an inpatient this will include any decision regarding transfer, leave, CPA reviews or contact arrangements with children. These decisions must not be delegated to a junior doctor.
- The above cases are likely to be the small minority. Therefore, care coordinators must have a low threshold for acting in cases where there may be a significant risk to children. All such cases must be discussed in the multi-disciplinary team meeting to ensure a group decision is taken about how to manage risks and plan actions. When a consultant psychiatrist is not present at the meeting the discussion must include whether it is necessary for the consultant to be alerted to the case to make a decision about whether there is a need for direct consultant involvement and / or oversight of the case.
- If urgent action is required to safeguard a child, before the routine team meeting, the clinician must seek advice from the manager or senior clinician immediately and make a referral to CSF if needed. If in any doubt advice should be sought from the Lead Doctor or Nurse for Safeguarding Children. Refer also to the HPFT policy on managing risks associated with child protection and safeguarding children.
- The named nurse (or associate nurse) is responsible for co-ordinating and undertaking preparation for the service user's transfer including overview of care/treatment plans and risk management. A pre-transfer checklist may be used to assist this process as set out in the Trust document "Role and Function of the Named Nurse''.

- For people with learning disabilities, the health action plan or Purple Folder (Hertfordshire patients only) is updated, if necessary, and changes shared with the service user and/or main carer/professional and the GP.
- The named nurse (or associate nurse) is responsible for arranging the transfer planning meetings. These are CPA meetings and all standards for CPA meetings apply (see Delivery of Care Policy).
- As a minimum these will include the service user, the carer (as appropriate), the Consultant Psychiatrist responsible for inpatient care and the care co-ordinator.
- Where possible, representation from the appropriate community team will be present at the transfer meetings to ensure that requirements for community services are in place.
- It is acceptable for transfer planning meetings to take place when a service user transfers from acute care to community services rather than specifically from inpatient care. Tele-conferencing as a means of ensuring full involvement of community staff in such meetings is encouraged.
- Where necessary the service user will be supported by an advocate or language support/interpreters.
- As stated above, transfer planning meetings are CPA meetings and all those standards apply. Those involved have the responsibility to discuss, assign responsibilities and address needs arising in the following areas:
  - Identification of the community care-co-ordinator if not known and handing over care co-ordination responsibilities.
  - The outcome of risk assessment and strategies to provide risk management support within aftercare arrangements including social care needs.
  - Identification of issues that have emerged during admission or that can be anticipated on transfer.
  - Contingency plans for service users who have complex needs
  - Any issues surrounding the home situation e.g. is the return home practicable and safe?
  - Pharmacy Arrangements for Transfer. For guidance refer to the Medicines Policy.
- Verbal and written information for the service user which includes medication and ongoing treatment follow-up arrangements and date of first contact, access to the relevant community team including emergency help line.

7.2.1 Final CPA prior to transfer and 7 day follow up

RULE

The final CPA review, prior to transfer, must identify the date of the first community review, the level of CPA (or other type of care co-ordination if discharged from CPA) on transfer, the name of the Care Co-ordinator and the date for the 7 day follow-up contact. The person responsible for carrying out the 7 day follow–up contact must be agreed.

A 7-day follow-up appointment must be recorded on the EPR, prior to or immediately following transfer.

When someone is transferred from inpatient status to community services including CATT, this decision should in all cases be informed by an updated risk assessment. Likewise, when someone is transferred from CATT to non-acute community services, this decision should be supported by an updated risk assessment. (See Clinical Risk Assessment and Management: Policy and Procedures).

In exceptional circumstances, such as when an unplanned transfer occurs, if the meeting cannot take place before transfer, it must take place within 7 days of transfer.

The Consultant Psychiatrist should ensure that physical examination is carried out prior to transfer in every case and that this is clearly recorded in care record.

Service users with no formal address are referred to the homeless unit, crisis homes or to the housing department. If, in exceptional circumstances, service user is being transferred to 'no formal address', discussion should take place in a multi-agency meeting which includes the care co-ordinator and the community team regarding care co-ordination and covering and addressing needs arising in the following areas:

- Time of day of transfer
- Access to Primary Care Services
- Access to benefits
- Medication
- Referral to support agencies, social services and local advocacy services, housing support
- The involvement of the community team regarding care co-ordination.
- Date and time of follow up

The named nurse or deputy will give a copy of the care plan to the service user prior to transfer and record that this has been given in the care record.

Information on the Trust service the service user has been transferred to should be provided to the service user, relatives and carers. This should be recorded in the care record.

When discharging a service user with a suspected or proven infection the named nurse must follow the HPFT Infection Control Healthcare Associated Infection Risk Assessment Guidelines and further advice obtained from the Infection Control Team if necessary. All information is to be recorded in the care record.

For discharge arrangements and responsibilities for service users admitted under the Mental Health Act 1983, refer to the Mental Health Act policies.

For service users without capacity to make decisions regarding transfer the Trust must work within the safeguards of the Mental Capacity Act 2005.

If there are concerns regarding the transfer of a young person, staff should refer to the Trust Guidelines for all professionals, Managing risks associated with child protection and safeguarding children. This should be followed. It incorporates guidance on referral to Children, Schools and Families (Hertfordshire Child Protection Procedures).

If there are concerns regarding the transfer of a vulnerable adult it may be necessary to make a referral under the Hertfordshire Adult Protection Procedure.

For transfer following inappropriate behaviour (such as the use of alcohol or illegal drugs on the unit) those who require specialist mental health services or who have severe and enduring mental health problems/learning disabilities, the involvement of the care co-ordinator and the community team regarding care co-ordination is required.

7.2.2 GP Notification

RULE

The GP must be notified of the transfer by letter within 48 hours and this action must be recorded in the care record. It is the responsibility of the inpatient Consultant Psychiatrist to ensure this takes place.

7.2.3 Transfer Summary

RULE

The inpatient Consultant Psychiatrist is also responsible for ensuring the transfer summary is sent within 14 days together with the final CPA Care Plan and risk assessment and any physical health requirements if applicable. The GP is to be notified which physical examinations have been undertaken, any ongoing physical care requirements including continuation of smoking cessation and weight management programme (if applicable) and who is now expected to carry on the monitoring checks. Refer to the Policy and Procedure for the Physical Assessment Examination and ongoing physical care of service users.

The named nurse is responsible for providing as a minimum the following to the receiving team:

a) For service users transferred to mental health/learning disability services:

- Updated needs agreement which includes current mental health assessment
- Care plan /transfer plan
- Updated risk assessment
- Transfer letter to GP

b) After care plan for those admitted under the Mental Health Act. For further information refer to the HPFT Mental Health Act policies.

c) Updated Advance decision (if appropriate)

All transfer arrangements made or discussed must be recorded in the care record, together with a list of the documents forwarded to the receiving teams.

7.3 Transfer of Service Users from Community Services to Inpatient Services.

- Admissions to Trust services are made via the Single Point of Access.
- Inpatient admissions are made via the Crisis Assessment and Treatment teams for Mental Health inpatient services
- Inpatient admissions are made by MHSOP Crisis Assessment and Treatment Team for service users with a diagnosis of dementia. See Community Mental Health Services for Older People Policy.
- Admissions to Learning Disability inpatient services are through referral via:
  - the Intensive Support Team – Hertfordshire
  - the borough Learning Disability consultant psychiatrist – Tertiary referrals
- All services users admitted to inpatient services are reviewed and cared for under the care programme approach.

- When a service user is referred for admission to the inpatient services the referral team are responsible for providing the following records to the receiving team via the electronic patient record:

  - Needs Agreement
  - Updated risk assessment
  - Last care plan

- For Tertiary Learning Disability services a referral profile is required from the referring consultant and a pre-admission meeting will take place.
- If there is a requirement to transfer paper records please follow the standards as set out in section 9.13 of the Care Records Management Policy.

7.4 Transfer of service users to another Mental Health Trust

Service users may move between Trusts and counties. However the move has taken place, the current care co-ordinator is responsible for sharing information as necessary with the new Trust and handing over care co-ordination responsibilities.

When such a move takes place in a planned way – which may be to independent accommodation or residential or nursing home care – the care co-ordinator and Consultant Psychiatrist should liaise at an early stage with their counterparts in the new area, providing such information as is required to ensure the continuation of the discharge care plan.

It may be agreed that Trust services should continue for a defined period, as long as this is both clinically appropriate and reasonable practicable.

If the receiving Trust has a Care Co-ordination/CPA policy which expects attendance at a handover meeting, the HPFT care co-ordinator should comply with that.

If the transfer out of county is of an inpatient being discharged on CPA, the Trust care co-ordinator with the inpatient team must ensure that 7 day follow up takes place and agree whether it is done by this or the receiving Trust.

If a service user is remanded into custody in a prison outside Hertfordshire the care co-ordinator role will stay with this Trust.

7.5 Process for the transition of service users to commissioned providers

When service users are being transferred from inpatient or community services to a funded placement, it is essential that Trust services are clear about their respective responsibilities.

On the basis of the latest needs assessment and risk assessment, where other options have been exhausted, it may be necessary to make the case for a commissioned accommodation solution to enable safe transfer into the community to be completed.

These will generally be registered care homes or supported living projects.

For inpatients, the key staff involved in this decision will be the care co-ordinator, the named nurse and the Consultant Psychiatrist.

Different processes are to be followed depending on whether the service user meets the criteria for continuing healthcare funding or not. If they do not, the process to be followed is as described in the Social Care Funded Placements Policy.

The Bed Management and Placement Service (BMPS) has a placement seeking and advisory role.

RULE

The care co-ordinator should ensure that all necessary information on the service user's care record, including the risk assessment, is up to date.

The service user should be kept informed of the progress of placement decisions by the care coordinator.

When a proposed placement has been agreed at panel, the care co-ordinator is responsible for ensuring that a pre-placement meeting takes place to review the care plan and risk assessment and that a contingency plan for the management of crisis is agreed. This will be part of a transfer CPA. The contingency plan should clearly record any trial period for the placement, and the care plan that will be followed if the placement breaks down at any time both during and after the trial period. If a trial period is agreed, a further CPA/review meeting should take place at the end of the trial period to confirm the placement, or agree the on-going care plan if the placement is not suitable

Following the pre-placement meeting the care co-ordinator will ensure that the following information is made available to the prospective placement providers. The information to include as a minimum:

- The up to date risk assessment (this must be either the risk assessment done for panel or the one subsequently completed because circumstances changed)
- The revised written care plan including any physical health requirements.
- A contingency plan for the management of crisis.

The care co-ordinator ensures that a written copy of the care plan is provided to the service user and their carer (with the service user's agreement).

Contact details for the care co-ordinator are provided to the non-Trust provider.

The service user and carer are provided with contact details for their care co-ordinator and the out of hour's mental health helpline.

If the service user is an inpatient, the service user's Consultant Psychiatrist is responsible for ensuring the transfer summary is completed and sent to the placement provider and GP within 14 days of transfer.

If an agreed and funded placement breaks down the non-Trust provider informs the care co-ordinator and the service user is referred to the CATT team, local to their most recent home address prior to placement, for assessment and a decision on future care.

Whether the placement is in-county or out of county, the care co-ordinator remains in that role unless or until the role is transferred to the local service.

Appendix 3 outlines the process for ensuring safe and clinically appropriate placements are always made. This checklist must be completed in all cases by the care co-ordinator, team manager and Bed Management and Placement Service for their respective areas and scanned onto the electronic patient record by the care co-ordinator.

RULE

The risk assessment must either be completed within 48 hours of the placement starting or the team manager must sign on the checklist that the most recent risk assessment remains valid.

7.6. Social Care Responsibilities.

Under the Care Act (2014) when someone with a personal budget to address their social care needs changes their ordinary residence to another local authority area, if the Trust has set up and is responsible for reviewing the package of care, then the Trust is also responsible for playing its role in ensuring pro-actively that the care package is continued.

When the currently responsible agency is informed that the person is moving, it must with their consent do a number of things:

- It must provide a copy of the adult's care and support plan, so that the second local authority knows what the adult's needs are;
- It must provide a copy of the "care account", if there is one;
- If the adult has been arranging their own care and support, it must provide a copy of the "independent personal budget", as well as the most recent assessment;
- It must also provide any other information that the second authority requests, such as their financial assessment.

If the person has a carer who will continue to care for them after the move, the Trust must also provide a copy of the carer's support plan.

7.7. Transfer of Service Users between inpatient units within the Trust or to local Acute Trusts e.g. for physical health treatment

Following agreement on bed availability[1] and agreement by the medical and ward/unit referring and receiving teams, the referring team will be required to send relevant information to the receiving team. This includes a written summary of the care plan and if not available on the electronic patient record, copies of clinical notes, including physical assessment and monitoring, prescription chart, updated risk assessments and management plans. A joint multi-disciplinary review of care may be applicable.

The referring and receiving team will negotiate an appropriate transfer time. The referring team will organise transport.

It is essential when transferring a service user with a suspected/proven infection that an appropriate risk assessment is completed to ensure that the correct infection control precautions can be implemented in order to prevent the spread of the infection. For further information refer to the Healthcare Associated Infection Risk Assessment Guidelines.

Further advice can be obtained from the Infection Control Team if necessary.

In order to facilitate the efficient transfer of service users between inpatient settings a care summary is prepared by the named nurse for the receiving nurses. Usually handover is from the electronic patient record, referring to the care plans. Where this is not possible a written report is provided.

[1] For bed availability refer to the HPFT Bed Management Policy.

The member of Trust staff escorting the service user will utilize this summary to ensure that the handover covers all areas of care.

In addition to service user identification data, the care summary covers key information (as appropriate) on:

- Information provided to service user/carer relating to the transfer
- Reason for transfer
- Diagnosis
- Admission status
- Reason for admission to HPFT
- Known allergies
- Significant cultural or spiritual issues
- Specific communication needs e.g. interpreter
- Significant previous medical/psychiatric history
- Present care/treatment plan including physical/mental health/medication and if applicable: Self caring ability/Nutrition intake/Continence/Mobility

If the Service user is being transferred to another Mental Health Hospital, a letter is completed and the following accompany service user:

- Updated risk assessment
- Updated care plan
- Relevant copies of nursing and medical notes
- If detained under the MHA the Trust MHA policy for the transfer to service users to be followed.

People should not be transferred home from inpatient care after 8 pm.

8. Seven Day Follow Up after Transfer from Mental Health Inpatient Units and Other Acute Care Pathway Services to Community Services

RULE:

8.1 Requirements

These procedures are designed to ensure that all vulnerable service users have access to face to face follow up as a first contact in the community within 7 days of transfer. This includes those who take their own transfer.

This section applies both to those transferred direct from inpatient care to community mental health teams, and to those transferred from other Acute Care Pathway services (eg.Crisis Assessment and Treatment Teams (CATTs) and Acute Day Treatment Units) to community mental health teams.

7 day follow up should always be face to face. However, in exceptional circumstances if face to face contact is not possible a phone conversation is acceptable.

8.2 Those identified as particularly vulnerable should be followed up within 48 hours.[2]

This procedure applies to all eligible service users. The responsibility for eligibility is held by the consultant or other designated doctor in consultation with the multi-disciplinary team.

[2] NPSA, (November 2009) *Preventing suicide A toolkit for Mental Health Services*, Standard 3, Post-Discharge Prevention of Suicide

The procedures also ensure that people who do not need specialist mental health services are given advice and support at the point of transfer and that this information is passed on to the GP. The GP then has the responsibility to provide follow up care.

8.3 Who will be followed up within 7 days?
Those service users who have been discharged from hospital and are on CPA must be followed up with a face to face appointment (or, in exceptional circumstances, a phone conversation), within 7 days of leaving hospital. This will usually be done by either the CAT team (if taken on for home treatment) or the care co-ordinator (if transferred to community services).

Those service users who have transferred from all other acute care pathway services to a community mental health service on CPA must be followed up through a face to face appointment (or, in exceptional circumstances, a phone conversation), within 7 days of the transfer date. This would usually be done by the care co-ordinator.

Service users on CPA who as inpatients go on leave for 7 days or more as a step towards being discharged from hospital must also be followed up through a face to face appointment within 7 days of the start of the leave period.

It should be noted that to ensure patient safety this policy is more demanding than the standard required to meet the performance indicator about 7 day follow up, which only applies on discharge from inpatient care

8.4 Transfer planning meeting/CPA meeting

a) Community teams such the CMHT, Assertive Outreach, Crisis And Treatment teams etc. must ensure that they are represented at the transfer planning meetings as appropriate.

b) At the transfer planning meeting all service users who meet the criteria for 7 day (or 48 hours) follow up will be given a date, time and place for the follow up meeting.

8.5 Who will follow up the service user?

Allocation of Care Co-ordinator:

a) The person who is allocated the task to follow up within 7 days (or 48 hours) will be identified at the transfer planning meeting. This would normally be the care co-ordinator who should be identified prior to transfer. If CATT are providing initial follow up from inpatient care, they will ensure this takes place within 7 days
b) In cases where it is not possible for the care co-ordinator to follow up, responsibility may be delegated to another appropriate team member. This must be agreed in consultation with the multi-disciplinary team. This should preferably be someone who is already known to the service user but, if it is a new worker, the service user should be given details prior to transfer.
c) 7 day follow up should take place in all cases, including those service users who have moved out of county.

8.6 Responsibilities of care co-ordinator

a) The care co-ordinator will arrange a face to face follow up appointment as the first contact with the service user within 7 days of transfer (or 48 hours).
b) This meeting will be agreed with the service user prior to transfer from the inpatient unit.

c) Details of the follow up meeting must be recorded in the care record.
d) The risk assessment must be updated after the follow up appointment and the care plan amended.
e) The care co-ordinator must feedback the outcome of the follow up appointment at the multi-disciplinary team meeting.

8.7 Service users who are not given a follow up appointment

a) It is the responsibility of the consultant or other designated doctor to make a decision about service users who do not meet the criteria for follow up by secondary mental health services.
b) In these cases, all decisions must be clearly documented and a letter sent to the GP on the day of transfer.
c) Consideration should be given to the following:
    - Should the CPA level be reviewed?
    - Have the risks increased?
    - What support networks exist?
    - Is there a history of self-harm?
    - Is the service user aware of how to contact further help and advice?
    - Is the service user registered with a GP?
    - Is there a history of substance misuse?
    - Has the service user been given information and advice about other support services?

This must be based on the updated risk assessment.

If it has proved impossible to contact the service user in the 7 day period, a letter must be sent before the end of this period to the service user stating the importance of contact and how this will be done.

8.8 Procedure if a Service User does not attend a follow up appointment (DNAs)

RULE:

If a service user does not attend their follow up appointment, for instance at an outpatient or duty appointment this must be treated as a cause for concern and further arrangements must be made to follow up and review at the earliest possible time.

More detail is available in the Did Not Attend policy.

If it has proved impossible to contact the service user in the 7 day period, a letter must be sent before the end of this period to the service user stating the importance of contact and how this will be done.

9 Transfer of patients out of hours

When a service user is transferred from inpatient care outside normal working hours or over a weekend or bank holiday risks will be assessed and the Ward Manager (or their delegated representative) will consider the most appropriate short term follow-up e.g. by way of CATT or the GP. The bleep-holder and first on call manager will be advised of the situation and the actions taken.

The GP, the CATT and community teams, the care co-ordinator, any other referrer, carer and other relevant agencies should be notified immediately by the named nurse or deputy of

any discharge against advice together with information regarding any known risks. Urgent follow-up in the community is essential.

The Care Co-ordinator is responsible for arranging an urgent home visit/contact within 7 working days in accordance with this policy.

10 Discharge requirements and responsibilities

As stated above 'discharge' refers to when service users leave Trust care.

Discharge from Trust services follows shared care principles.

The discharging service communicates the relevant information to primary care services, the service user and with the service user's permission, relatives and carers, to support their ongoing recovery. The care co-ordinator is responsible for ensuring this takes place.

The following documentation is required:

- Needs agreement
- Risk assessment

To transfer paper records please follow the standards as set out in the Trust Care Records Management Policy.

For full information on the discharge of service users from community services refer to the discharge requirements of the specific service available in the operational policy that service e.g.

- Community Mental Health Team
- Crisis Assessment and Treatment Team
- Intensive Support Team

The care co-ordinator should explain clearly and in writing to the service user, carer (where appropriate) and GP how Trust services may be accessed again in future. This should be supported by assistance to the service user and (where appropriate) the carer in recognising if they are becoming unwell again. A relapse signature may be agreed with the service user, or a health and well-being plan should be used.

Staff should always consider the implications of their decision to discharge a service user from the Trust, including any possible risks to themselves or others.

The needs of any children in the family must be considered. Where concerns have been identified a referral to Children's services must be made in line with HPFT safeguarding procedures. Staff should seek to discuss concerns about the welfare and safety of the child with the service user and relevant family members unless to do so would place the child at increased risk of harm. Disclosure of relevant information for the purpose of referral may need to take place against the wishes of the service user if the child is considered to be at risk of harm.

There must always be a case note to show that risk to children has been considered. A final risk assessment does not need to be completed.

At the point of where it is considered the service user has recovered or functions to a degree they no longer require secondary Mental Health Services consideration as to the safety of any children cared for by that adult must be made. 'Stepping a case down' to primary care via the CPA process must be in agreement with the service user and primary care team.

Health and well-being plans and other tools to assist with self-management should be used where possible to help service users prepare for a more independent life. This should always be accompanied by clear information on how to reaccess mental health care via SPA if necessary in future.

11 Mental Capacity Act 2005

The Mental Capacity Act 2005 sets out the requirements for a best interest decision for the care and treatment of people who have been assessed as not having the capacity to make the decision in question.

The Trust has responsibility for applying for authorisation of deprivation of liberty for any person who may come within the scope of the deprivation of liberty safeguards. For further information refer to Deprivation of Liberty Safeguards Code of Practice, which is a supplement to the Mental Capacity Act 2005 Code of Practice and the Herts County Council, Deprivation of Liberty safeguards Supervisory Body Policy and Procedure.

For service users admitted under the Mental Health Act refer to the Mental Health Act policies.

For full information on the admission process to specific services refer to the Acute Ward Operational Policy or the operational policies of the inpatient services.

Where the service user is under the Care Programme Approach (CPA), the community care co-ordinator will retain that role. For service users new to Trust services, the named nurse takes on a co-ordinating role at first but part of their job is to refer to the community team for allocation of a care co-ordinator.

12 Access to healthcare for people with a learning disability

All mental health services in HPFT are available to people with a learning disability. HPFT have a responsibility to ensure that all people with a learning disability access appropriate services and that they receive the best treatment available in line with good practice and legal frameworks. Therefore all services will ensure that:

- Reasonable adjustments are made to ensure that each person has the same opportunity for health, whether they have a learning disability or not. (Disability Discrimination Act 2005)
- Assume that each person presented to the service has capacity. If assessment shows they don’t, a decision must be made in their best interest. (Mental Capacity Act 2005)
- Everyone has a right to expect and receive appropriate healthcare. (Human Rights Act 1998)

Adjustments will include

- Spending time with the individual to gain an understanding of their preferences for treatment
- To ask them where they would prefer to be treated,
- To provide additional support to assist with communication, this support will be available via easy read material/and/or audio equipment. Templates for appointment letters and easy read information leaflets are available via the Performance page on the intranet.
- If an individual continues to have difficulty understanding their treatment it is the responsibility of the staff to refer them to a specialist learning disability service for additional support
- All people with a learning disability should have a Health Action Plan or a Purple Folder (Hertfordshire patients only) (Valuing People) and all HPFT staff will ask for permission to see these and contribute to the plan when appropriate
- To value and welcome the contribution of the relative/carer/advocate

13 Training/Awareness

No formal training is considered necessary to ensure the effective use of this policy.

Where resources permit, aspects of this policy will be covered in the mandatory clinical risk training.

14 Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

RULE: Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

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Service user, carer and/or staff access needs (including	The discharge/transfer process takes into account the recommended follow up within 7 days of discharge for those with severe mental illness or who self-harm. The process requires adherence to the Mental Capacity Act and the

disability)	Deprivation of Liberty safeguards. The Trust has responsibility for applying for authorisation of deprivation of liberty for any person who may come within the scope of the deprivation of liberty safeguards
Involvement	The policy outlines service users involvement
Relationships & Sexual Orientation	There is no specific positive impact with regard to sexual orientation.
Culture & Ethnicity	There is no specific positive impact with regard to ethnicity
Spirituality	There is no specific positive impact with regard to spirituality
Age	The discharge process focuses on the needs of the individual and is not age specific.
Gender & Gender Reassignment	The discharge process focuses on the needs of the individual and is not gender specific.
Advancing equality of opportunity	N/A

15 Process for monitoring compliance with this document

Action:	Lead	Method	Frequency	Report to:
CPA 7 day follow up reporting	Performance Improvement Manager	Key performance indicators for each service	Quarterly Performance reports	SBU MDs
Delayed Transfer of Care	Performance Improvement Manager	Key performance indicators for each service	Quarterly Performance reports	SBU MDs
Clinical Audit – Timeliness of inpatient discharge summaries and notifications	Head of Practice Governance	Clinical Audit	Annual	PAIG

PART 3 – Associated Issues

16 Version Control

STANDARD

Version	Date of Issue	Author	Status	Comment
V1	August 2008	Practice Standards Facilitator	Superseded	Archived
V2	May 2010	Practice Standards Facilitator	Superseded	Protocol for the transition of service users to commissioned service providers added 31.12.10
V3.1	August 2012	Head of Practice Governance	Superseded	Minor revisions in response to internal learning
V3.2.	November 2012	Head of Practice Governance	Superseded Interim Update	Further minor revisions re placements and 7 day follow up
V3.3.	March 2013	Head of Practice Governance	Superseded Interim Update	Further minor revisions re delayed transfers of care, referral to tertiary providers and 7 day follow up
V4	10th March 2014	Head of Practice Governance	Superseded	Full Review
V4.1.	March 2015	Head of Practice Governance	Superseded Interim Update	Interim update re 7 day follow up and Care Act
V4.2	1st July 2015	Head of Practice Governance	Superseded	Updated to include Care Act 2014
V5	14th July 2015	Head of Practice Governance	Current	Full Review

17 Archiving Arrangements

All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet

A database of archived policies is kept as an electronic archive administered by the Compliance and Risk Facilitator. This archive is held on a central server and copies of these archived documents can be obtained from the Compliance and Risk Facilitator on request.

18 Associated Documents

Operational Policies of the following services:

- Child and Adolescent Mental Health Services
- County Acute Ward
- Community Mental Health Teams
- Crisis Assessment and Treatment teams

- Eating Disorder Service
- Enhanced Primary Mental Health Team
- Intensive Outreach Team
- Intensive Support Team
- Specialist Mental health Team for Older People
- Inpatient unit operational policies

HPFT Corporate Policies

- Bed Management Policy
- Delivery of Care (formerly Care Co-ordination) Policy
- Clinical Risk Assessment & Management for Individual Service Users
- Communicating With Service Users From Diverse Communities
- Cross Service Protocols Delivering Social Care Across Service Boundaries.
- Single Equality Scheme
- Managing risks associated with child protection and safeguarding children.
- Healthcare Associated Infection Risk Assessment Guidelines (Admission, Transfer And Discharge)
- Mental Capacity and Deprivation of Liberty Safeguards
- Management of Care Records
- Managing Risks Surrounding the General Transporting of Service Users
- Medicines Policy
- Mental Health Act 1983 revised 2007 and Code of Practice 2008 policies
- Preferred Place of Care policy and delayed transfer of care
- Role and Function of the Named Nurse / Associate Nurse in developing Care / Treatment Plans
- Safeguarding Vulnerable Adults
- Safer Services' – the five year report of the work of the National Confidential Inquiry into Homicide and Suicide.
- Social Care Funded Placements Policy
- The Single Assessment Process in Hertfordshire
- Transfer of service users to and from psychiatric intensive care unit (PICU)

19 Supporting References

- CSIP/NIMHE, National Suicide Prevention Strategy for England, 2006
- Avoidable Deaths: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, December 2006
- Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2001
- National Patient Safety Agency (November 2009) Preventing Suicide: A toolkit for Mental Health Services *www.nrls.npsa.nhs.uk*
- Department of Health (1999) National Service Frameworks, Mental Health www.dh.gov.uk
- Department of Health (January 2010) NHS Constitution www.dh.gov.uk
- Department of Health (February 2010) New Horizons: working together for better mental health www.dh.gov.uk
- Care Quality Commission Essential Standards of Quality and Safety ww.cqc.org.uk
- Department of Health Delayed transfer of care guidance
- Care Act (2014)

20. Comments and Feedback – List people/ groups involved in developing the Policy.

Practice Governance Lead (SBU LDF)	Practice Governance Lead (SBU East and North)
Practice Governance Lead (SBU West)	Head of Nursing and Patient Safety

APPENDICES

Appendix 1 – 7 Day Follow Up

Appendix 2 - Definition for delayed transfer of care (taken from SITREP Definitions and Guidance)

Appendix 3 – Funded Placements for Social Care Placements ONLY – Checklist

Appendix 4 - Reasons for delayed transfer of care

Appendix 5 - Internal Process for the West Strategic Business Unit

Appendix 6 - Guidance for the referral of Trust Service Users to Tertiary Service Providers for clinical opinion

A GUIDE FOR CPA 7 DAY FOLLOW-UP

Main Purpose	The main purpose of the 7 Day Follow-up is Suicide Reduction. 7 day follow ups apply to all service users who are discharged from an HPFT inpatient unit on a CPA care level. This also links to the Trust's strategy and annual plan, and the Discharge policy.
Ownership	The 7 Day Follow-Up is the responsibility of the Care Co-ordinator and the Community Team. Any other designated community team such as CATT & ADTU, IOT can carry out a 7 Day Follow-up, but this team should be notified at discharge and recorded in the discharge summary. It is not adequate for the 'refer on' from the Inpatient ward to be only documented on PARIS. This also needs to be clearly communicated to the care coordinator, team leader and the senior social worker within the community team via email and/or phone. This is to ensure the duty team will pick up the referral in case the care coordinator is not available. If the Inpatient Ward does not 'refer on' to a team, the responsibility of the 7 Day Follow-Up rests with Inpatient staff to carry out and record it. Data Quality Officers will remind teams that a follow-up is required. The DQOs checking this report does not replace the responsibilities of the Inpatient units and Community teams
What Is The Target?	95% Monitor & Care Quality Commission 97% Contractual
How Are The Follow Ups Monitored?	7 Day Follow-Ups are monitored by Data Quality Officers using the Cognos Reporting System. The report is checked daily then a monthly summary is sent to the commissioners and the Exec. A report is also done every quarter which goes to Monitor and the Board.
How To Conduct And Record A 7 Day Follow Up	A 7 Day Follow-Up is to be carried out and recorded on Paris by adding a case note & Activity within 7 days of discharge from the Inpatient Ward. **Inpatient Teams** • It is vital that the correct discharge date from the Ward is recorded accurately on Paris. • Inpatient staff must add the Care Level on admission and amend, if necessary, on discharge • Inform the Care coordinator or relevant team of the discharge from the ward.

	Community Teams • Carry out and record a '7 Day Follow-Up after Discharge' activity on Paris. The activity must be done and recorded as Face to Face or Telephone Contact. 'Client Not Present' or 'DNA' are not valid follow ups. • Ensure a Care Co-ordinator is allocated on Paris. • Respond to DQO's emails and telephone calls and ensure you inform them of the plan/date for the 7 day follow up if this is not noted on Paris. • It would be helpful if Care Co-ordinators put their Out of Office on when on annual leave.
Exceptions and Breaches	The following will not count as a 7DFU: • A 7 Day Follow-Up cannot be carried out on the date of discharge • A text message to a service user • A follow-up with family or friends, unless they are the named carer
	If a 7 Day follow-up is not carried out within 7 Days, it will be recorded as a breach of the Trust's key target. The responsible team will need to provide reasons for the breach to be included in the Commissioners' Report. The follow up is still required after the 7 days to ensure the service user's safety and every effort should still be made to contact the person.
How The Data Quality Officers Will Help You	The DQOs will monitor discharges on a daily basis and inform the Care coordinator or responsible team when the follow up is due by. They will also send reminders and include managers and service line leads if there is no response to their emails, or evidence of contacting the service user on Paris.
When A 7 Day Follow Up Is Required	All service users discharged on CPA to: • Their place of residence • A care home • Residential accommodation • Non-psychiatric care, i.e. general hospital • A prison (contact via the In-reach Team) • Out of County (unless a formal handover is done with the local team) • NFA (hostel / temporary accommodation) - Ward to obtain a contact address prior to discharge or agree an alternative arrangement with the Care Co-ordinator) • Discharged following 'leave' from the Ward.

Good Practice	The following situations mean that it is not mandatory to carry out a follow up, but it is good practice: • Learning Disabilities service users • Service users discharged on SAP or standard care levels • Discharged abroad within the 7 days following discharge – these service users should have a handover to the local services or failing this every effort should be made to contact the person or their family to ensure they are safe.
Contacts	Kristine Wilson, Data Quality Officer – 07785 555745 Hayley Seamoore, Data Quality Officer - 07771 521487 Alex Lewis, Data Quality Officer - 07979 595855 Aaron Morrison, Data Quality Officer - 07789 542141 Omraiz Khan, Performance Improvement Officer - 07785515163 Suji Jeerasinghe, Performance Improvement Analyst – 07818061469 Mark Landau, Performance Improvement Advisor - 01727 804702 Sally Wilson, Performance Improvement Manager - 01727 804710 Please contact the Paris Helpdesk should you experience any difficulties using Paris (telephone: 01707 294080 options 1 then option 3)

Definition for delayed transfer of care (taken from SITREP Definitions and Guidance)

"A delayed transfer of care from acute or non-acute (including PCT and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

a. A clinical decision has been made that patient is ready for transfer **AND**
b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
c. The patient is safe to discharge/transfer.

A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting.

For patients of no fixed abode, the council responsible for the patient is the council whose area they reside. This is irrespective of whether the patient lives on the street or in a hostel.

Asylum seekers and others from overseas should be listed under the council in which they currently reside. It is the responsibility of this council to decide whether they are eligible for social services."

- Relevant trusts will therefore need to monitor the following separately for acute and non-acute (including PCT and mental health) patients:
- Which council is responsible for each patient delayed
- Number of patients whose discharge is delayed – subdivided by responsible council
- Number of reimbursable days – subdivided by responsible council
- Agency responsible for the delay (NHS, social services, or both)
- Reason for delay
- Local monitoring will need to take place on a **daily** basis in order to calculate any reimbursement charges payable. However, SITREP returns will continue only to be required on a **monthly** basis by Strategic Health Authorities and the Department of Health.

Funded Placements for Social Care Placements ONLY – Checklist

Guidance for completion:

1. This form starts with the Placement Team
2. Following the Panel Approval, the Placement Team will complete the first section of the form, and it will be emailed with the Panel Decision to the Care Co-ordinator.
3. The care co-ordinator completes the second section of the form and scans it onto the client's entry on PARIS, clearing identifying it as a Pre Placement Check List.
4. The care co-ordinator's team manager needs to approve that the placement is safe to proceed by completing the final section of the form prior to it being scanned onto PARIS
5. Audits of the completed forms are to be expected; line managers may also choose to audit forms as part of supervision.

Action	Placement Team
Having identified a possible placement following the Panel, check that it is CQC registered (this does not apply to Supported Living Provisions, who are not required to register with CQC)	
The Inspection Report Link will be attached, **this should be read by the Care Co-ordinator and any concerns raised with the Provider**	
Confirm provider is registered for the care group which represents this service user	
Check that there is a valid contract with HCC Contracts Department	
Enter price agreed at Panel for Placement (and if there were any extra staffing costs approved)	

Name of Placement	
Placement Team staff member	
Service User Name	
Date of completion	

Action	Care Co-ordinator
Having received approval from the panel, arrange for the placement provider to assess the Service User	
If accepted by the Placement, visit the Placement with Service User	Date of Visit:

Risk Assessment updated and shared with provider	Date reviewed:
Request from provider evidence that all staff are CRB approved	
Check that the establishment's Statement of Purpose is clearly displayed (CQC requirement)	
Seek and record service user views on placement	
Seek and record (where appropriate) carer views on placement	
Consider suitability of the environment for service user (eg. mobility issues, sufficient space)	
Consider suitability in terms of level of security (eg. are there more restrictions than are necessary for this service user?)	
Consider suitability in terms of equalities (eg. diet, gender mix, spiritual needs)	
Consider suitability in terms of available activities, recovery-oriented social opportunities and model of care	
Consider competence of staff re medicines management	
On basis of all the above, record whether placement is satisfactory and scan completed checklist onto care-notes	

Care co-ordinator signature	
Team	
Date of completion	

Action	**Team Manager**
Confirm Checklist completed satisfactorily	
Risk assessment reviewed and remains current	
Confirm placement is safe to proceed	

Team Manager signature	
Team	
Date of completion	

Reasons for delayed transfer of care

Both the number of patients whose transfer of care is delayed (a) and the number of days delayed within the month (b) are subdivided by the reasons for delay:

	Attributable to NHS	Attributable to Social Care	Attributable to both
A. Awaiting completion of assessment	✓	✓	✓
B. Awaiting public funding	✓	✓	✓
C. Awaiting further non-acute (including PCT and mental health) NHS care (including intermediate care, rehabilitation services etc)	✓	×	×
D i). Awaiting residential home placement or availability	✓	✓	×
D ii). Awaiting nursing home placement or availability	✓	✓	✓
E. Awaiting care package in own home	✓	✓	✓
F. Awaiting community equipment and adaptations	✓	✓	✓
G. Patient or Family choice	✓	✓	×
H. Disputes	✓	✓	×
I. Housing – patients not covered by NHS and Community Care Act	✓	×	×

A patient should only be counted in ONE category of delay, this category should be the one most appropriately describing their reason for delay and total numbers allocated to reasons for delay should equal the number of patients delayed. The table also shows which reasons can be attributed to NHS, Social Care and both.

Data for the indicators covering reasons for delay should include ALL adults who have been receiving treatment and are awaiting discharge, not just those aged 75 and over.

A) Delay awaiting assessment
All patients whose transfer is delayed due to them waiting completion of an assessment of their future care needs and an identification of an appropriate care setting. This can include any assessment by health and/or social care professionals of a patient's future care needs. Therefore, delays can be due to either: NHS, Social Services or a combination of both. Trusts will want to identify with their Social Services partners where in the process, and why, delays are occurring. Any existing local agreements about built-in time to undertake assessments before delay is counted no longer apply.

Trusts need to monitor locally the amount of time taken to arrange assessment. Good practice would suggest this process should be in place prior to the decision to discharge being made.

B) Delays awaiting public funding
All patients whose assessment is complete but transfer has been delayed due to awaiting Social Services funding (e.g. for residential or home care), or NHS funding (e.g. for nursing care or continuing healthcare). This should also include cases where Social Services and

NHS have failed to agree funding for a joint package or an individual is disputing a decision over fully funded NHS continuing care in the independent sector. It does not include delays due to arranging other NHS services (residential or community) – see below.

C) Delay awaiting further NHS care, including intermediate care
All patients whose assessment is complete but transfer is delayed due to awaiting further NHS care, i.e. any non-acute (including PCT and mental health) care, including intermediate care. Also continuing health care fully funded by the NHS in the independent sector. It also includes where a decision has been made to defer a decision on continuing health care eligibility, and to provide NHS-funded care (in a care home, the patient's own home or other settings) until an eligibility decision is made but the transfer into this care is delayed.

Acute delayed transfers of care:
Include all delays of patients leaving acute care. This includes patients waiting to move to non-acute care within the same trust. Do ***not*** include delays of patients continuing to receive acute care moving from one bed to another, even if these beds are in different trusts.

Non-acute (including PCT and mental health) delayed transfers of care:
Include all delays of patients leaving non-acute (including PCT and mental health) care. This includes patients waiting to move to other types of non-acute (including PCT and mental health) care within the same trust. Do ***not*** include delays of patients continuing to receive the same type of non-acute (including PCT or mental health) care moving from one bed to another, even if these beds are in different trusts.

These should not include delays in providing NHS-funded care provided in the patient's own home, such as that provided by a District Nurse (rather than a conscious decision to defer consideration of eligibility for continuing health care). These delays should be recorded under 'E' – delay due to awaiting care package in own home. See below for details.

D) Delay awaiting Residential/Nursing Home Placement/Availability
All patients whose assessment is complete but transfer is delayed due to awaiting Nursing/Residential home placement, because of lack of availability of a suitable place to meet their assessed care needs.

This does not include patients where Social Services funding has been agreed, but they or their family are exercising their right to choose a home under the Direction on Choice. These patients should be counted under category G.

E) Delay due to awaiting care package in own home
All patients whose assessment is complete but transfer is delayed due to awaiting a package of care in their own home.

The delay should be logged as the responsibility of the agency responsible for providing the service that is delayed. This should be possible to ascertain even where agencies operate in partnership, as statutory responsibilities for care do not change under partnership arrangements. NHS input to a home care package might include the services of a district nurse or CPN, an occupational therapist or physiotherapist.

The 'further non-acute (including PCT and mental health) NHS care' box should be used to record NHS services where these are not provided in the patient's home, examples of which might include intermediate care, rehabilitative care, care provided in a community hospital, or fully-funded NHS continuing care.

The delay should *only* be logged as the responsibility of *both* agencies where both NHS and local authority services are delayed.

F) Delays due to awaiting community equipment and adaptations
All patients whose assessment is complete but transfer is delayed due to awaiting the supply of items of community equipment. (Note that the Community Care (Delayed Discharges etc.) Act (Qualifying Services) England) Regulations 2003 stipulate that all items of community equipment and minor adaptations must be provided free of charge.)

Where equipment is provided via a service delivered in partnership between the NHS and the local authority, it should nonetheless be possible to identify the cause of any delay, and the parties responsible. Where delays are solely the responsibility of the council, such delays should be included in the attributable to Social Care columns.

G) Delay due to patient or family exercising choice
All patients whose assessment is complete and who have been made a reasonable offer of services, but who have refused that offer. It would also include delays incurred by patients who will be funding their own care e.g. through insisting on placement in a home with no foreseeable vacancies.

Note that the Direction on Choice should not be used as a reason to delay a patient's discharge. The provisions of the Direction on Choice continue to apply to patients leaving hospital for a place in a care home. Health and social care systems should put in place locally agreed protocols on patient information incorporating how the issue of patient choice will be dealt with. These should make it clear that an acute setting is not an appropriate place to wait and alternatives will be offered.

Where social services are responsible for providing services and a person's preferred home of choice is not immediately available, they should offer an interim package of care. All interim arrangements should be based solely on the patients assessed needs and sustain or improve their level of independence. If no alternative is provided which can meet the patient's needs, social services are liable for reimbursement.

Where patients have been offered appropriate services, either on an interim or permanent basis, by the local authority but are creating an unreasonable delay as above, such delays are not held to be the responsibility of the local authority and thus do not incur reimbursement charges. The responsibility for discharging the patient reverts to the NHS body. Such delays should be recorded in the column 'Attributable to the NHS'.

H) Disputes
This should be used only to record disputes between statutory agencies, either concerning responsibility for the patient's onward care, or concerning an aspect of the discharge decision, e.g. readiness for discharge or appropriateness of the care package.

Disputes may **not** be recorded as the responsibility of both agencies. NHS bodies and councils are expected to operate within a culture of problem solving and partnership, where formal dispute is a last resort. The patient should not be involved in the dispute, and should always be cared for in an appropriate environment throughout the process.

Accordingly, frontline staff should allocate responsibility for the patient's care to one organisation, who may then take the dispute to formal resolution without involving the patient or affecting his/her care pathway. The delay should be recorded as the responsibility of the agency that is taking interim responsibility for the patient's care.

Where a delay is caused because of a patient's disagreement with an aspect of the care package or decision to discharge, this should not be listed under disputes but recorded under patient choice.

For example, a disagreement with the decision to discharge would be listed as NHS responsibility, assessment. If a patient had been offered a care package in their own home and they felt they should be offered a residential care placement, it would be listed under social services responsibility, residential care.

I) Housing – patients not covered by NHS and Community Care Act

The guidance accompanying the Community Care (Delayed Discharges etc.) Act 2003 requires social services departments to make appropriate interim arrangements for patients delayed waiting for housing, rather than allow them to remain in hospital when they are fit to move on. If there are delays in arranging the interim placement, the reason for delay should be recorded under that of the delayed interim package (eg residential care, care package in own home).

However, some patients delayed for housing reasons may not be eligible for community care services and therefore are not the responsibility of social services. Examples could be asylum seekers or single homeless people.

We have therefore introduced a new box to cover housing delays **where these relate to people who are not eligible for community care services.** All other patients with long-term housing delays should be found an interim placement, and any delays in arranging this logged under the care package they are waiting for as discussed above.

The focus of the form is on delays to patients leaving the medical environment. Where patients are eligible for community care services, and major home adaptations or alternative housing arrangements are needed for safe discharge, social services staff should inform and work with housing counterparts to arrange the necessary services. Remaining in a medical setting whilst long-term adaptations are made, however, is not an appropriate care option. In these circumstances, social services will need to make appropriate interim provisions to enable the patient to move on from the medical environment. Social Services are deemed liable for reimbursement for delays in the arrangements of interim social care provision in these circumstances.

The revised form reflects these arrangements. If there is likely to be a housing-related delay, social services should focus on finding an interim placement. Any delays in providing interim care should be recorded under the appropriate box on the new form, for instance, under domiciliary care or residential care, as appropriate.

Interim arrangements are of course intended to be provided on a temporary basis. If long-term arrangements of housing support are a significant problem in making discharge arrangements for patients, councils should ensure they have their own monitoring arrangements to inform progress.

Some patients delayed waiting for housing support are **not** eligible for community care services. This means their discharge is not the responsibility of social services and such delays are not eligible for reimbursement. In response to feedback from councils, we have introduced a new category 'I' on the form to cover this group of patients, who might include asylum seekers or single homeless people. Please see the section I in this guidance document for further detail.

Internal Process for the West Strategic Business Unit

The bed manager will be responsible for collating and reporting the information weekly. The decision needs to be agreed by the multidisciplinary team and recorded clearly in the care notes as to when the service user was clinically fit and the reason.

- All service users will be reviewed weekly at the bed meeting for any delays to transfer of care and what category they are delayed under. See Appendix 4 for definitions. Any updates will be recorded within the weekly spreadsheet by the Bed Manager.

- Any service user who looks likely to become a DTC will be added to the potential spreadsheet list. This will enable work to commence on preventing the delay occurring or reducing the number of days they are delayed.

- Through CPA reviews, multidisciplinary meetings and ward rounds decisions and agreement will be made about service users that are delayed. The ward nurse present will be responsible for ensuring the decision is recorded in care notes.

- Any agreed DTC must be recorded in the care notes by nursing staff to act as a point of reference and for audit purposes. The information must reflect that they have been agreed as fit for discharge, the date, the definition and the reason for the delay and that it is a multidisciplinary decision See Appendix 1 for definitions.

- If a service user that has been identified as a DTC becomes clinically unfit for discharge then they need to be suspended as part of the DTC process until they are fit for discharge again. This will accurately reflect the number of days they are a DTC. This too needs recording within the care notes and will be verified by the bed manager..

- On receipt of any information the Bed Manager will ensure that a multidisciplinary approach and agreement has been applied and will challenge information where required. Staff will be reminded to record this accurately in care notes and failure to do so may result in the team leader and matron being informed.

- The bed manager will collate the information check the information is recorded in care notes and send the form to information services by midday on the Tuesday.

- Reporting timescales may change due to public and bank holidays – agreed changes will be communicated by information services.

- A DTC spreadsheet will be circulated prior to the conference call to Deputy and Service Line Lead, Modern Matrons and CMHT managers by the Bed Manager..

- A weekly conference call meeting chaired by the Deputy Service Line Lead, West SBU, will review the reasons for the delays to determine any repetitive blockages and to proactively resolve the themes of the delays. A review of wards compliance with the process will also be discussed. Any actions or progress will be recorded within the DTC electronic report and reviewed weekly. The bed manager will act as vice chair.

Guidance for the referral of Trust Service Users to Tertiary Service Providers for clinical opinion

This guidance clarifies the procedure to obtain specialist opinions that are required from Tertiary Providers, for example, neuro-psychiatric services.

Stage One
Clarify the need for referral to a Tertiary provider for clinical opinion and other services. The need will be identified by the Consultant Psychiatrist of the service user, in consultation with the team manager. The need will be agreed with the Medical Lead for the Consultant Psychiatrist and Service Line Lead for the team manager.

Factors to take into account before reaching this decision:-

- Have all relevant Trust resources already been utilised?

Stage Two
Contact the Trust Contracts department to establish if there are any commissioned services that may meet the service user's needs.
If there is no SLA in place the Consultant psychiatrist makes the referral direct to the provider who contact the JCT in order for funding to be agreed.

Stage Three
Following confirmation of funding, tertiary provision can proceed.

Our Values

Welcoming Kind Positive Respectful Professional