



Transfer of Care - Transition Between Services

Inmind Reference:	CLN15
Category:	Clinical Policy
Version Number:	V2.0
Reviewed on:	January 2019
Next review date:	January 2021
Lead Officer:	Director of Nursing
Equality Impact Assessment completed:	Yes

Applicable Legislation/Regulations:

Codes of Practice:

Purpose:

Good Practice in the Transfer of Service User Care & Support between Providers and Local Authority Areas.

Version Control Table

Date Ratified	Version Number	Status
October 2016	V1.0	Closed
January 2019	V2.0	Live

Date	Key Revision
January 2019	Removed CC43 - Discharge of Service Users Policy (now incorporated in this). Ratified and put onto new template.

Please check to ensure this is the most current electronic copy of this document as it is updated and published in electronic format only (hard copies may become out of date).

Equality Impact Assessment for this policy

Protected Characteristic (domain)	Area of conflict	Resolution
Age	Nil	N/A
Disability	Nil	N/A
Gender Reassignment	Nil	N/A
Pregnancy & Maternity	Nil	N/A
Race	Nil	N/A
Religion or Belief	Nil	N/A
Sex	Nil	N/A
Sexual Orientation	Nil	N/A
Marriage and Civil Partnership	Nil	N/A

All relevant persons are required to comply with this policy and must demonstrate sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation. If you feel you are disadvantaged by this policy, please contact the Registered Manager and the service will actively respond to the enquiry.

1. Introduction

It is the responsibility of health and social care agencies to collaborate effectively to ensure continuity, care and support to people with mental health needs when they move from one area to another.

Assessment, care planning and support are provided by Local Authority and healthcare providers working in partnership within the framework of national guidance Refocusing the CPA: DH 2008, including the Care Programme Approach (CPA) to ensure a robust systematic framework for the care and treatment of people with mental health needs.

Whilst the detail of local policies may differ, the core principles are the same. A key objective of the CPA is to ensure individuals in need of care have smooth transitions between different services. Where service users move from one place to another, there is the potential for interruption in the continuity of care and treatment. This has been highlighted in several Inquiries.

This protocol reflects the principles of Refocusing the CPA. It is designed to support good practice and legal requirements in transferring service user care and support between different NHS Trust areas,

but reference must always be made to current local and national policy, legislation and practice in these areas.

Terminology: In this protocol 'transferring' (team/Trust/service/etc.) refers to the team/etc. for the area the service user is leaving, and 'receiving' (team/etc.) refers to the team/etc. for the area the service user is moving to.

Although the term CPA will be used throughout, the principles and process should be used for all service users accessing secondary mental health care, including those not on CPA.

The officer responsible for leading work on the CPA in each Service (or their equivalent) and/or the officer responsible for overseeing contracts, can provide advice on local arrangements. This may involve, for example, providing advice about points of contact in other mental health services and advising on decision making if the service users transfer is problematic.

2. Planning Moves

Roles: Care Coordinators/Lead Professionals are responsible for coordinating individual transfers until care is accepted by another team/service and handover has taken place. Team/Service managers, and where necessary, senior managers are responsible for facilitating transfer processes and consulting with their counterparts to ensure transfers are timely, consistent and well managed.

Team/Service Responsibility:

Arrangements should always make it clear which team or service has lead responsibility for providing care and support. The transferring team maintains responsibility for providing care and services until the agreed transfer date. Necessary services or treatment must not be refused or delayed because of doubts about who should be providing them. If there are any delays in the process, or if distance or other factors mean it is not practicable for the existing team to continue providing services, the two teams should liaise to agree interim or transitional arrangements, involving team managers, service directors and/or other senior managers if necessary.

The transferring team/lead professional is responsible for identifying the appropriate service for the new area and contacting them to advise them of the move and the service user's currently assessed need.

If a service user is moving from one area to another and the destination address and date/approximate date of the move are known in advance transfer details should be considered at the earliest possible opportunity so that transfer can be planned properly.

The originating Care Coordinator should contact the services in the new area and transfer relevant information. Care Coordinators / Lead professionals should follow local Information Governance Policies or guidelines in relation to this transfer.

Ideally the plan to transfer responsibility for the care of a service user should take place through a CPA review involving the service user (and any carers involved, unless the service user objects). If this is not possible e.g. the service user moves at short notice, the arrangements for support in the interim must be agreed by both the transferring and receiving service with an agreed transfer date as soon as possible.

Representatives from the receiving team should be invited to attend the review meeting, or to contribute by other means.

Representatives could include:

- The proposed new Care Coordinator
- The Responsible Clinician.
- Social Services staff, where care management responsibility issues are involved, Section 117 or Section 25 of the Mental Health Act, other statutory issues such as Guardianship, Community Treatment Orders (CTO), Sex Offender registration or Public Protection, or other risk, safeguarding or statutory issues.

This Review must identify:

- any risks associated with the move and plans to manage them
- any decisions the service user has been assessed as lacking capacity to make, with details of a formal capacity assessment and best interest determination
- plans for agreed transfer of care (or plans for how transfer will be agreed, if this is not yet finalised)
- any legal arrangements which are being transferred or terminated (for example Guardianship, Community Treatment Orders (CTO), Sex Offender registration, Public Protection Panel registration, probation arrangements, court orders, child and/or adult safeguarding arrangements)
- any s.117 aftercare arrangements and plans for managing them once the service user has moved.

The Transfer Care Plan should:

- Identify a date for completion of handover to the new Care Team
- Set out that the receiving team / service has identified / will identify a new Care Co-ordinator who accepts responsibility for them, with an agreed handover date ☐ Identify appropriate services that will have been set up with the receiving team / service to meet the needs before the transfer takes place, where possible.
- Include a contingency / risk management plan
- Identify how the service user will be supported to register with a GP in the new area as soon as possible
- Include contingency plans should the service user return to the originating team during the agreed handover period. In this case, ideally, the original Care Co-ordinator / lead professional and team should resume responsibility for patient care, where possible, based on level of need, risk, availability etc.

If the service user's capacity to decide about future care, at the point of transfer, is an issue, then the CPA review must include a capacity assessment and best interest determination. The transferring Care Coordinator should ensure that complete and accurate records are made of the discussions surrounding the move.

Informing the Service User and Others

The transferring Care Coordinator/Lead Professional should ensure that the service user, carer (where appropriate) and the GP are informed of the date of transfer and of the contact details of the new Care Coordinator / lead professional. This information should be included within the care plan, and all involved should receive a copy.

3. Service User & Carer Involvement, Consent, Confidentiality:

Service users (and any carers involved, unless the service user objects) must normally be involved in any decisions to transfer care and must be kept informed of progress and actions taken.

If the service user is unwilling or unable to participate in decision making or refuses consent, information should only be provided to the receiving area service if:

- The service user has been assessed as lacking capacity to make the decision/s required and information sharing/transfer of care has been assessed as being in their best interests
- If it is justified by the needs/risks involved. Any information shared must be reasonable, necessary and proportionate and comply with legislation and good practice guidelines. The rationale for sharing information must be clearly recorded in local clinical records, and where needed advice should be sought before disclosure.

4. Transfer Dates:

Dates for transfer of care should be agreed as soon as possible and whenever practicable take place with effect from the service user's move date. Where this is not practicable it should be within four weeks of the transfer request.

5. Transfer Information/Documents:

Enough details must be provided in case the receiving team needs to respond to an emergency situation, particularly if a service user is at risk, is under 18 or is caring for children or young people, or there are adults in the household who may be at risk. Transfer documents must include up to date:

- Assessment of need, including risk assessment, clearly identifying the nature, complexity and content of risk.
- Legal status.
- Care Plan (CPA or Lead Professional), including Crisis and Contingency plans, risk management plan where this exists, including indicators of relapse if identified.
- Additional documents may also be provided depending on the circumstances of the case.

6. Placements:

This protocol applies equally in situations where service users move of their own volition, and where they are placed in residential or supported accommodation out of area. If service users are placed out of area, then care and support under CPA arrangements will usually be transferred. The placing local authority retains responsibility for managing funding for the placement, monitoring and reviewing the placement, and arranging subsequent placements if they are necessary (in cooperation with local services by agreement). (Ordinary Residence: Guidance on the identification of the ordinary residence of people in need of community care services, England) (DH 2013)

7. Section 117 Aftercare:

Service users are eligible for aftercare under s.117 of the Mental Health Act (MHA) if they have been detained for treatment under that Act and assessed as needing aftercare when they are on leave from or discharged from detention in hospital. s.117 aftercare provision is the joint duty of the responsible Clinical Commissioning Group (CCG) and the responsible local authority, which normally commission NHS Trusts to arrange and monitor that provision on their behalf, monitor continuing need for aftercare, and recommend discharge from aftercare when appropriate.

Arrangements must be clarified as part of any transfer process and must be specified clearly in transfer documents. Local arrangements for funding s.117 aftercare and apportioning costs between the CCG and local authority vary. Legal advice on residence, funding and/or section 117 responsibilities may be needed in complex cases.

Responsible CCG: The CCG responsible for providing s117 aftercare is:

- Where a patient is registered on the list of NHS patients of a GP practice, the CCG of which the GP practice is a member
- Where a patient is not registered with a GP practice, the CCG in whose geographic area the patient is 'usually resident' (based on their actual address or location, or the service user's perception of their address/location)
- If a patient who is resident in one area (CCG A) is discharged to another area (CCG B), it is then the responsibility of the CCG in the area where the patient moves (CCG B) to pay for their aftercare under section 117 of the Act as agreed with the appropriate local social services authority (Who Pays? Determining responsibility for payments to providers (NHS England: 2013))

Responsible Local Authority: The local authority responsible for providing s117 aftercare is:

- The local authority for the area in which the person was resident before being detained in hospital ☐ Responsibility normally remains with that local authority if they subsequently become resident in another area ☐ If the service user is then detained again under a section of the MHA which makes them eligible for s117 aftercare, then the responsible local authority is the one for the area they are resident at the point of the new detention (Ordinary Residence: Guidance on the identification of the ordinary residence of people in need of community care services, England) (DH 2013)

9. Unplanned Move

If the move is not known in advance, or is only discovered after it has taken place, the transferring team/lead professional must notify the receiving team/service as soon as practicable. The arrangements for support in the interim must be agreed by both the transferring and receiving service with an agreed transfer as soon as possible.

Where this move is local, and the transferring team is aware of this, it should continue working with that patient (if this is possible within service resources) until formal handover arrangements described above, can take place.

Where it would be impracticable for the transferring team to do this. The Care Coordinator must write to the receiving team/service setting out the reasons for transfer, highlighting any urgent information and enclosing transfer documents (listed at):

- The receiving team must review the transfer information to identify whether the service user will be supported under CPA or non-CPA arrangements (it may be appropriate to support the service user on CPA with a view to reviewing the continuing need for this once the service user is established in the new location)
- The receiving team must identify a new Care Coordinator (or Lead Professional) who must contact the transferring Care Coordinator to agree a formal transfer date and make transfer arrangements – which may involve a formal transfer meeting
- Service users and any carers should be consulted about arrangements for transfer CPA meetings as for any other meeting
- The transferring and receiving team should liaise to clarify and agree any issues around continuity of service provision, s117 aftercare arrangements or funding before the transfer date

In the interim, the receiving district should contact the service user to ensure continuity of care as a clinical priority.

The complete formal handover should be as soon as possible and at the latest within 1 calendar month from time of service users known change of address.

10. Service Users who go missing from Services

Where a client is reported to have gone missing from services there is a duty of care to make all reasonable efforts to locate them to negotiate arrangements for their care and treatment. Actions to achieve this should be clearly recorded.

The Care Coordinator / Lead professional should contact other members of the care team, including any Carers and relatives where appropriate, and other known associates to try to locate the client, in order to offer support and monitor their wellbeing.

The Care Coordinator / Lead professional should initiate a review as soon as possible to determine action based on an assessment of the risk caused by the person disengaging. This should be clearly recorded.

It will be necessary to consider the patient's last known mental state, vulnerability, previous history, potential and actual risk to self or others, the likelihood that the person has left the local area, and the other available support networks, in order to plan intervention.

Where risk to or vulnerability of the service user, or risk to others is identified, appropriate decisions should be made, and recorded actions taken. Where indicated, follow local policies relating to missing service users, and consider contacting other trusts, the police, or CCA

missing persons process as appropriate. Refer to the Caldicott Guardian/information governance manager for advice as appropriate.

Refer to the CPA lead officer, or equivalent, for advice on local arrangements. This may involve, for example, assisting in decision making if the case is problematic, providing advice about points of contact in other mental health services, and processing Missing Persons Alerts.

11. Transfer to or from Prisons

Communication of information regarding prisoners on CPA should be made in line with these guidelines.

12. Review of arrangements

It is proposed that these guidelines are formally reviewed on a three-yearly basis through the national Care Coordination Association.