Health and Social Care in Northern Ireland

PROTOCOL FOR THE TRANSFER OF ADULT MENTAL HEALTH PATIENTS BETWEEN TRUSTS

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Review date	This policy will be reviewed every three years or at times considered necessary as a result of operational or legislative changes

CONTENTS

Principles

This protocol represents best practice in the transfer arrangements between Health and Social Care Trusts' Adult Mental Health Services. This includes the Prison Mental Health Service managed by South Eastern HSC Trust on behalf of the region.

This protocol should be read in conjunction with:-

- Protocol for the Inter Hospital Transfer of Patients and Their Records (CREST 2006). https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/protocol-patient-record-transfer.pdf
- Northern Ireland Opioid Substitution Therapy Services Interface Protocol Between Prisons And Health & Social Care Trust Community Addiction Services January 2016.

PRINCIPLES

- When a Patient/Service User moves between Trust areas (including a transfer to or a release from prison) continuity in the treatment and care provided is paramount.

- Good written and verbal communication between practitioners and services to ensure smooth transfer and continuity of care is critical.

- Transfer arrangements will take account of the Patient's/Service User's needs and facilitate robust management of risk to protect the safety of the Patient/Service User and others.

- The Patient/Service User and, where appropriate, Family/Carers, will be kept involved and informed of transfer arrangements throughout the process.

- Transfer arrangements will be in line with existing regional protocols, guidance and legislation.

- When a Patient/Service User moves to live in another Trust area, the Trust of origin will retain responsibility for treatment and services until a transfer, in line with this protocol, is achieved.

- Each Trust will assist the other in delivering treatments/services locally throughout the transfer process, when it is appropriate to do so.

- When a Patient/Service User is in prison they remain the responsibility of their Trust of origin (Agreed DOH/DOJ 2008) and remain registered with their community GP.

- Community staff (including staff working in Custody suites and Prison Healthcare) should communicate effectively to maintain continuity of care and treatment.

1. Request for Transfer

1.1 A written request for permanent transfer to another Trust should be sent to the identified single point of contact/appropriate Community Mental Health Service/ Team[1].

1.2 A standard Transfer Referral Form will be completed (Appendix 1) by hard copy or by email using the secure HSC email system *(Code of Practice on Protecting the Confidentiality of Service User Information, DHSSPSNI, Data Protection Act, 1998)*.

1.3 The receiving Community Mental Health Team will:-

- Acknowledge receipt of the transfer request in writing or via HSC Secure email system within 3 working days of receipt;
- Identify the most appropriate Team/Service/Clinician within their Trust;
- Forward the request to the appropriate Team Leader/Clinician within 3 working days of receipt;
- Provide the name and contact details of the Team Leader/Clinician to the referrer within 3 working days of receipt of the transfer request.

1.4 Prison Healthcare staff will correspond with the Trust of origin through identified Prison liaison staff, to ensure smooth transfer. It is noted that people released from prison may require referral to Crisis response or unscheduled care.

1.5 Prison Healthcare will notify the community GP and relevant Trust staff when a Patient/Service User comes into and leaves Prison. Appropriate transfer of information to the Prison Healthcare Team when their Patient/Service User is in Prison is important and should be completed is a timely manner.

[1] *Community Mental Health Service/Team refers to the appropriate Team in the Community and may include Single point of access, Primary Care Liaison Team, Crisis Teams or Support and Recovery Teams.*

2. Procedure for Permanent Transfer

2.1 When a Patient/Service User moves to another Trust area a request for transfer should be initiated by the Lead Clinician/Key worker/Team Leader when the Patient/Service User's assessed needs require this.

2.2 The proposed transfer should be discussed with the Patient/Service user in advance of the request, and they (and their Family/Carers if appropriate) should be involved and kept informed as the transfer proceeds.

2.3 The written request must include the Patient's demographic details; case history; information about current care and treatment, and an up to date risk assessment/safety plan, including, where appropriate, an enhanced safety plan[2].

2.4 Receipt of all transfer requests must be acknowledged, in writing, by the Community Mental Health Team within 3 working days of receipt, indicating the name and contact details of the Team Leader/Lead Clinician who will be considering the transfer.

2.5 All requests for transfer should be allocated to a named appropriate Clinician/Key worker within two weeks of receipt of the request.

2.6 The referring Trust will have responsibility to arrange a transfer meeting and this should occur within 4 weeks of the receipt of the request for transfer. Arrangements to facilitate the continuity of care including joint working, if required, will be considered at first contact. The Family/Carers should be invited to attend this meeting if the Patient/Service User gives consent. Full copies of the Patient/Service User file, including printouts of computerised records will be handed over at the transfer meeting.

[2] *An enhanced safety plan refers to those plans completed following a comprehensive risk assessment outlined in Promoting Quality Care (2009)*

2.7 The minutes of the Transfer Meeting (compiled by the referring Trust) will include the arrangements and date of formal transfer of responsibility and the name and contact details of the new Clinician/Key worker from the receiving Trust. The referring Trust will forward a copy of the minutes (within 1 week) detailing the arrangements to the receiving Team Leader/Clinician; the Patient/Service User and the Patient/Service User's General Practitioner.

2.8 A date for a joint visit involving the transferring key worker and the receiving key worker will be agreed as part of the transfer arrangements, and there may be a period of joint working to facilitate continuity of care. Lead responsibility for the case will remain with the Trust of origin until the transfer is fully complete. A decision will be taken to consider when this should occur.

2.9 Generally a transfer of responsibility should be completed within six weeks of the formal request to transfer except when there are sound clinical reasons for a longer period.

3. Transfer of Patients known to Consultant Psychiatrist only

3.1 The request for transfer will be initiated by the Consultant Psychiatrist with clinical responsibility for the Patient's treatment and sent to the Community Mental Health Team nearest to the Patient's new address.

3.2 The referral should include a comprehensive case history, and details of any other services being provided, and an up to date risk assessment.

3.3 Transfer of clinical responsibility will not be completed until the Patient has been reviewed by the receiving Consultant Psychiatrist. A copy of the Patient's medical notes will be transferred to the receiving Consultant Psychiatrist prior to the first appointment, which will be held within 6 weeks.

4. Transfer of Care Managed Patients/Service users

4.1 Where a Patient/Service User is transferred under Care Management arrangements (ref: CRAG) the formal Care Management Review will remain the responsibility of the placing Trust. This is in line with regional arrangements for Patients/Service Users placed in Residential; Nursing Home and some Supported Housing schemes (where care is a component of the service costs), funding for the care package.

4.2 Responsibility for all other care and treatment services (including supported housing placements where a Trust funded care component is not part of the costs) will transfer as outlined in Section 4.1 above, except that a period of 6 weeks is allowed to affect the transfer.

4.3 Patients/Service Users in need of domiciliary care packages; day care; or other community based services will transfer as outlined in Section 4.2 above, with responsibility for their social care needs transferring along with other aspects of their care and treatment.

4.4 Copies of the most recent Care Management assessment of need and agreed care plan should be provided to the receiving Trust along with the initial request for transfer.

4.5 Where a person transfers while under Guardianship (Mental Health Order) or a Declaratory Judgement, the particular requirements of the order must be followed.

5. Patients/Service Users who <u>Move Temporarily</u> to an Address in Another Trust Area

5.1 Patients/Service Users who move to a temporary address in another Trust area (eg staying with family) will remain the responsibility of the Trust of origin until such times as they declare intent to remain permanently at that address. Where this is a planned holiday or short term arrangement, the Trust of origin may seek support

for the Patient/Service User from the Trust in which the Patient/Service User is temporarily resident.

5.2 The referring Trust will negotiate the support required from the community mental health services, including local home treatment team, if it is appropriate and practical to do so. These arrangements should be agreed between the respective Team Leaders. This is usually arranged by phone in the first instance. Where assistance with the care and treatment to the local Trust is agreed, the relevant notes will be scanned and emailed on the day of discussion.

5.3 If a Patient/Service user comes to the attention of the local Trust as the result of a presentation to the local Emergency Department or GP, the Trust in which they are temporarily resident should seek information from the Trust of origin; assess and treat the Patient/Service User.

5.4 Clinical and funding implications remain the responsibility of the Trust of origin. It is only where the Patient/Service User intends to remain permanently that a transfer in line with these protocols is achieved and clinical and funding implications become the responsibility of the receiving Trust.

6. **Next Day Appointments** (previously known as Card Before You Leave)

6.1 Referrals for a next day appointment are normally made directly by Emergency Departments to the local Community Mental Health Services. This service is suitable for people who are considered to be at low risk and do not require an emergency mental health assessment; Patient/Service Users who decline to wait for a mental health assessment; or Patient/Service Users who appear to have mental health needs but discharge themselves against medical advice, before an assessment is completed.

6.2 Emergency Departments should refer these Patients to the appropriate point of contact in the Trust ie unscheduled care/RAID/Mental Health Assessment centre.

If the Patient/Service User is not resident in the Trust area in which they present, the Community Mental Health Team (in that Trust) will make direct contact with the Patient's Trust of origin in order that the trust of origin can proceed with their usual CBYL process.

6.3 As outlined in the 'Protect Life' Strategy, it is the responsibility of the Trust where the Patient/Service User normally resides to offer a next day appointment to the Patient/Service User, or agree an alternative service with Patient/Service User if required.

6.4 If however, the Patient/Service User is residing in the local Trust area, eg on holidays, temporary accommodation, the local team will respond to the referral, ensuring that the Trust of origin is contacted for appropriate information to assist in the assessment. If the Patient/Service User is known to services, a copy of the completed assessment and Risk Assessment will be sent to the Trust of origin. If they are not known, a letter will be sent to the Patient/Service User's GP.

Please note this section will be removed when the Early Liaison Service is available in each Trust

7. Addictions Patients/Service Users

7.1 In situations where a Patient/Service User is moving across Trust boundaries with on-going care and treatment needs for an addiction, the responsibility for care is retained by Trust of origin until formally handed over and accepted by the receiving Trust. The transfer must follow the procedure for all transfers outlined in Section 2 above.

7.2 The Addictions Key Worker/Practitioner from the Trust of origin has responsibility for making the referral to the receiving Trust Service and advising the GP in writing of these arrangements.

7.3 A full and detailed account of the Patient/Service User's care and treatment needs and an updated risk assessment/safety plan should be formally delivered to the receiving Addictions service to enable continuity of care (see Section 2 for time frames).

7.4 Where Patient/Service Users' are in receipt of opioid substitution, a detailed record of medication prescribed, dose, frequency and method of dispensing should be clearly documented and shared. Community pharmacy contact details should be shared where it is anticipated that these arrangements will not change in the interim.

7.5 Where there is community/voluntary sector involvement, in the Trust of origin, the Addictions Key Worker /Practitioner has the responsibility to inform them, in writing of this transfer and the new address, if available.

8. Acute Care

8.1 See Regional Guidance on the Transfer of Patients and their Records between Psychiatric Hospitals[3]

8.2 The transfer of existing In-Patients from hospital to hospital will adhere to Crest Guidelines 2006[4]; Northern Ireland Regional Guidance (2009)[3] and Regional Bed Management Protocol for Acute Psychiatric Beds (July 2016)[5].

8.3 Patients/Service Users on Home Treatment are generally assessed as being at "higher levels of risk". Any changes to the Care Plan or managerial arrangements for such Patients/Service Users must be carefully managed, **if considered appropriate**.

9. Approved Social Work Arrangements

9.1 When a Patient/Service User from another Trust presents as in need of assessment under Section 4 of the Mental Health (Northern Ireland) Order 1986, an Approved Social Worker from the Trust where the Patient/Service User normally resides will attend to carry out the assessment.

9.2 An Approved Social Worker from a Trust where the Patient/Service User presents **may** carry out an assessment if the matter is deemed urgent. However, if the Patient/Service User requires an admission this will be to a hospital within their Trust of origin, except when the plan is to admit to a specialist regional unit.

9.3 Out of Hours, the Regional Emergency Social Work Service should be contacted when an Approved Social Worker is required.

[3] DHSSPS (January 2009), Guidance on the Transfer of Patients and their Records between Psychiatric Hospitals.
[4] Protocol for the Inter Hospital Transfer of Patients and Their Records (CREST 2006)
[5] HSC Regional Bed Management Protocol for Acute Psychiatric Beds (July 2016)

9.4 For Patients/Service Users in Prison the Healthcare staff will liaise with the Trust of origin and the Northern Ireland Office to ensure correct processes are followed for the Direction Order. On occasion an individual may be released (sometimes without warning) during this process and where an assessment under the MHO is required, an Approved Social Worker from the Trust of origin will attend to carry out the assessment.

10. Out of Country

10.1 It is acknowledged that transfer meetings and/or joint visits may not be appropriate or feasible for Patients/Service Users who decide to move between jurisdictions mid-way through treatment. However, as far as possible, when notified of a Patient moving to Northern Ireland from another jurisdiction, HSC Trust mental health services should adhere to the principles, procedures and timescales in respect of accepting a transfer request as set out in the Protocol.

10.2 If a Trust is made aware that a Patient/Service User receiving on-going treatment in Northern Ireland plans to move to another jurisdiction, the Trust should also observe the notification and information requirements set out in this protocol.

10.3 If a Patient/Service User is referred to the Trust through urgent/unscheduled care services, or from their GP, and they indicate that they have previously had treatment in another jurisdiction, the Trust should proactively seek information from the service provider (if known); or the Patient's GP who may have further information from the GP medical records. In particular, it is important that the receiving Trust has access to any on-going treatment plan prior to the relocation.

References

DHSSPS (revised May 2010) Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services

CREST (2006) Protocol for the Inter Hospital Transfer of Patients and their Records

DHSSPS (January 2009) Guidance on the Transfer of Patients and their Records between Psychiatric Hospitals

SHSCT (March 2009) Policy on the Transfer of patients/clients and their records to another hospital or in-patient facility

DHSS (1992) Mental Health (Northern Ireland) Order 1986 Code of Practice

HSCB (September 2010) Mental Health Services Integrated Elective Access Protocol Addendum: Promoting Accessible, Safe and Effective Care

DHSSPS (January 2012) Code of Practice on Protecting the Confidentiality of Service User Information

Data Protection Act 1998

DHSSPS (January 2009) Regional Bed Management Protocol – Acute Psychiatric Admissions

HSC (2014) You in Mind: Regional Mental Health Care Pathway – Promoting Hope Opportunity and Personal Control

APPENDIX 1 **TRANSFER REQUEST /REFERRAL FORM**

NAME	DOB
ADDRESS	**PHONE NO.**
NEXT OF KIN	**GP**
ADDRESS	**SURGERY ADDRESS**
PHONE NO.	**PHONE NO.**
REASON FOR TRANSFER	
SUMMARY OF CASE HISTORY AND SERVICE INVOLVEMENT	

CURRENT TREATMENT PLAN
REFERRED BY: **DESIGNATION:** **CONTACT DETAILS:** **DATE**
PLEASE ATTACH UPDATED REGIONAL RISK ASSESSMENT/SAFETY PLAN