

**Transfer and Management of Sussex Partnership Inpatients Requiring Care
in a Local General Hospital
(Replaces Policy No. TP/CP/024 V1.1)**

POLICY NUMBER	TP/CL/024
POLICY VERSION	V.2
RATIFYING COMMITTEE	Professional Policy Forum
DATE RATIFIED	30 th September 2021
NEXT REVIEW DATE	29 th September 2024
DATE OF EQUALITY & HUMAN RIGHTS IMPACT ASSESSMENT (EHRIA)	
POLICY SPONSOR	Chief Nursing Officer
POLICY AUTHOR	Matron, Physical Health

EXECUTIVE SUMMARY:

This policy provides guidance to staff in such circumstances ensuring that the mental health, substance misuse and/or learning disability care needs of a patient continue to be met, both appropriately and effectively, throughout their period of care in the general hospital.

**If you require this document in another format such as large print, audio or other community language please contact the Corporate Governance Team on:
0300 304 1195 or email: policies@sussexpartnership.nhs.uk**

Did you print this document yourself?

Please be advised that the Trust discourages the printing and retention of hard copies of policies and can guarantee that the policy on the Trust website is the most up-to-date version. As a contingency a full set of up-to-date Trust policies are held by the Corporate Governance Team based at Trust HQ, Swandean

CONTENTS

	PAGE
1.0 Introduction	1
1.1 Purpose of policy	1
1.2 Definitions	1
1.3 Scope of policy	1
1.4 Principles	1
2.0 Policy Statement	3
3.0 Duties	3
4.0 Procedure	3
4.1 Assessment of Need	3
4.2 Arranging Transfer	5
4.3 Escorts	5
4.4 Observation Levels	7
4.5 Patients subject to the provisions of the Mental Health Act 1983	7
4.6 Medication	8
4.7 Transfer back to a Trust inpatient service	10
4.8 Infectious Disease	11
4.9 Discharge from the general hospital	12
5.0 Development, Consultation and Ratification	13
6.0 Equality and Human Rights Impact Assessment (EHRIA)	13
7.0 Monitoring Compliance	13
8.0 Dissemination and Implementation of Policy	13
9.0 Document Control including Archive Arrangements	13
10.0 Reference documents	13
11.0 Bibliography	13
12.0 Glossary	13
13.0 Cross reference	13
14.0 Appendices	
1. Service user Transfer	14
2. Protected Characteristics Coding	16
3. Checklist for Patient Transfer to an Acute Hospital	17

1.0 Introduction

1.1 Purpose of policy

Sussex Partnership NHS Foundation Trust (The Trust) provides inpatient and residential care to mental health, and learning-disabled patients in a number of inpatient units across Sussex. Furthermore, the Trust provides a Mental Health Liaison Team (MHLT) service in most general hospitals across the Trust area, who can assess/review and offer support around risk/presentation and management plans concerning mental health issues. The Mental Health Act (MHA) Administration offices at SPFT provide MHA administration services to all NHS acute Trusts in Sussex under contract.

- 1.1.1 Although the care of patients in these settings essentially relates to their mental health, and/or learning disability needs, many people may also have significant physical care needs.

In many instances these physical care needs can be met appropriately in the admitting mental health or learning disability unit. There will however be occasions when a patient requires physical care and treatment in a local general hospital. This may require their assessment at A&E, attendance at an outpatient clinic, admission to a general hospital ward or access to maternity services, either as an emergency or planned/elective.

On such occasions it is important that collaboration, partnership working practices and a culture of reciprocity prevails, in order to ensure that all staff involved in each organisation are clear regarding their accountability for particular aspects of the patient's care and their responsibility for providing different aspects of care required whilst continually striving to deliver a positive patient experience.

- 1.1.2 This policy provides guidance to Trust staff in such circumstances ensuring that the needs of a patient continue to be met, appropriately and effectively, on and throughout their admission and to facilitate safe discharge from the general hospital- whether this is discharge home or a transfer to a mental health unit once acute medical treatment has been completed.
- 1.1.3 The policy also sets out the need to address the patient's Mental Health Act status and necessary legal documentation.

1.2 Definitions

General Hospital – For the purpose of this policy the term General Hospital refers to any hospital or clinic to which a patient is either transferred or attends as an outpatient in relation to a physical health need.

1.3 Scope of Policy

This policy applies to all inpatient settings across the Trust.

1.4 Principles

- 1.4.1 The general hospital will hold responsibility in the provision of care and treatment required whilst the patient is in their care. Sussex Partnership's inpatient clinical team from the transferring ward or service will retain responsibility for advising on how the patient's specialist mental health, and/or learning disability care needs can

be effectively met during their period of admission to general hospital.

- 1.4.2 When a patient is transferred from a mental health facility to the general hospital, the inpatient clinical team will liaise closely with the general hospital care team ensuring there are adequate plans in place to meet the **specialist** mental health & learning disability care needs of the transferred patient.
- 1.4.3 Where there is a need for a review of the mental health/ learning disability needs of the patient, the general hospital ward can access support from the Sussex Partnership inpatient clinical team, or via the Mental Health Liaison Team (MHLT)/ Learning Disability Liaison Service (LDLS) where available.
- 1.4.4 Where the patient is to be transferred to a general hospital outside the Trust area, Trust staff should seek to establish contact with the local MHLT/LDLS (if available) to ensure continuity of care.
- 1.4.5 Such plans will include a comprehensive assessment of the patient's individual needs, the development of a risk management plan to address identified risks and a clear indication of the level and nature of observation required.
- 1.4.6 Wherever possible, involving the patient in planning their transfer is important, as is informing their family and carers, with consent of the patient.
- 1.4.7 Where the transfer of a CAMHS patient is being considered, the clinical team planning the transfer must consult with the patient's parents/ carers/ guardians as appropriate, to keep them informed of clinical need for transfer.
- 1.4.8 Where a patient is unable to present their own views as a result of their physical health condition, the opinions of the relatives or carers may be obtained. Our legal duty is to seek informed, voluntary consent from people about their care and treatment. Where someone doesn't have capacity, we should take a decision in their best interests- please refer to the *Mental Capacity Act 2005 Policy*. Where people have capacity to make a specific decision we should record this in their personal care plan.
- 1.4.9 Decisions relating to the care and treatment of a patient assessed as not having capacity may be made by a person granted with Lasting Power of Attorney.
- 1.4.10 An Advanced Directive to Refuse Treatment must be considered as part of clinical best interest decision making on behalf of the patient.
- 1.4.11 Children aged 16 and over are presumed to have capacity and to be able to consent to or refuse treatment.
- 1.4.12 It is not required to carry out and record formal mental capacity assessments for all patients because the Mental Capacity Act (MCA) 2005 and MCA code of practice make it clear that there is a presumption of capacity.
- 1.4.13 Where capacity to make a decision is in doubt, a proper assessment must be completed, following the principles of the Mental Capacity Act- see *Mental Capacity Act 2005 Policy TP/MHA&MCA/307*.

- 1.4.14 Detained patients must not be disadvantaged, it is the responsibility of the Responsible Clinician to ensure the correct legal documentation is completed to support leave or transfer to the general hospital in a timely manner, so as not to delay access to necessary care and treatment, and to document a clear plan around the conditions of leave from Mental Health/ Learning Disability services and necessary escorting arrangements. In an emergency, the patient should be transferred for urgent medical care, and the necessary paperwork completed afterwards if this is not able to be completed immediately.

2.0 Policy Statement

It is not uncommon for inpatients of mental health / learning disability services to require services from general hospitals either as an emergency or routine appointment. In such circumstances the patient can expect the mental health/ learning disability service and the general hospital to work together and ensure the patient's full needs are understood and met.

3.0 Duties

Executive Director of Nursing & Quality

To ensure an up to date, fit for purpose, based on best practice policy is in operation. To ensure the policy has been shared for information with the Directors of Nursing of the Acute NHS trusts across Sussex.

Service Directors

To ensure the policy is disseminated and available to all teams.

Matrons

To ensure the policy is implemented in all inpatient areas. To monitor compliance and report any difficulties in application.

All inpatient clinical staff

To comply with the policy.

4.0 Procedure

4.1 Assessment of need and risk

- 4.1.1 If it is determined that a patient requires care in a local general hospital the Trust clinical team will ensure that a comprehensive assessment of the individual's needs and an updated risk assessment and risk management plan to reflect change in health has been completed and shared with the receiving team in the general hospital setting and that this is shared with the local MHLT/ LD Liaison Team.

This assessment should be completed ideally before the patient has left Trust services- or in the case of emergency transfer, as soon as possible afterwards. It is essential to inform the MHLT/LDLS at earliest opportunity-to ensure management of mental health, learning disability presentation, safety and risks and opportunity to support the patient and the general hospital staff. It should be embedded as part of processes.

The assessment will include the identification of the specialist mental health/ learning disability care needs and any dietary, religious and cultural requirements which may impact on treatment that can be given to the patient. It must be ensured that there is a risk management plan in place to appropriately address any risks associated with their specialist needs- for example, the risk of self-harm or risk to others, risk of absconding and which considers any environmental risks associated with the acute hospital setting.

- 4.1.2 If there is a need for input from a specialist learning disability or mental health service (e.g. perinatal/ eating disorder services), specialist advice and consultation can be requested via the MHLT/ LDLS on site, where available.
- 4.1.3 The risk management plan should also include contact details of the SPFT inpatient clinical teams involved in the mental health or learning disability care of the patient, and should include a clear contingency plan for any observed change in patients physical/ mental health presentation. This will need to be available to general hospital acute colleagues, for use alongside their local observation policy.
- 4.1.4 The MHLT/LDLS can assess/review and offer support around risks/presentation and management plans concerning mental health/ learning disability issues. The MHLT/ LDLS can access information for this purpose through the Carenotes clinical notes.
- 4.1.5 The Doctor will provide an overarching summary letter to accompany the patient. A copy of the clinical assessment documentation, updated risk assessment, risk management plan, a copy of the medication chart and other care plans should accompany the patient and be made available to the general hospital staff as part of the written and verbal handover of care. The transferring team, where there is time to do so, should complete the Transfer form which can be found in Appendix 1 of this policy.
- 4.1.6 Where the transfer is an emergency, a patient information sheet can be produced directly from Care Notes by clicking 'Summary' and then 'patient summary', which will provide demographic information to supplement the letter written by the medics.
- 4.1.7 In instances where a patient has a routine outpatient appointment the level of information to be shared should be considered and may be adjusted, taking account of the level of risk involved. The risk assessment should be reviewed to reflect the change in patient circumstances (see the *Safe and Effective Assessment & Management of Clinical Risk: Risk Management Policy and Procedure TP/CL/008*).
- 4.1.8 In the event that a patient is to be treated in a general hospital where the local MHLT/ LDLS do not have access to Carenotes or Trust clinical records, the transferring inpatient clinical team must arrange a secure transfer of relevant clinical information by secure email, with hard copies of relevant information to be sent with the patient to the receiving general hospital setting. Contact information for the transferring inpatient clinical team must also be shared with the receiving clinical team in order that supporting/ supplementary information may be shared thereafter, as required.

- 4.1.9 In the event that the necessary documentation not being completed at the point of transfer a comprehensive verbal assessment will be given by a member of the Trust clinical team to the receiving general hospital care team. In these circumstances, copies of any necessary documentation will follow as soon as possible. Best practice would include both a medical and nursing handover of care. The MHLT/LDLS can access mental health clinical records (via Carenotes) if required and keep colleagues within the general setting updated if needed. The escort will need to be able to hand over the care and treatment as well as communicate the risk management plan.
- 4.1.10 If it is anticipated or known that a patient will require admission to a general hospital ward, a transfer summary form should also be completed, which includes patient information relating to Protected Characteristics, cultural characteristics, dietary requirements, next of kin details and pregnancy status (see *Appendix 1*).
- 4.1.11 Coding for description of these protected characteristics can be found in *Appendix 2* of this policy. It should be clarified as to whether the patient wish for information of the transfer of care to be shared with their next of kin.

4.2 Arranging transfer

- 4.2.1 The mental health/ learning disability inpatient clinical team has responsibility for ensuring that appropriate transfer arrangements are in place to ensure safe conveyance of the patient.
- 4.2.2 When it is appropriate for the transfer to be planned, arrangements should be made for this to take place between 0900 hours and 1700 hours, Monday to Friday. This should facilitate the maximum availability of staff in both hospitals.
- 4.2.3 If it is confirmed that an admission to a general hospital ward is required, a mental health patient's length of stay and medical/surgical treatment needs should be regularly reviewed by the SPFT inpatient clinical team, which will be used to inform the retention of their mental health/ learning disability bed.
- 4.2.4 For those subject to the provisions of the Mental Health Act, a transfer of section will be completed following discussion with the consultant liaison psychiatrist/ responsible clinician or equivalent at the general hospital. The patient's detention could be permanently transferred to the acute hospital, or they could be temporarily moved under section.17 (MHA) leave.

4.3 Escorts

- 4.3.1 Best practice suggests that a member of Trust staff, with the appropriate skills and knowledge necessary to undertake the role, should accompany the patient. If the risk assessment or Mental Health Act status indicates it, more than one staff member may be required to accompany the patient, and the transferring team should make an assessment of their support needs with reference to their Mental Health Act status.
- 4.3.2 Wherever possible staff undertaking escorting duties will suitably qualified and experienced to support them in relation to their MHA status and their care needs,

and ideally will be known to the patient.

- 4.3.3 The role of the escort is to ensure that the patient's needs are appropriately met during their transfer to the general hospital and for communicating any necessary information required by the receiving general hospital team on arrival. The escort will normally take responsibility for transferring any necessary copies of sections of the healthcare records and any medication that may be required in the short term and until such time as this can be provided by the general hospital pharmacy.
- 4.3.4 There may be occasions where it is deemed appropriate for a patient to be transferred to another care setting without an escort- for example when the risk assessment undertaken by the SPFT team indicates that an escort may not be deemed necessary.
- 4.3.5 If it is identified by the transferring Trust clinical team that an escort for an informal patient is not required, the reasons for this decision must be clearly recorded in the patient's healthcare records. Suitable arrangements must be made to ensure that copies of any necessary healthcare records and medication are made available to the receiving general hospital department on arrival. In this instance, copies of necessary transfer documentation should be passed to ambulance service personnel, if they are transporting the patient, to be passed to the receiving clinical team within the general setting.
- 4.3.6 If an escort is not accompanying the informal patient, a comprehensive verbal summary of care needs should be given by an identified member of the Trust clinical team to the receiving general hospital department. Copies of the relevant transfer documentation will also be securely emailed to the receiving department in advance of the arrival of the patient.
- 4.3.7 In certain circumstances the informal patient may be accompanied by a relative. If ambulance staff are not involved then relatives may be given responsibility for transferring any medication and documentation in a sealed envelope/container if deemed absolutely necessary, safe and appropriate to do so by the Trust clinical team. Where access to clinical documentation can be facilitated by the MHLT/LDLS within the receiving general hospital, it may not be necessary to issue copies to the relative, but this must be confirmed with the MHLT/LDLS beforehand.
- 4.3.8 Responsibility for ensuring that effective communication takes place with the receiving general hospital department remains with the Trust inpatient clinical team. Safe arrival of the medication and documentation should also be confirmed and documented in the patient's care records. The Trust inpatient clinical team arranging the transfer of care must ensure that the relative has adequate support, that they have all required information to support the safe transfer of the patient and that they have contact details for the Trust clinical team in case of an emergency.
- 4.3.9 On initial transfer of CAMS patients, an initial escort must always be provided, subject to review of the ongoing need by the CAMHS team, with additional input as required from the Physical Health Team, or CAMHS liaison team (where available).

4.4 Observation levels

- 4.4.1 Details regarding the level of observation should be included in the SPFT transfer documentation (*Appendix 1*) to inform the general hospital's plan of care. Details regarding the observation level required to ensure that the patient's needs, their safety and that of others, are appropriately met in the general hospital should be identified as part of the risk assessment by the Trust inpatient clinical team.

This risk assessment should be shared with the general hospital care team in verbal and/ or written communication. The SPFT *Therapeutic engagement and observation policy and procedure* should be used to inform this process, which can be made available upon request.

4.5 Patients subject to the provisions of the Mental Health Act 1983

- 4.5.1 If the patient is subject to the provisions of the Mental Health Act 1983 and they require a period of planned care and treatment in a general hospital they will be placed under Section 17 leave and the appropriate documentation completed.
- 4.5.2 Documentation should be completed by the Responsible Clinician in advance of the transfer, but in the event of an emergency it should be completed as soon as possible afterwards. The patient's transfer to a general hospital in an emergency should not be delayed by this process.
- 4.5.3 A leave bed will be held for the patient until such time as their medical/ surgical treatment needs are established through liaison with the acute general hospital team.
- 4.5.4 If the patient requires an extended period of care and treatment in the general hospital, then consideration should be given to transferring their detention under the MHA to a Responsible Clinician within the Acute Trust, subject to local arrangements.
- 4.5.5 It is the responsibility of the Trust inpatient clinical team to inform the Mental Health Act Office of the admission to general hospital. Consideration of the patient's treatment in an acute general setting may be required in terms of any pending hearings or tribunals.
- 4.5.6 Where there is a change in Responsible Clinician, a new section 17 leave form authorised by the new Responsible Clinician, will need to be completed.
- 4.5.7 The inpatient clinical mental health or learning disability team will work in consultation with the acute Trust clinical to support how the **specialist** mental health or learning disability care needs of the patient are addressed in, and provided by, the general hospital whilst they remain subject to the provisions of the Mental Health Act 1983. This may involve daily telephone contact or visiting, and may also include utilisation of the MHLT within the general setting to offer support to the patient.

4.6 Medication

- 4.6.1 If a patient is transferred to general hospital either in an emergency (e.g. to A&E or acute medical unit or equivalent) or as a planned routine admission (e.g. elective surgery) all named patient medication **currently in use** within the medication trolley/cupboard for that individual patient should be transferred with the patient to the general hospital.
- 4.6.2 Where ward stock medication is being used and the transfer is taking place out of hours, a small supply up to 72 hours should be dispensed in line with the nurse dispensing section of the medicines code, to allow time for the general hospital to obtain further supply from their pharmacy service, and to avoid missed doses.
- 4.6.3 Controlled drugs which have not been supplied directly to patients against a valid controlled drug prescription cannot be transferred to the general hospital as they are trust property. Ward stock-controlled drugs also cannot be transferred to the general hospital as they are SPFT property.
- 4.6.4 Where a controlled drug is a patient's own medication brought in from home, or where the controlled drug has been supplied by our trust pharmacy services against a valid controlled drug prescription and thus **has a dispensing label with directions for administration on it**. These can be transferred to the general hospital in-line with the transport of medication section of the medicines code, as these are the patient's property.

4.6.5 Clozapine

Where a patient is prescribed Clozapine, it is vital that this medication is definitely transferred with them to hospital as further supplies will not be readily available, and missed doses can have significant effects potentially leading to treatment breaks, relapses which may affect adherence to physical health treatment, and increased duration of psychiatric admission. Full details of dose, frequency of Full Blood Count (FBC), date of last FBC, and date of next FBC must be communicated to the general hospital.

- 4.6.6 The SPFT pharmacy team must be informed of any patient prescribed clozapine who is transferred to the general hospital.
- 4.6.7 The MHLT located within the general setting must also be advised of the transfer of a patient prescribed Clozapine.
- 4.6.8 Clozapine should not be stopped without discussion with the transferring responsible clinician, on-call consultant, or liaison psychiatrist if care has been transferred to the MHLT.
- 4.6.9 A copy of the medication chart/s must be supplied to the transferring ward from the mental health/ learning disability ward initially during working hours. If a discharge summary or e-discharge has been written then this must also be sent with the patient.

Where available, the MHLT within the general hospital setting will have a dedicated liaison psychiatrist in hours who can liaise with the admitting medical

team to provide advice around prescribing medications. Where the MHLT has no psychiatrist available to advise in this capacity, MHLT can act as an intermediary between the general and psychiatric settings for prescribing advice, or facilitate contact with the psychiatric on-call consultant to seek resolution out of hours.

- 4.6.10 Where a patient is prescribed a long acting antipsychotic injection/depot which is likely to be due during the general hospital admission, consideration should be given to transferring a supply sufficient for the dose with the patient.

Arrangements must be made with the general hospital for administration of the long acting anti-psychotic injection (LAI) with the general hospital ward during the admission in line with section 3.3 of the trusts *“Guidelines for the Administration of Long Acting Antipsychotic Injections in Adults”*. Full details of drug name, dose, frequency, last administration date and next administration date must be provided which should be on the copy of the medication chart transferred with the patient.

- 4.6.11 Administration during the general hospital admission may be carried out either by appropriately trained general hospital nurses independently following guidance from the transferring ward or by a general hospital nurse and suitably trained visiting psychiatric nurse in collaboration. Either way this administration must be recorded on both the general hospital’s prescribing system and the SPFT’s electronic Carenotes records.

- 4.6.12 It is vital that responsibility for LAI administration is made clear for the benefit of all to avoid accidental double-dosing.

If there are concerns about the appropriateness of continuing the long acting antipsychotic injection/depot for physical health reasons then this must be assessed by the transferring wards responsible clinician in liaison with the general hospital medical team within working hours. A long acting antipsychotic injection/depot can usually be safely delayed out of hours until the transferring wards responsible clinician is available to review the on-going administration of the medication.

- 4.6.13 Where a patient’s care has been transferred from the inpatient ward to the MHLT then this responsibility may fall to their services in liaison with their available psychiatric consultant input, be this a dedicated liaison consultant, the patient’s community consultant, the on-call consultant, or communication with the original transferring inpatient consultant.

- 4.6.14 The written information that accompanies the patient should detail the information necessary to ensure that medication required to meet their specialist mental health or learning disability needs can continue to be administered appropriately within the general hospital unit. MHLT can offer guidance on current medications for mental health conditions. MHLT can support general hospital staff with care and treatment.

- 4.6.15 For patients who are subject to the provisions of the Mental Health Act 1983 the arrangements for how the specialist medication required by the patient will be administered to them during their general hospital stay should be included within the care plan that is jointly agreed between the two teams. This care plan should indicate which staff will undertake responsibility for administering the medication required, and when, and provide details of review arrangements that are in place.

4.6.16 Where a decision is made to discharge a patient from the original transferring ward to the general hospital; to transfer their care to the MHLT; or a decision is made that no further psychiatric care is required at this time, an electronic discharge summary must be completed on Carenotes by the original transferring ward and signed off by pharmacy, to document the end of the admission. This discharge summary is to be sent to the patients GP and to the patient in the general hospital. However, no further supply of medication will be made by the trust pharmacy service in this instance, as on-going supply responsibility lies with the general hospital at that time.

Where treatment has been transferred to another health institution (i.e. not discharged to home) the electronic discharge summary should clearly state that the patient's care was transferred to X and therefore their medication list may be subject to further changes.

4.6.17 When patients are transferred back to the care of the Trust, it is expected that the general hospital will follow their usual discharge process as the patient is being discharged from their care. This includes production of an A&E or hospital discharge summary and supply of discharge medication via their pharmacy services or FP10/outpatient prescriptions (in cases of A&E attendances). Any remaining medications originally brought into the general hospital with the patient should also be returned on discharge as part of their usual discharge processes. The above should be requested when arranging transfer of a patient back to our wards to avoid medication errors and missed administration of medications on the patients return.

4.7 Transfer back to a Trust inpatient service

4.7.1 If after a period of admission to a general hospital ward or assessment within an accident and emergency unit, it is identified by the general hospital care team that the patient is medically optimised for transfer/ no longer requires acute inpatient medical care back to a mental health or learning disability unit, they should liaise with the Trust inpatient clinical team in order to ascertain that the receiving service can manage future physical health care needs.

4.7.2 This liaison will need to include arrangements to be made to transfer the detention under the MHA back to SPFT services (if the detention was transferred originally).

4.7.3 It is generally accepted that Trust inpatient clinical teams are not equipped to provide any acute physical health care and that transfer should only take place when the patient's condition no longer requires acute medical or inpatient nursing care to address their physical health needs and the overriding health need is no longer physical in origin. This would include, for example, the management of I.V. therapy, medical or surgical intervention or the use of specialist equipment.

4.7.4 SPFT Trust medical and/or nursing staff will then consult with the general hospital care team and first discuss whether there is a continuing need for inpatient mental health, or learning disability care, this may require a full mental health assessment. MHLT can assist in the assessment of need for continuing mental health care as required.

4.7.5 If inpatient mental health or learning disability care is required then it must be

confirmed in a discussion between the general hospital treating physician/ team and the SPFT inpatient clinical team that the physical health care needs of the patient can be appropriately met within the mental health or learning disability unit.

- 4.7.6 If it is confirmed that the patient requires continuing inpatient mental health or learning disability care and that the physical health care needs can be safely met by SPFT services then the appropriate arrangements for transfer will be made.
- 4.7.7 The transfer arrangements will be organised by the general hospital team, liaising closely with the appropriate mental health or leaning disability unit to ensure that the specialist mental health and learning disability needs of the patient can be safely met during the transfer period.
- 4.7.8 Transfer should not take place until the receiving care team has confirmed that they are satisfied with the arrangements proposed. This may entail the consideration of assessments and care plans relating to ongoing physical health management (e.g. wound management), equipment or medical products necessary to enable continuity of physical health care or the necessary skills and experience required by the receiving SPFT team to maintain patient safety and quality of care between settings.
- 4.7.9 Prior to transfer, the SPFT clinical team must be provided with written information detailing the care and treatment provided within the general hospital setting including all medication details – and a supply of any medicines/ clinical supplies (e.g. wound dressings) not routinely stocked in the mental health or learning disability unit and details of any follow-up arrangements in relation to physical health issues treated within the general setting.
- 4.7.10 Discussions regarding medical fitness to return and the plan for transfer back to the mental health or learning disability unit should be clearly documented on patients' records on care notes and the medical checklist (in *Appendix 3*) should be completed.
- 4.7.11 The discharging hospital retains responsibility for informing the patient's GP that the patient has been transferred. Next of kin (if appropriate) should also be notified by the discharging care team. Transition of care can be a challenging time for patients, and the MHLT/LDLS can help support the discharge from the general hospital to the SPFT hospital if required. Physical and mental health review should be arranged upon arrival back to the Trust service/ hospital.
- 4.7.12 A discharge summary from the general hospital treating team must be sent to the SPFT inpatient clinical team at the earliest opportunity, as this will inform the plan of care for the patient upon their return to SPFT services.

4.8 Infectious disease

- 4.8.1 Prior to transfer back to Trust care, the receiving team must ascertain whether the patient has been exposed to an infection or contagion whilst within the general hospital setting e.g. cared for within a 'Red zone'. General hospitals will routinely screen patients upon admission to their premises, and the pre-transfer discussions must include details of any recent tests relating to infection and

consider the need for a pre-transfer/ discharge test from the general setting. The Trust Infection Prevention and Control Team will be able to advise in this regard if clarification is required, based on current national guidance.

4.8.2 Throughout the procedure of facilitating transfer between health/ learning disability settings, all staff must ensure that they observe local and national infection control guidance and precautions.

4.8.3 Upon returning to Trust care the patient must be routinely screened for infections via appropriate testing (e.g. nasopharyngeal swab test) and if exhibiting symptoms, the patient will require care in isolation or within a cohorted area. Admitting ward must also inform the physical health/infection control team of any patients with suspected notifiable infections.

4.8.4 In the event that the patient is not willing to undergo relevant tests for infections, or lacks the capacity to consent to a test upon their return to the ward, then the Trust clinical team will be required to make a decision to ensure the safety of other patients and staff on the ward. The infection control team will be able to offer advice and support on management of a patient who refuses a test. The appropriate Sussex Partnership NHS Foundation Trust ethical decision making forum and the Mental Capacity Act Lead for SPFT should be consulted where there are issues of capacity to consent which impede the diagnostic/ treatment process which is reliant on a test. All decisions and actions must be taken in the patient's best interests, be necessary and proportionate and performed in the least restrictive manner. All decisions and actions must be clearly documented in the patient's electronic records.

4.8.5 The discharging hospital retains responsibility for informing the patient's GP that the patient has been transferred.

4.9 Discharge from the general hospital

4.9.1 If following a period of admission to a general hospital ward it is identified by the Trust clinical team or MHLT/LDLS that the patient no longer requires readmission to, or transfer back to a mental health or learning disability unit, it may be appropriate for them to be discharged home directly from the general hospital ward. In this situation, if the patient is still detained under the MHA, their detention will need to be reviewed by the Responsible Clinician, and any changes to MHA status relayed to the Mental Health Act office.

4.9.2 In these circumstances the Trust clinical team must have clearly identified that this action is appropriate and documented this in the patient's healthcare records, following consultation with the general hospital clinical team responsible for their care.

4.9.3 Any arrangements for follow-up care by the Trust clinical team should be identified and communicated clearly to all those involved in the patient's care.

5.0 Development, consultation and ratification

The policy has been updated from the previous version.
The policy was considered by the PPF for ratification.

6.0 Equality and Human Rights Impact Assessment (EHRIA)

This policy and protocol has been equality impact assessed in accordance with the Procedural documents policy

7.0 Monitoring Compliance

The Matrons from the Trust will monitor compliance with this policy. Any difficulty with its implementation will be raised with the Trust's Governance team.

8.0 Dissemination and Implementation of policy

The policy will be uploaded onto the Trust intranet policy pages and advertised in the Partnership Bulletin. Staff will be alerted of this review in the Report and Learn Bulletin.

The policy will be shared with the Directors of Nursing in all acute trusts across Sussex by the Executive Director of Nursing & Quality.

9.0 Document Control including Archive Arrangements

This policy will be stored and archived in accordance with the Trust wide procedural documents policy.

10.0 Reference documents

- Mental Health Act (1983)
- Safe and Effective Assessment & Management of Clinical Risk: Risk Management Policy and Procedure TP/CL/008
- Mental Capacity Act 2005 Policy TP/MHA&MCA/307- can be accessed at:
- <https://policies.sussexpartnership.nhs.uk/mental-health-act-and-mental-capacity-act-policies/mental-capacity-act-2005-policy>
- All Sussex Partnership NHS Foundation Trust Infection Control Policies can be found on the Trust intranet:
<https://policies.sussexpartnership.nhs.uk/clinical-3/infection-control-policy-procedure>
- Therapeutic Engagement and Observation Policy and Procedure TP/CL/029
- Medicines code

11.0 Bibliography

None

12.0 Glossary

None

13.0 Cross reference

1. Trust observation and therapeutic engagement policy and procedure
2. Safe and Effective Assessment & Management of Clinical Risk: Risk Management Policy and Procedure TP/CL/008
3. Mental Health Act 1983 Code of Practice
4. SPFT Medicines Code
5. Mental Capacity Act 2005 Policy TP/MHA&MCA/307

6. TPMHA&MCA/101/Clinical Assessment of Persons under Sections 135 and 136 of the Mental Health Act 1983

14.0 Appendices

Appendix 1

PATIENT TRANSFER FORM				DATE:			
Transfer from:		Tel. No:		Transfer To:		Tel No:	
Patient Details							
Title:		Surname		Forename(s)		Gender	
						<input checked="" type="checkbox"/>	
						Female	
						Male	
						Other	
						Prefer not to say	
DoB: xx/xx/xxxx		NHS No:		CIS No:		Ethnicity Code	
Preferred Language			Interpreter required?			Religion Code (Appendix 2)	
Disability Code (Appendix 2)			Pregnancy Code (Appendix 2)			Sexual Orientation Code (Appendix 2)	
Communication Needs:							
Date of Admission to SPFT Bed				Consultant Psychiatrist (RC):			
GP Details				Lead Practitioner/ Named Nurse			
				Tel No: <input type="text"/>			
				Next of Kin Details			
GP Tel: <input type="text"/>				Tel No: <input type="text"/>			
MHA Status:				Relationship with Pt: <input type="text"/>			
Copy of S17 Leave form enclosed?		Y <input type="checkbox"/> N <input type="checkbox"/>		Transfer discussed with NoK?		Y <input type="checkbox"/> N <input type="checkbox"/>	
						Permission to share info?	
						Y <input type="checkbox"/> N <input type="checkbox"/>	
Copy of Consent to Treatment / Second Opinion Form enclosed?		Y <input type="checkbox"/> N <input type="checkbox"/>		Risk Assessment			
				Completed?		Y <input type="checkbox"/> N <input type="checkbox"/>	
				Date/ Time completed		Date: <input type="text"/>	
						Time: <input type="text"/>	
Risk Management Plan Attached		Y <input type="checkbox"/> N <input type="checkbox"/>		Key Risks Identified:			
Brief Summary:							

Observation level required / Special nursing procedures, including gender risk issues:					
Rationale for escort not being provided:					
Prescribed Medication: (Please also send <u>copy</u> of Prescription Chart)					
Medication last Administered:			Known Allergies:		
Diet:		Mobility:			
Bowels/ Continence:		Catheter in situ?	Y	N	Type:
Pressure Areas:					
Relevant Medical History:					
Healthcare records with patient?		Y	N	X-rays with patient	
				Y	N
List of clothing / personal effects / valuables accompanying patient:					
Comments and other information:					
Signature:		Designation:		Date/ Time:	
Please save a digital copy of this Transfer Form in the Patient's Care Notes					

Appendix 2

Protected characteristics coding

ETHNICITY

Description	Code	Description	Code
Any Other Asian Background	01	Mixed White / Asian	11
Any Other Black / African / Caribbean Background	02	Mixed White / Black African	12
Any Other Mixed Background	03	Mixed White / Black Caribbean	13
White British	04	Other Ethnic Background	14
Arab	05	Pakistani	15
Bangladeshi	06	Prefer Not To Say	16
Black African	07	Any other White Background	17
Black Caribbean	08	White Gypsy / Irish Traveller	18
Chinese	09	White Irish	19
Indian	10		

RELIGION

Description	Code	Description	Code
Agnostic	01	Japanese (Shinto)	10
Atheist	02	Jewish	11
Bahai	03	Muslim	12
Buddhist	04	Other	13
Chinese (Confucian Or Taoist)	05	Pagan	14
Christian	06	Rastafarian	15
Do Not Wish To Disclose (At This Time)	07	Sikh	16
Hindu	08	Spiritualist	17
Humanist	09		

DISABILITY

Description	Code	Description	Code
Asperger's Syndrome / Autism	01	Mental Or Emotional Distress	07
Blind / Partially Sighted	02	Need Personal Care / support	08
Deaf / Hard Of Hearing	03	Other	09
Dyslexia	04	Unseen Disability (E.G. Diabetes, Epilepsy)	10
I Do Not Have A Disability	05	Wheelchair User / Mobility Impairment	11
Learning Difficulty / Disability	06		

SEXUALORIENTATION

PREGNANCY & MATERNITY

Description	Code	Description	Code
Bisexual	01	Description	Code
Heterosexual	02	Pregnant	01
Lesbian, Gay	03	Not Pregnant	02
Prefer Not to Say	04	Within 26 week maternity period	03
Undecided	05	Not within	04

Appendix 3

Physical Healthcare Assessment of Patient for Transfer from the Acute Trust to an SPFT Unit					
<p>Prior to the transfer of patients to SPFT Mental Health/Learning Disability Units from a general hospital, the following information must be obtained in order to ensure that:</p> <ul style="list-style-type: none"> the patient is medically fit for transfer. a full understanding of the clinical picture is passed on to SPFT staff. SPFT staff are aware of any issues that require immediate or follow up action. <p><i>This form can be completed by either SPFT staff visiting the patient or contacting the acute ward by telephone.</i></p>					
Patient's Name		DOB		NHS Number	
Date Information Collated			Name of SPFT staff receiving information		
Name of Acute Ward/Nursing Home providing information:					
Name of Acute Ward/ Nursing Home staff providing information					
What is the patient's diagnosis? (Ask for a copy of discharge summary).					
Has the reason for admission to general hospital been established and resolved?			Yes		No
Last Blood test date:		Follow up required?		Abnormal Results?	
		Y N			
What has their NEWS score been in the last 24 hours and what is their current NEWS score?			Previous NEWS		Has NEWS been stable?
			Current NEWS		
INFECTION CONTROL: Does the patient have any current infections?			Y Details:		
			N		
Covid-19					
Has the patient been swabbed for Covid 19?		Y N		Is the patient exhibiting any symptoms of Covid-19 (e.g. cough, pyrexia, anosmia)?	
Date of last swab:				Y N	
Result				Details:	
Medication:			Details		
<p>Detail any new medication commenced within the general setting, and the reason for its prescription.</p> <p>Has the patient developed or displayed a sensitivity or allergy to any newly prescribed medication?</p> <p>Obtain a copy of the patient's medication chart</p>					

from the transferring ward				
Wounds and dressings: <ul style="list-style-type: none"> • Does the patient have any sutures, staples or drains insitu? • If yes, what are the arrangements for removing these? • Does the patient have any wounds or skin breaks which require dressing, if so with what? <i>(If the patient has any wounds request they send a supply of dressings).</i>		Details:		
Does the patient have any pressure sores? What pressure relieving equipment is needed?		Details:		
Waterlow score				
Are there any nutrition and hydration concerns?		Details: MUST Score:		
Are there any mobility concerns? Do they use mobility aids? (Zimmer frame/ wheelchair/ hoist)		Details:		
Does the patient have a catheter? If so what type? Is there a catheter passport in place and spare bags for them? What is the plan for the use of catheter and who will be managing this?		Details:		
Does the patient have a DNAR/Advanced CPR/ RESPECT care plan in place?		Details:		
Has the patient got any history of long term conditions such as diabetes, MS, COPD, cancer? If so, who manages these chronic diseases?		Details:		
Any further information				
Handover documented on care notes?	Y N	Signed	Position	Date