Policy:

NP 031 - Transfer of Clinical Care Duties

Executive Director Lead	Executive Director of Nursing, Professions and Quality
Policy Owner	Head of Nursing – Acute and Community
Policy Author	Head of Nursing – Acute and Community

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Summary of policy

This policy applies to the transfer of all service users of the Trust. All staff must ensure & achieve effective transfer of informal and detained service users through good communication between professionals, whether verbal or written, in a planned and structured way. The duties of staff involved in the process should be clear to ensure all risks relating to the transfer of a service user are identified and discussed so that appropriate risk management plans can be put into place and to ensure that appropriate documentation is completed throughout the transfer process.

Target audience	All staff involved in the transfer of service users working in Sheffield Health & Social Care NHS Foundation Trust.

Keywords	Transfer, Service Users

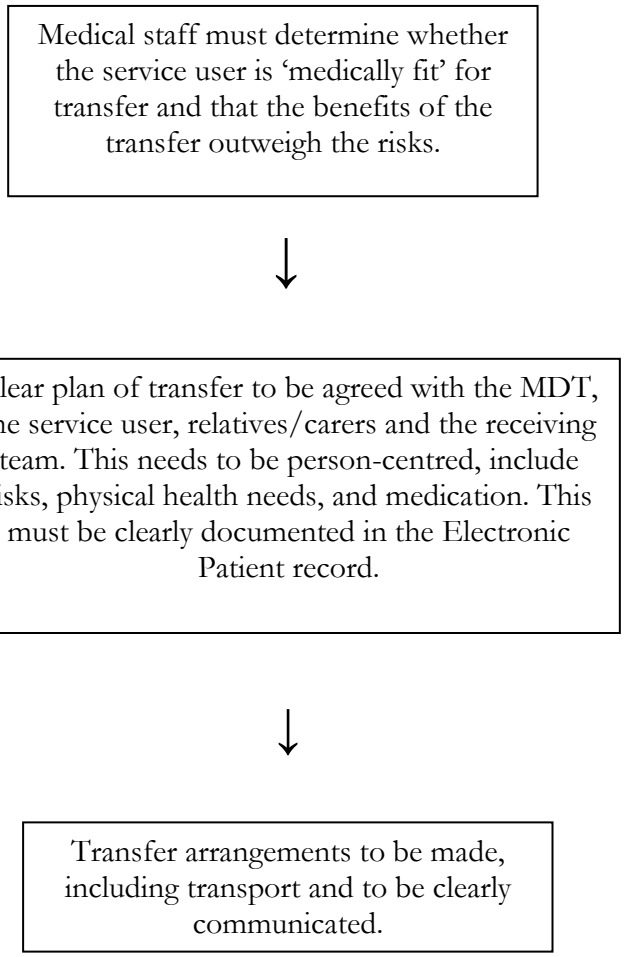
Storage & Version Control

Version 6 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (V6). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
5.0	Review/Approval/Issue	May 2020	Full review completed as per schedule
6.0	Review/Approval/Issue	Sep 2023	Full review completed as per schedule, no changes made.

Flowchart



Contents

1. Introduction

Sheffield Health & Social Care NHS Foundation Trust (SHSCFT) provides mental health, learning disability and primary care services. This policy applies to the transfer of all service users of the Trust. All staff must ensure & achieve effective transfer of informal and detained service users through good communication between professionals, whether verbal or written, in a planned and structured way. The duties of staff involved in the process should be clear to ensure all risks relating to the transfer of a service user are identified and discussed so that appropriate risk management plans can be put into place and to ensure that appropriate documentation is completed throughout the transfer process. For detained patients please refer to Section 19, Procedure for the Transfer of Patients Detained Under MHA 1983 to another Hospital/Unit Policy.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) is an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests.

The DOLS provide a framework for approving the deprivation of liberty for people who lack the capacity to consent to treatment or care in either a hospital or care home that, in their best interests, can only be provided in circumstances that amount to a deprivation of liberty.

The Code of Practice for DoLS (para 2.14 & 2,15) states
Transporting a person who lacks capacity from their home, or another location, to a hospital or care home will not usually amount to a deprivation of liberty (for example, to take them to hospital by ambulance in an emergency.) Even where there is an expectation that the person will be deprived of liberty within the care home or hospital, it is unlikely that the journey itself will constitute a deprivation of liberty so that an authorisation is needed before the journey commences. In almost all cases, it is likely that a person can be lawfully taken to a hospital or a care home under the wider provisions of the Act, as long as it is considered that being in the hospital or care home will be in their best interests.

In a very few cases, there may be exceptional circumstances where taking a person to a hospital or a care home amounts to a deprivation of liberty, for example where it is necessary to do more than persuade or restrain the person for the purpose of transportation, or where the journey is exceptionally long. In such cases, it may be necessary to seek an order from the Court of Protection to ensure that the journey is taken on a lawful basis.
The receiving hospital or care home is required to make the DoLS application if the care arrangements in the new setting will amount to a deprivation of liberty.

2. Scope

This policy applies to all service areas within the Trust and covers all staff and all service users being transferred from one service to another within the Trust or being transferred to another Trust.

3. Purpose

The purpose of this policy includes the provision of guidance to staff when transferring service users to ensure a safe, effective and properly managed transfer and re-iterates some of the key points of the Mental Health Act. It is essential that this policy is read in conjunction with the Mental Health Act Code of Practice 2015 (and where necessary the Mental Health Act itself) as it is statutory guidance and provides detail not contained in this Policy.

4. Definitions

Service user - any service user i.e. client, resident, patient.

Transfer - care of Service user, service user, client or resident being moved between any service, team or Trust.

Discharge - refers to the end of an in-service user care spell within the Trust (when reference should be made to the Trust In-service user Discharge Policy).

5. Detail of the policy

The policy promotes the planned and structured transfer of service users both internally and externally to the Trust. The Trust recognises that all transfers should be service user centred ensuring that service users, families and carers are well oriented, safe and secure in their environment. It is essential that a multi-disciplinary and multi-agency approach is adopted to provide seamless transfer to services.

6. Duties

Medical Staff

- Must determine whether the service user is ‘medically fit’ for transfer and that the benefits of the transfer outweigh the risks.
- Agree a clear plan for the transfer of the service user to the agreed facility (hospital, home, GP care etc.) taking account of the judgement and opinions of their colleagues in the multidisciplinary team, as well as the views of the service user and their carers or relatives.
- Clearly document the plan in the Electronic Patient Record (RiO, system-one, paper records)

The Senior Management Team will identify the duties of different staff groups within multidisciplinary teams with respect to transfer/discharge according to the needs of individual service users. Where applicable Care Programme Approach (CPA) should apply and or collaborative care planning processes to ensure all risks as identified in the Detailed Risk Assessment Module (DRAM) are taken into account to maintain safety of the service user during the transfer. This includes identifying **a named person to co-ordinate transfer arrangements** for the service user.

7. Procedure

7.1 General Principles relating to transfer of a service user (see Appendix 4 – Checklist to assist with any transfer)

a. The Trust clinical team will liaise closely with the receiving Team/Trust to ensure that there are adequate plans in place to ensure a smooth transfer.

b. These plans will include a comprehensive assessment of the service user's individual needs, the development of a risk management plan (DRAM) to address identified risks and a clear indication of the level and nature of observation required and how this would be provided. The principles of the Care Programme Approach (CPA) should be adhered to in line with the CPA framework and the Trust's CPA Policy

c. All service users will be central to and involved in the planning for their transfer.

d. With the consent of the service user - relatives and/or carers will be informed and be fully engaged in this process.

e. Where a service user lacks capacity to make an informed decision about their treatment, the Mental Capacity Act 2005 provides a legal framework for acting and making decisions on their behalf. Everyone working with and/or caring for an adult who may lack capacity for making specific decisions must comply with the Act.

f. If a service user is subject to detention in hospital under the Mental Health Act 1983, any decision about their care must be made after consideration of the Guiding Principles (see Appendix 3) which inform decisions but do not determine them.

g. Where a service user is transferred to an Acute Care Trust, overall responsibility for their care will be the responsibility of the destination hospital.

7.2 Standards for Transfer

All service users should have an agreed care plan or transfer/discharge summary which has been developed with the involvement of:

a. The Multi-Disciplinary Team

b. The service user/ Carers or relatives as appropriate.

c. The relevant Community Services or Teams involved, including the Care Coordinator, where one has been identified.

d. GP / Primary Care Mental Health services.

e. Other relevant agencies, e.g. Probation, Housing

7.3 The transfer plan should:

- Be person-centred and reflect the service user's choices as far as possible and be made available in a form which can be read and understood by the service user,

e.g. in an appropriate language. This may be a print-out from RiO system, an audiotape, a series of pictures, etc.
Be consistent with and developed within the Single Assessment Process (SAP), the Care Programme Approach (CPA), and / or other relevant processes and procedures for ensuring effective multidisciplinary, multi-agency, or across-team working.

- Be developed with the involvement of advocacy services where service users request their help or lack capacity to engage in the process or decision-making.
- Be provided in a written or other form acceptable and accessible to the service user and their carers.
- Be considered and commence development as soon as transferred care begins.
- Consider Statutory (Mental Health Act) provisions, e.g. Section 117.(refer to Section19 policy)
- Original MHA papers will need to be provided if the person is subject to the Mental Health Act (Refer to Section 19 policy)

7.4 The transfer plan should cover arrangements for:

- Supply of medication/medication reconciliation
- If appropriate, further appointments with services or agencies.
- Where appropriate, contact with services and agencies which will be involved with on-going care and support after discharge.
- Contact with Carers including the possibility of an assessment of Carer needs.
- Where appropriate, the impact on the provision of social care services.
- Meeting physical health care needs including issues of Infection Control
- Review of care and treatments plans including issues of Infection Control
- Where appropriate, finance and benefits.
- Management of risk and any other safety concerns.
- Management of the risks of substance misuse.
- Any issues relating to children who may normally live with the service user or for whom the service user has parental responsibilities.
- Information for the services user and their carers or relatives to access help and support in the event of crises.
- The provision of information in an appropriate form outlining the care plan, information about medication, and information necessary to enable the service user or carers to access the mental health services.
- Where appropriate, the transfer of valuables, possessions, and monies held for safe keeping.
- Communicating the transfer plan to others, including accommodation providers, primary care staff, community support, or other services or agencies.
- Transport where appropriate.
- The transfer plan should clearly identify the roles and responsibilities of people involved for each part of the plan. The plan should identify a named co-ordinator of these transfer arrangements.

7.5 Documentation to be provided to the service user when being transferred

A copy of the Transfer Plan will be given to the service user and will include:

- Arrangements for the next appointment or contact with services, information about medication, and information necessary to enable the service user or carers to access the mental health services.
- Information for the services user and their carers or relatives to access help and support in the event of crises, which is culturally appropriate. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation as required (Original document only) as detailed in the Resuscitation Policy

- Infection Prevention and Control team should be contacted for support and advice if it is suspected that the patient may have an infection risk to themselves or others as indicated it the Infection Prevention and Control Policy
- Patients consent or utilisation of the appropriate legal framework.
- relevant case records being shared in a secure manner and a formal documented handover of care between the Trust and the receiving service

7.6 Unplanned Transfer and Transfer outside normal hours

There will be occasions where service users need to be transferred and proper care plans cannot be developed or put into place.
In these situations the following must be considered:

- Appropriate arrangements for medication reconciliation.
- Arrangements for communicating as soon as possible with relatives or carers, community services or teams or outside agencies such as Police or accommodation providers who need to be informed.
- Multi-Disciplinary review at the earliest opportunity to consider further plans.
- The provision of written information for the client and their carers or relatives if appropriate, regarding arrangements for care.

7.7 Transfer Records

All care details / incidents related to transfers must be recorded in the service users Electronic patient record (RiO, System one / paper notes).

7.8 Disputes

Transfers should not take place until there are clearly agreed arrangements as above which address identified risk. The Resolution of Clinical Disputes Guidance should be consulted and used where there are clear professional disagreements about transfer arrangements.
All teams should raise any concerns or problems relating to the implementation of this policy either generally or in relation to specific service users with their Service or Clinical Directors.

8. Development, Consultation and Approval

This policy has been reviewed by the Acute and Community Directorate Leadership team as part of the clinical model review throughout September 2023.

9. Audit, Monitoring and Review

This section should describe how the implementation and impact of the policy will be monitored and audited. It should include timescales and frequency of audits.

If the policy is required to meet a particular standard, it must say how and when compliance with the standard will be audited.

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Handover requirements between all care settings, to include both giving and receiving of information	Supervision, governance meetings, incident reports, complaint and compliments.	Ward managers	Annual	Ward managers and senior management teams	Ward managers and senior management teams	Ward managers and senior management teams
How transfer is recorded	Supervision, governance meetings, incident reports, complaint and compliments Audit of use of transfer form and local record keeping audits.	Ward managers	Annual	Ward managers and senior management teams	Ward managers and senior management teams	Ward managers and senior management teams

Out of hours transfer process	Supervision, governance meetings, incident reports, complaint and compliments.	Ward managers and Senior Management Teams	Annual	Ward managers and senior management teams	Ward managers and senior management teams	Ward managers and senior management teams

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. The policy review date is 28 September 2026

10. Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Head of Nursing – Acute and Community	October 2023	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Head of Nursing – Acute and Community	October 2023	

11. Dissemination, Storage and Archiving (Control)

The issue of this policy will be communicated to all staff via the Trust Intranet Jarvis. Local managers are responsible for implementing this policy within their own teams.
This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.
Any printed copies of the previous version (V5) should be destroyed and if a hard copy is required, it should be replaced with this version.

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0				
2.0				
3.2				
4.0	November 2016	November 2016	November 2016	N/A Minimal changes
5.0	July 2020	July 2020	July 2020	Team brief
6.0	TBC	TBC	TBC	TBC

12. Training and Other Resource Implications

There are no specific training needs in relation to this policy, however the legal requirements under Section 19 are included in the Trust mental Health Act training. However, the following staff will need to be familiar with the policy contents:

- Inpatient Consultant Psychiatrists
- Registered inpatient nursing staff
- Non- registered inpatient staff
- Junior Doctors.

Awareness will be achieved via Team briefings of the updated policy.

13. Links to Other Policies, Standards (Associated Documents)

- Observation Policy
- Discharge Policy
- Risk Management Policy
- Resolution of Clinical Disputes Guidance
- Care Programme Approach (CPA) Policies and Procedures
- Acute Care Pathway and Scheduled care Pathway
- Records Management Policy
- Infection Control Policy
- Mental Capacity Act 2005, Deprivation of Liberty Safeguarding
- Mental Health Act 1883
- Physical Health Policy.
- Medicines Optimisation Policy, Risks and Processes
- Resuscitation Policy

14 Contact Details

The document should give names, job titles and contact details for any staff who may need to be contacted in the course of using the policy (sample table layout below). This should also be a list of staff who could advice regarding policy implementation.

Title	***Name***	***Phone***	***Email***
Executive Director of Nursing, Professions and Quality	Salli Midgley	07970721311	salli.midgley@shsc.nhs.uk
Head of Nursing – Acute and Community	Kelly McKernan	07890988785	Kelly.mckernan@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Kelly McKernan, September 2023	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**No**	**No**	**No**
Disability	**No**	**No**	**No**
Gender Reassignment	**No**	**No**	**No**
Pregnancy and Maternity	**No**	**No**	**No**

Race	**No**	**No**	**No**
Religion or Belief	**No**	**No**	**No**
Sex	**No**	**No**	**No**
Sexual Orientation	**No**	**No**	**No**
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - no changes made.

Impact Assessment Completed by:
K McKernan 25th September 2023

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Yes
2.	Is the local Policy Champion member sighted on the development/review of the policy?	Yes
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Yes
5.	Has the policy been discussed and agreed by the local governance groups?	Yes
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	No
	Template Compliance	
7.	Has the version control/storage section been updated?	Yes
8.	Is the policy title clear and unambiguous?	Yes
9.	Is the policy in Arial font 12?	Yes
10.	Have page numbers been inserted?	Yes
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Yes
	Policy Content	
12.	Is the purpose of the policy clear?	Yes
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Yes
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	Yes
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Yes
16.	Does the policy include any references to other associated policies and key documents?	Yes
17.	Has the EIA Form been completed (Appendix 1)?	Yes
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Yes
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Yes
20.	Is there a plan to i. review ii. audit compliance with the document?	Yes
21.	Is the review date identified, and is it appropriate and justifiable?	Yes

Appendix C – Statement of Guiding Principles under the Mental Health Act 2007 Statement of Guiding Principles

The Mental Health Act 2007 (s118) identifies a set of guiding principles which should always be considered when making decisions about a course of action under the Act.

Guiding Principles

Purpose Principle

Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of service users, promoting their recovery and protecting other people from harm.

Least Restriction Principle

People taking action without the consent of the service user must attempt to keep to a minimum the restrictions they impose on the liberty of the service user, having regard to the purpose for which the restrictions are imposed.

Respect Principle

People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each service user, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the views, wishes and feelings of the service user whether expressed at the time or in advance, so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

Participation Principle

Service users must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the welfare of the service user should be encouraged, unless there are particular reasons to the contrary and their views taken seriously.

Effectiveness, efficiency and equity Principle

People taking decisions under the Act must seek to use the resources available to them and to service users in the most effective, efficient and equitable way, to meet the needs of service users and achieve the purpose for which the decision was taken.

Appendix D – Checklist to assist with any transfer

The transfer plan should:

a. Be person-centred and reflect the service user's choices as far as possible and be made available in a form which can be read and understood by the service user, e.g., in an appropriate language. This may be a print-out from Insight system, an audiotape, a series of pictures, etc.

b. Be consistent with and developed within the Single Assessment Process (SAP), the Care Programme Approach (CPA), and / or other relevant processes and procedures for ensuring effective multidisciplinary, multi-agency, or across-team working.

c. Be developed with the involvement of advocacy services where service users request their help or lack capacity to engage in the process or decision-making.

d. Be provided in a written or other form acceptable and accessible to the service user and their carers.

e. Be considered and commence development as soon as transferred care begins.

f. Consider Statutory (Mental Health Act) provisions, e.g. Section 117.

Checklist

1. As far as is possible, is the assessment of need a multi-disciplinary decision?

2. Is capacity an issue? (See Mental Capacity Act 2005 and Code of Practice)?

3. If the service user is detained under the Mental Health Act 2007, have the Guiding Principles been considered (Appendix H) (see Mental Health Act 2007 and Code of Practice)

4. Have any specialist care needs been identified?

5. Has a Risk Assessment (DRAM) been completed, and a Risk Management Plan been identified (this should include any infection control issues)?

6. Where appropriate, are the comprehensive assessment documentation, risk assessment and management plan and any other care plans including CPA documentation available to accompany the service user?

7. If the service user is detained under the Mental Health Act 2007, has the transfer form been completed and signed by a senior member of the clinical team or care coordinator?

8. If it is an out-of-town placement, has the funding been confirmed by the Contracts Department?

9. Have transfer arrangements been planned, preferably between 0900hrs and 1700hrs?

10. Have the transfer arrangements been recorded in the service user's records?

11. Is an escort required?

    a. If the escort is a member of staff, are the care records and required medication available for them to take with the service user
    b. If an escort is not required, has this information been communicated to the receiving team/Trust where appropriate?
    c. If an escort is not required, has it been documented in the service user notes with reasons?
    d. If an escort is not required, have arrangements been made to convey necessary documents and medication?
    e. If an escort is not required, has a comprehensive verbal summary of the service user needs been given to the receiving team/hospital department and subsequently a copy of the relevant transfer documentation communicated in advance of the service user?
    f. Has the service user been given documentation / copy of the transfer plan.

12. Have the levels of observation been assessed and included in the transfer documentation? (See SHSC Observation Policy)

13. If the service user is detained under the Mental Health Act 2007 and is being transferred to STHFT, has the documentation for section 17 leave been completed?

14. If the transfer is to STHFT, has there been a discussion with the General Hospital ward about the degree of specialist input from Trust services into the service user's care?

15. Has there been consideration of whether the service user might need continued support whilst under the treatment of STHFT and have arrangements been made to ensure this need is regularly assessed?

16. Does the documentation include detailed information about how regular medication to meet specialist mental health needs can be provided and administered.

17. When the service user is ready for discharge from STHFT, the STHFT Team should advise the Consultant Psychiatrist concerned and/or appropriate SHSC Manager. If the service user is compulsorily detained under the Mental Health Act 2007 or the subject of a Community Treatment Order, the Responsible Clinician – if not a medic, should also be informed.

18. Have any transfer arrangements back to the SHSC in service user unit been discussed and made by the STHFT Team?

19. If the service user can be discharged back into the community, have the appropriate SHSC care team been involved in a discussion about this and has follow up mental health/learning disabilities care been arranged?

20. If the service user can be discharged back into the community, have the carers and family been consulted?

21. If the risk assessment undertaken by the mental health or learning disability team has not identified a risk that would require an escort to be present and the information

necessary for the receiving Team to safely manage the service user on their arrival has been effectively communicated.

22. If it is identified by the transferring clinical team that an escort is not required to accompany the service user the reasons for this decision must be clearly recorded within the healthcare records. Suitable arrangements should be made to ensure that copies of all necessary healthcare records and necessary medication are made available to the receiving ward on arrival of the service user e.g. copies of necessary transfer documentation passed to the ambulance service if they are transporting the service user via an ambulance.

23. If an escort is not accompanying the service user a comprehensive verbal summary of the service users care needs should be given by an identified member of the transferring clinical team to the receiving team. Copies of the relevant transfer documentation should also be faxed to the receiving department in advance of the arrival of the service user.

24. In certain circumstances the service user may be accompanied by a relative. In these instances responsibility for ensuring effective communication with the receiving team remains with the transferring clinical team.