ADMISSION, TRANSFER, DISCHARGE AND COMMUNITY FOLLOW UP POLICY

POLICY NO & CATEGORY	**C51**	**Clinical**
VERSION NO & DATE	**Version 1**	**August 2018**
RATIFYING COMMITTEE	**Clinical Governance Committee**	
DATE RATIFIED	**September 2018**	
NEXT REVIEW DATE	**September 2021**	
EXECUTIVE DIRECTOR	**Executive Director of Operations**	
POLICY LEAD		
POLICY AUTHOR *(if different from above)*	**Head of CPA**	
FORMULATED VIA		

POLICY CONTEXT:

This policy aims to and consistent. It will ensure that service users discharged from all inpatient settings ensure that admissions, discharge and transfers are safe, effective

(whether BSMHFT wards or external) are followed up appropriately post discharge.

POLICY REQUIREMENT (see Section 2)

- The decision to **admit / accept into services, transfer** or **discharge** should be supported by an appropriate multi-disciplinary review. For discharge, this should be discussed and agreed by the multi-disciplinary team in MDT or CPA Review. For transfers to another team this should normally be preceded by an appropriate multidisciplinary review. However in exceptional circumstances transfer can be facilitated following discussion with the Responsible Clinician or on-call Consultant.

- **Admission / acceptance into service, transfer or discharge** should not be unplanned and wherever possible should be within core working hours, with an emphasis on recovery.

- Any handover of care should include a discussion of the risk assessment, risk management plan and contingency plan with the team taking over responsibility for the service user, including any risks associated with the **transfer** or **discharge** to ensure optimum communication of risk issues and co-ordinated, seamless management.

- All service users discharged from inpatient care will have a follow up contact by a qualified mental health professional at least once within the first three days of discharge.

Where possible, follow up will be planned prior to discharge and inputted into the
- progress notes on Rio.
- Dates of ward admission, leave, discharge and follow up will be recorded on Rio fully within 24 hours of the information becoming known.

CONTENTS

INTRODUCTION

1.1 Rationale (Why)

This policy aims to ensure that admission / acceptance into service, discharge from, or transfer within BSMHFT is safe, effective and consistent.

The National Confidential Inquiry into suicide and homicide by people with mental illness annual report 2017 found that the pattern of high risk immediately after discharge continues, post discharge suicide being most frequent in the first week after leaving hospital. Over one-quarter of post-discharge deaths occurred in the patient-initiated discharge group and there was further evidence of disengagement from care in this group prior to suicide.

The report recommends that the care of patients on hospital discharge should be a priority, specifically:

- Careful and effective care planning is needed on discharge, including for patients who discharge themselves.
- Early follow up should be routine: we suggest that suicide within 3 days of discharge should be considered as an NHS 'never event' in England and Wales. (Never Events are serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.)
- Adverse events that precede admission should have been addressed before discharge.

1.2 Scope (Where, When, Who)

This policy identifies the core requirements for all service users open to BSMHFT being admitted, discharged from or transferred within secondary mental health services. The policy is therefore directly applicable to all clinical staff employed by BSMHFT.

1.3 Principles (Beliefs)

The following principles will apply to all admissions, transfers within and discharges from BSMHFT services

- Continuity of care is essential to minimise the potential for interruption in treatment and care and ensure that there is no delay in accessing appropriate care and treatment during the admission, transfer or discharge process. This will entail effective collaboration and communication between agencies, services and teams as well as enhancing the recovery journey of the service user.
- BSMHFT will focus on the need to ensure risk is effectively communicated between all of the individuals and agencies involved in a person's care when care is being transferred from one team to another within BSMHFT or where care is transferred to another agency including discharge from Trust services.
- Service users, families and carers will be involved in all decisions related to admission, transfer and discharge, where clinically appropriate.
- Service users will be provided with information about follow up arrangements.
- GP's will receive prompt information about treatment, current medication and follow up.
- Confidentiality principles will be adhered to but should not compromise patient safety.
- The Trust positively supports individuals with learning disabilities and ensures that noone is prevented from accessing the full range of mental health services available.

Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode

of care whilst in our services and that recovery is promoted. Information is shared appropriately in order to support this.

- The CPA process will provide the supporting framework and evidence for decisions relating to admission, transfer and discharge.

2. POLICY (What)

- The decision to admit, transfer or discharge should be supported by an appropriate multidisciplinary review (including the service user, families and carers where clinically appropriate to do so). For service users on CPA this should usually be a CPA review unless exceptional circumstances prevent this. For discharge this should be discussed and agreed by the MDT within MDT meeting / CPA Review. For transfer to another inpatient unit this should normally be preceded by MDT Review. However, in exceptional circumstances transfer can be facilitated following discussion with the Responsible Clinician or on-call Consultant.
- Admission, transfer and discharge must be supported by an appropriate exchange of information.
- Admissions, transfers or discharge should not be unplanned and wherever possible should be within core working hours.
- The only exception will be the requirement for emergency admission or transfer. In such circumstances all relevant assessment information including risk must be communicated immediately.
- Any handover of care should include a discussion of the risk assessment, risk management plan, contingency plan and recovery focussed care plan with the team taking over responsibility for the service user, including any risks associated with the transfer or discharge to ensure optimum communication of risk issues and co-ordinated, seamless management
- At discharge, risks of disengagement and non-concordance should be taken into account and handover plans should consider compliance and engagement
- This policy should be read in conjunction with:
- Medicines Code (C06) and medicines reconciliation policy (C06a) for detailed guidance and procedure for safe management of medicines during transfer and discharge including in patient admission and discharge
- Section 117 policy and guidance (MHL 07S)
- Care Management and CPA policy (C01)
- Clinical Risk Assessment Policy (c57)
- Local Operational Standards and Protocols
- Informal admission (MHL 08) policy
- Referrals and Appointments policy (C11)
- Transition Policies for SOLAR / FTB / BSMHFT

3. PROCEDURE (How)

3.1 Admission / acceptance

All operational protocols / standards, where there is direct patient contact, must cover the following points: • Access criteria

- Exclusion criteria
- Referral process
- Method of assessment (who can assess and when)
- Available interventions / service provided
- Documentation to be completed and frequency of reviews (must seek prior approval from the CPA team first)

3.2 Transfer (Including admission to and discharge from in-patient care)

All transfers must be supported by an exchange of documented information and a handover between the teams involved. Where the service user is on CPA this should usually be a CPA review unless exceptional circumstances prevent this in which case a verbal handover must be undertaken between the referring and receiving teams.

Transfers should not take place until there is agreement and confirmation from the receiving team.

The statutory obligations of the Mental Health Act must be considered where transfer occurs for those who continue to be detained.

Service users, families and carers are to be included in the decision making process relating to transfer, where clinically appropriate.

3.2.1 Where a service user is discharged from an inpatient setting, and where the system is available, a nominated medic who has been involved in the care and discharge of the patient will complete the Discharge Form located on Rio. A letter will then be generated and sent to the GP via the Hybrid mail system by a nominated member of staff. This needs to be completed within 24 hours of discharge.

3.3 Handover of Information at transfer

All operational protocols / standards must clearly define information that needs to be available at the point of transfer. This should include documentation that needs to be completed and should not contradict existing operational protocols / standards or policies (i.e. CPA and Care Management Policy, Clinical Risk Policy, Referrals and Appointments Policy).

In addition it is expected that any paper records will be transferred with the service user. If this is not possible for any reason then copies should be made of appropriate documents and sent to the receiving team or service.

A handover can be completed in several various formats (i.e. face to face, telephone conversation, formal letter, attendance at MDT / Ward Round) and so therefore the most appropriate form of handover must be agreed between the transferring and receiving team.

3.4 Confirmation of handover of information

The receiving care coordinator / lead clinician / NIC must make an entry in the progress notes on Rio to reflect discussion and to detail any actions required with timescales.

3.5 Arrangements for on-going care

Service users should be informed of when their first contact with the receiving team post transfer will be and this should be recorded on Rio.

Where the service user is being transferred from a forensic team there must be clear arrangements and time-frames for accessing forensic assessment and advice.

Any infection issues must be identified and communicated including treatment and management. Where appropriate an electronic warning marker should be in place.

3.6 Community Follow Up

3.6.1 Prior to discharge from inpatient care inpatient and community teams (and where appropriate Home treatment teams) should undertake a joint multi-disciplinary pre discharge review.

3.6.2 At the pre discharge review the specific arrangements for appropriate and safe follow up from inpatient care should be agreed in conjunction with the service user, family and carer. Decisions must be based on an up to date risk assessment, consideration of support networks and any concerns related to engagement, compliance with treatment and capacity. The decision making process must be recorded including the risks considered.

3.6.3 The team responsible for undertaking follow up must be confirmed and recorded as part of the MDT review.

3.6.4 A contingency plan should be agreed which includes the actions that should be taken in the event that the arrangements for follow up do not take place or if additional concerns are raised. Actions will vary from case to case but should reflect the degree of risk, concern or vulnerability attributable to the service user. This should be recorded in the care plan given to the service user prior to discharge.

3.6.5 It is the responsibility of the professional in charge to inform the team manager and consultant of the responsible team of the discharge date and confirm the requirement for follow up.

3.6.6 Prior to a mental health tribunal provisional follow up arrangements should be put in place and confirmed in the event that the service user is discharged. This should take place as part of the Section 117 meeting (a statutory process), where applicable.

3.7 Community follow up after discharge from inpatient services

3.7.1 On the day of discharge the professional in charge of shift will be responsible for ensuring that follow up arrangements are confirmed prior to the service users departure from the ward and the service user is given a copy of their care plan detailing who will be providing follow up, when and where and how to access help in a crisis. The professional in charge will meet with the service user (and carer if indicated) and ask them to confirm their understanding of the follow up arrangements and contingency plan. The professional in charge will make an entry in Rio to confirm that the service user has demonstrated understanding. Where the service user has family or carers involved, the ward must also ensure that they too have a copy of the care plan and how to access help in a crisis.

3.7.2 The professional in charge of shift will be responsible for ensuring that on the date of discharge all relevant information is recorded in the electronic record by the end of shift. This must include an accurate record of discharge date, destination and address, contact numbers, details of Next of Kin and a corresponding progress note detailing confirmed follow up arrangements.

3.7.3 Post discharge the consultant and manager of the team undertaking follow up will be responsible for ensuring that a designated clinician is identified to undertake follow up in

line with the agreed plan but as a maximum within 3 days of discharge. At least one contact within the first three days of discharge must be with a qualified mental health professional.

3.7.4 Follow up contact on the day of discharge may be clinically indicated but there must be a further contact on at least one of the 3 days following discharge in order to meet the requirement for formal follow up.

3.7.5 If the designated clinician is unable carry out the follow up contact the team manager will be responsible for putting in place contingency arrangements to ensure that follow up is provided within policy timescales.

3.7.6 Follow up contact must be made directly with the service user, it is expected that this will be face to face with the service user and all efforts must be made to ensure this. In exceptional circumstances where this is not possible (e.g. compromises staff safety or service user refuses to disclose discharge address) and following a review of risk, telephone contact directly with the service user may be judged appropriate. Third party contact at care home, non-mental health hospital or non NHS inpatient unit does not meet national or trust requirements therefore all attempts must be made to see or speak with the service user directly. Where it is not possible to conduct a telephone follow up with the service user due to their medical condition then a face to face meeting should be undertaken.

3.7.7 The first contact post discharge should include an assessment of how the service user is coping with the discharge and a return to the stressors of life, a review of risk, mental state and any concerns related to engagement, concordance with treatment and capacity. Consideration must be given to whether there is a need for increased intervention and/or support.

3.7.8 A progress note must be recorded to provide evidence that these factors have been considered. This also applies where in exceptional circumstances it has been agreed that telephone contact (or appropriate preferred alternative for deaf service users) is appropriate.

3.7.9 Where the service user does not attend a planned follow up appointment, is not in or will not allow access for a scheduled home visit, or cancels and does not wish to re book the Referrals and Appointments Policy should be followed.

3.7.10 Greater efforts in following up an individual would normally be expected in cases where the risk is considered high or the person is thought to be particularly vulnerable.

3.7.11 All efforts to make contact should be clearly documented in the progress notes and if contact has not been made the multi-disciplinary team should consider and determine further steps.

3.7.12 The designated clinician will be responsible for ensuring that all relevant information is recorded accurately in RIO. This must include all successful and unsuccessful contacts and a record in the progress notes.

3.7.13 Care plans should take into account the heightened risk of suicide in the first three months post discharge.

3.7.14 **Discharge to an out of area location** – Where a service user is discharged to an out of area location where face to face contact is not reasonably practical and care has been transferred to a community mental health team in another NHS Mental Health Trust the designated clinician should contact the receiving team to confirm and record that follow up has been completed within 7 days. The 7 day follow up form on RIO must also be completed.

3.7.15 Transfer to prison – for service users discharged/transferred to prison the designated clinician should contact the relevant prison in-reach team to confirm and record that follow up has been completed within 7 days. The 7 day follow up form on RIO must also be completed. There should be a Section 117 / CPA meeting held prior to a service user being returned to prison, to ensure a full handover of information relating to mental and physical health, risk assessments and medication. The prison should ensure that key staff attends the meeting and that a written record of the meeting is shared between the clinical team and the prison healthcare team.

3.7.16 Leaving the country to an overseas destination – where a service user is known to be leaving the country to an overseas destination following discharge,

arrangements should be made to provide a follow up contact if this is possible prior to their known departure date.

3.7.17 Visiting foreign nationals – Where a service user is a visiting foreign national and will be leaving the country directly on discharge this will be treated as an exception and the details entered on the 7 day follow up form on RIO. Details of any provision of handover information to their receiving healthcare team should be entered in the progress notes.

3.7.18 Treated out of area – Where a service user has been treated out of area and is discharged to the care of BSMHFT the trust will be responsible for providing a follow up as laid out in this policy.

3.7.19 Discharge following leave – Where the decision to discharge is taken following a period of leave and without the service user returning to hospital, the community team manager will be responsible for informing the in-patient ward of the discharge date and destination. Formal follow up will still be required and the community team manager must ensure that a designated qualified mental health professional is identified to undertake follow up within 3 days of the actual date of discharge which will be different from the date leave commenced.

3.8 Discharge from BSMHFT should be informed by a pre discharge risk assessment

The treating team should ensure that a copy of the service users discharge prescription is received by the GP within a timeframe that ensures continued prescribing of medication. In the majority of cases the GP should expect to receive information within 7 working days Information for the GP and service user should include:

- Summary of treatment
- Treatment/medication on discharge and recommendations
- Signs of relapse or recurrence (including known triggers) and recommended actions, where appropriate. This should be written so that the GP is aware of when to escalate back to secondary mental health services.
- Information about local services
- How to contact and access the service again if the need arises

For those patients that are discharged due to non-engagement then staff must follow the procedure set out in the Referrals and Appointments Policy.

3.9 Areas for special consideration 3.9.1

Unplanned transfers/moves

Where an unplanned move takes place, the original care coordinator must continue working with the service user until a clinical handover has been effected. Where risk concerns exist or where 117 aftercare or a Community Treatment Order is in place the care coordinator will contact the next of kin and inform the GP and where appropriate, discuss with the police.

Where the move is to such a distance as to make continued working impractical all information must be immediately sent to the appropriate Mental Health service to ensure a clinical handover at the earliest opportunity. The original care coordinator must continue to follow-up until the handover has taken place.

3.9.2 Discharge due to non-attendance – Trust staff must follow their local operational protocols and the Referrals and Appointments Policy (C11). The reason for referral, details of what attempts have been made to engage the service user and clinical risk must be considered and discussed with all professionals

involved in their care. Consideration should be given to alternative methods in order to try and engage the service user, where appropriate. Justifications for discharge should be based on clinical factors, such as low clinical risk, rather than on the number of DNAs / Cancellations. All decisions should be clearly and fully documented in the service users Rio record with an explanation of the decision making process.

3.9.3 Rapid Re-Access

Please refer to the Integrated Community Mental Health Team Operational Standards for the process regarding rapid re-access for eligible service users.

4 RESPONSIBILITES:

This should summarise defined responsibilities relevant to the policy.

Post(s)	Responsibilities	Ref
All Staff	Responsible for adhering to the procedures as laid out in this policy including ensuring that all information is recorded fully, accurately and on time in line with data quality policy requirements and trust data entry timeliness standards and for reporting any failures to comply.	
Matrons/Team Leaders/Ward Managers	Will ensure all staff in their areas are aware of and understand the policy and that it is implemented into practice within their areas of responsibility Will investigate breaches and ensure remedial actions are taken Will ensure that data quality checks are undertaken	
Service, Clinical and Corporate Directors	Will ensure this policy is disseminated and implemented within their areas of responsibility	
Policy Lead	Ensure the policy is kept up to date - Coordination of monitoring and assurance	
Executive Director	Executive Director of Operations has overall responsibility for ensuring compliance with and timely review of this policy	

5 DEVELOPMENT AND CONSULTATION PROCESS:

An outline of who has been involved in developing the policy and procedure including Trust forums and service user and carer groups.

Consultation summary

Date policy issued for consultation	6th August 2018
Number of versions produced for consultation	1
Committees / meetings where policy formally discussed	**Date(s)**
Clinical Quality Committee	

Where received	Summary of feedback	Actions / Response

6 REFERENCE DOCUMENTS:

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: NCISH. Annual Report (2017)

7 BIBLIOGRAPHY:

- Refocusing the Care Programme Approach (DOH March 2008)
- Suicide prevention strategy
- NICE Quality Standard (QS159): Transition between inpatient mental health settings and community or care home setting

8 GLOSSARY

Definition of terms
For the purpose of clarity the following definitions will apply

Transition and transfer	Any move of a service user from one part of the service to another including inter ward or team transfer.
Discharge	Discharge is the transfer back to primary care without further follow up by secondary mental health services, or transfer to another trust. *(NHSLA- the process whereby a patient is discharged from an NHS trust providing acute, community or mental health and learning disability services and independent sector providers of NHS care.)* The formal release of a patient at the conclusion of a hospital stay or series of treatments. This may incorporate the transfer of care to another provider.

3 Day Follow Up	A suicide reduction target comprising of a face to face contact (except in exceptional circumstances) within 3 days of discharge from an inpatient setting by a qualified mental health professional.
Admission	Admission is the act of transferring care from community or another environment to a Trust in-patient service.
Crisis	An unstable period, a crucial stage or turning point, a sudden change for better or worse, of extreme change or increase in

Page

	clinical risk.
Accepted (into service)	When a service user has been assessed and offered a follow up appointment or referred to another team within BSMHFT.
Clinical Handover	Transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person / family / legal guardian or professional group on a temporary or permanent basis.

9 AUDIT AND ASSURANCE consisting of:

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements
3.1 That all operational protocols, where there is direct patient contact, to include standards as set out in this policy	Author of Operational Protocols / Standards	Operational Protocol / Standard	Dictated by protocol / standards review date	Clinical Governance Committees
3.2 Update of core documentation at point of transfer	CPA Team	Insight	6 monthly	Clinical Governance Committees
Patients are being seen within 3 days of discharge from an inpatient setting	Information Services	Electronic report	Weekly Monthly Quarterly	Operational Performance Meeting Trust Board NHS Improvement
3.8 Discharge notification / summary is sent within set timeframes		Local Audit	6 monthly	Clinical Governance Committee

Title of Policy	**Manual Handling Policy**		
Person Completing this policy	**XXXX**	**Role or title**	**Head of Health and Safety and Clinical Governance**
Division	**Corporate**	**Service Area**	**Governance**
Date Started	**November 2018**	**Date completed**	**January 2019**

Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.

The purpose of the policy is to make staff aware of the legal requirements of the Manual Handling Operations regulations and what they need to do in the organisation to ensure compliance.

Who will benefit from the policy?

All staff who have responsibilities under the above regulations. All patients but especially those with complex physical health needs.

Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*	*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*

Please click in the relevant impact box or leave blank if you feel there is no particular impact.

Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age				
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability				

10 APPENDICES:

Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender				
This can include male and female or someone who has completed t Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				ıe gender reassignment process from one sex to another
Marriage or Civil Partnerships				
People who are in a Civil Partnerships must be treated equally to ma Are the documents and information provided for your service reflecti				rried couples on a wide range of legal matters ıg the appropriate terminology for marriage and civil par tnerships?
Pregnancy or Maternity				
This includes women having a baby and women just after they have Does your service accommodate the needs of expectant and post - Can your service treat staff and patients with dignity and respect rela				had a baby natal mothers both as staff and service users? tion in to pregnancy and maternity?
Race or Ethnicity				
Including Gypsy or Roma people, Irish people, those of mixed herita What training does staff have to respond to the cultural needs of diff What arrangements are in place to communicate with people who d				ge, asylum seekers and refugees erent ethnic groups? not have English as a first language?
Religion or Belief				
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service deliver When organising events – Do you take necessary steps to make sur				y area? e that spiritual requirements are met?

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
N/A
How will any impact or planned actions be monitored and reviewed?
N/A
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.