Sheffield Health and Social Care NHS
NHS Foundation Trust

Policy:

Transfer of Clinical Care Duties

[Second Extension to Review Date agreed on 31/3/2020]

Executive or Associate Director lead	Executive Director of Nursing, Professions & Care Standards
Policy author/ lead	Deputy Chief Nurse / Interim Clinical Director Acute & Inpatient Care
Feedback on implementation to	Deputy Chief Nurse/ Interim Clinical Director Acute & Inpatient Care Care

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

Keywords	Transfer, service users

Policy Version and advice on document history, availability and storage
Second extension to review date agreed on 31/03/2020.

This is version 4 of this policy and replaces the previous version 3 (ratified January 2009). This version was reviewed and updated as part of an on-going policy document review process.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version (V3) should be destroyed and if a hard copy is required, it should be replaced with this version.

Contents

1. Introduction

Sheffield Health & Social Care NHS Foundation Trust (SHSCFT) provides mental health, learning disability, substance misuse and primary care services. This policy applies to the transfer of all service users of the Trust. All staff must ensure & achieve effective transfer of informal and detained service users through good communication between professionals, whether verbal or written. The duties of staff involved in the process should be clear to ensure all risks relating to the transfer of a service user are identified and discussed so that appropriate risk management plans can be put into place and to ensure that appropriate documentation is completed throughout the transfer process.

Section 19 of the Mental Health Act 1983 regulates the transfer between trusts and hospitals of those patients who are detained for assessment or treatment, as well as the transfer between detention and Guardianship.

Section 19A regulates the assignment of responsibility of patients in receipt of a Community Treatment Order (CTO) from one trust to another. Patients subject to restriction orders cannot be transferred without the permission of the Ministry of Justice.

Patients detained under the following sections cannot be transferred under the provisions of section 19 as they are only either short term holding powers, remands to hospital or interim order from court:

- Section 5(4) nurse's holding power;
- Section 5(2) doctor's or approved clinician's holding power;
- Section 35 remand to hospital for assessment;
- Section 36 remand to hospital for treatment;
- Section 38 interim hospital order.

Deprivation of Liberty Safeguards (DOLS)

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

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

The DOLS legislation contains detailed requirements about when and how deprivation of liberty may be authorised. It provides for an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty. If applicable complete a DOLS authorisation form (see Deprivation of Liberty Safeguards (DOLS) Policy).

2. Scope

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

3. Definitions

Definition Section 19(1)
a) Is the formal transfer of a detained patient to another hospital under the care of a different hospital Trust or the formal transfer from hospital to Guardianship?
b) Is the formal transfer of a patient under Guardianship to a different social services authority or person or transfer to hospital under section 3. 2.2 Section 19(3) Is the removal of a detained patient between hospitals within the same Trust.

Section 19(3) Is the removal of a detained patient between hospitals within the same Trust.

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

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

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

Responsible Clinician - The Responsible Clinician is the Approved Clinician who has overall responsibility for the case of a service user subject to compulsion under the Act.
(Mental Health Act 1983 / Mental Health Act Code of Practice 2015.

4. Purpose

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

5. Duties

Medical Staff

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

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

6. Process

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

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

b. These plans will include a comprehensive assessment of the service user's individual needs, the development of a risk management plan (DRAM) to address identified risks and a clear indication of the level and nature of observation required and how this would be provided.

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

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

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

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

g. Where a service user is transferred to an Acute Care Trust, overall responsibility for their care will be the responsibility of the destination hospital. If the service user is subject to compulsion under the Mental Health Act 1983 the duties of the Responsible Clinician can only be transferred to an appropriate Approved Clinician. See **Appendix I.**

***It is acknowledged that there is a complicated interface between the MCA and the MHA if the person lacks capacity, may involve both s17 leave and DoL in the acute hospital. Is it envisaged here that that the patient is being transferred under s17 to the general hospital for treatment? If so, the RC would not change in those circumstances; if the patient goes to another hospital for MH care, e.g. trial leave, the day-to-day Responsible Consultant functions could be delegated to the Acute care Consultant at the destination hospital.**

6.2 Standards for Transfer

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

a. The Multi-Disciplinary Team
b. The service user/ Carers or relatives as appropriate.
c. The relevant Community Services or Teams involved, including the Care Coordinator, where one has been identified.
d. GP / Primary Care Mental Health services.
e. Other relevant agencies, e.g. Probation, Housing

6.2.1 The transfer plan should:

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

- Be consistent with and developed within the Single Assessment Process (SAP), the Care Programme Approach (CPA), and / or other relevant processes and procedures for ensuring effective multidisciplinary, multi-agency, or across-team working.
- Be developed with the involvement of advocacy services where service users request their help or lack capacity to engage in the process or decision-making.
- Be provided in a written or other form acceptable and accessible to the service user and their carers.
- Be considered and commence development as soon as transferred care begins.
- Consider Statutory (Mental Health Act) provisions, e.g. Section 117.

6.2.2 The transfer plan should cover arrangements for:

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

The transfer plan should clearly identify the roles and responsibilities of people involved for each part of the plan. The plan should identify a named co-ordinator of these transfer arrangements**.**

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

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

- Arrangements for the next appointment or contact with services, information about medication, and information necessary to enable the service user or carers to access the mental health services.
- Information for the services user and their carers or relatives to access help and support in the event of crises.

6.4 Unplanned Transfer and Transfer outside normal hours

There will be occasions where service users need to be transferred and proper care plans cannot be developed or put into place.

In these situations the following must be considered:

- Appropriate arrangements for medication.

- Arrangements for communicating as soon as possible with relatives or carers, community services or teams or outside agencies such as Police or accommodation providers who need to be informed.

- Multi-Disciplinary review at the earliest opportunity to consider further plans.

- The provision of written information for the client and their carers or relatives if appropriate, regarding arrangements for care.

6.5 Transfer Records

All care details / incidents related to transfers must be recorded in the service users electronic (insight, system one / paper) notes.

6.6 Disputes

Transfers should not take place until there are clearly agreed arrangements as above which address identified risk. The Resolution of Clinical Disputes Guidance should be consulted and used where there are clear professional disagreements about transfer arrangements.

All teams should raise any concerns or problems relating to the implementation of this policy either generally or in relation to specific service users with their Service or Clinical Directors.

7. Dissemination, storage and archiving (Control)

The issue of this policy will be communicated to all staff via the Communications Digest. Local managers are responsible for implementing this policy within their own teams.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version (V3) should be destroyed and if a hard copy is required, it should be replaced with this version.

8. Training and other resource implications

All teams providing care for service users should be familiar with the standards within this policy. Training programmes for staff in these teams should refer to these standards.

Specific training is not required, but the standards should be referred to in other relevant training, e.g. Risk Assessment and Management (DRAM), Care Programme Approach.

9. Audit, monitoring and review

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

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. The policy review date is October 2019.

10. Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	Within 5 working days of ratification	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Director of Corporate Governance	Within 5 working days of issue	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of issue	

11. Links to other policies, standards and legislation (associated documents)

- Observation Policy
- Discharge Policy
- Risk Management Policy
- Resolution of Clinical Disputes Guidance
- Care Programme Approach (CPA) Policies and Procedures
- Acute Care Pathway and Scheduled care Pathway
- Records Management Policy
- Infection Control Policy
- Mental Capacity Act guidance
- Mental Health Act 1883
- Physical Health Policy.

12. Contact details

Title	***Name***	***Phone***	***Email***
	Deputy Chief Nurse		Giz.sangha@shsc,nhs.uk

13. References

- The Deprivation of Liberty Safeguards (DOLS) (amendment to the Mental Capacity Act 2005).
- Mental Health Act 2007
- Department of Health (2008) Mental Health Act 1983 Code of Practice (Revised 2015).

Appendix A – Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
4.0	Review / ratification / issue	November 2016	Policy revised and updated for new policy template.

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
4.0	November 2016	November 2016 via Communications Digest	N/A minimal changes.

Appendix C – Stage One Equality Impact Assessment Form

Quality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, service users or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, service users or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	**No**	**No**	**No**
DISABILITY	**No**	**No**	**No**
GENDER REASSIGNMENT	**No**	**No**	**No**
PREGNANCY AND MATERNITY	**No**	**No**	**No**
RACE	**No**	**No**	**No**
RELIGION OR BELIEF	**No**	**No**	**No**
SEX	**No**	**No**	**No**
SEXUAL ORIENTATION	**No**	**No**	**No**

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)

Please delete as appropriate:

Policy Amended

Impact Assessment Completed by (insert name and date) Giz Sangha, 10th November 2016

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(Relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

X **Yes. No further action needed.**

2. On completion of flow diagram – is further action needed?

☐ **No, no further action needed.**

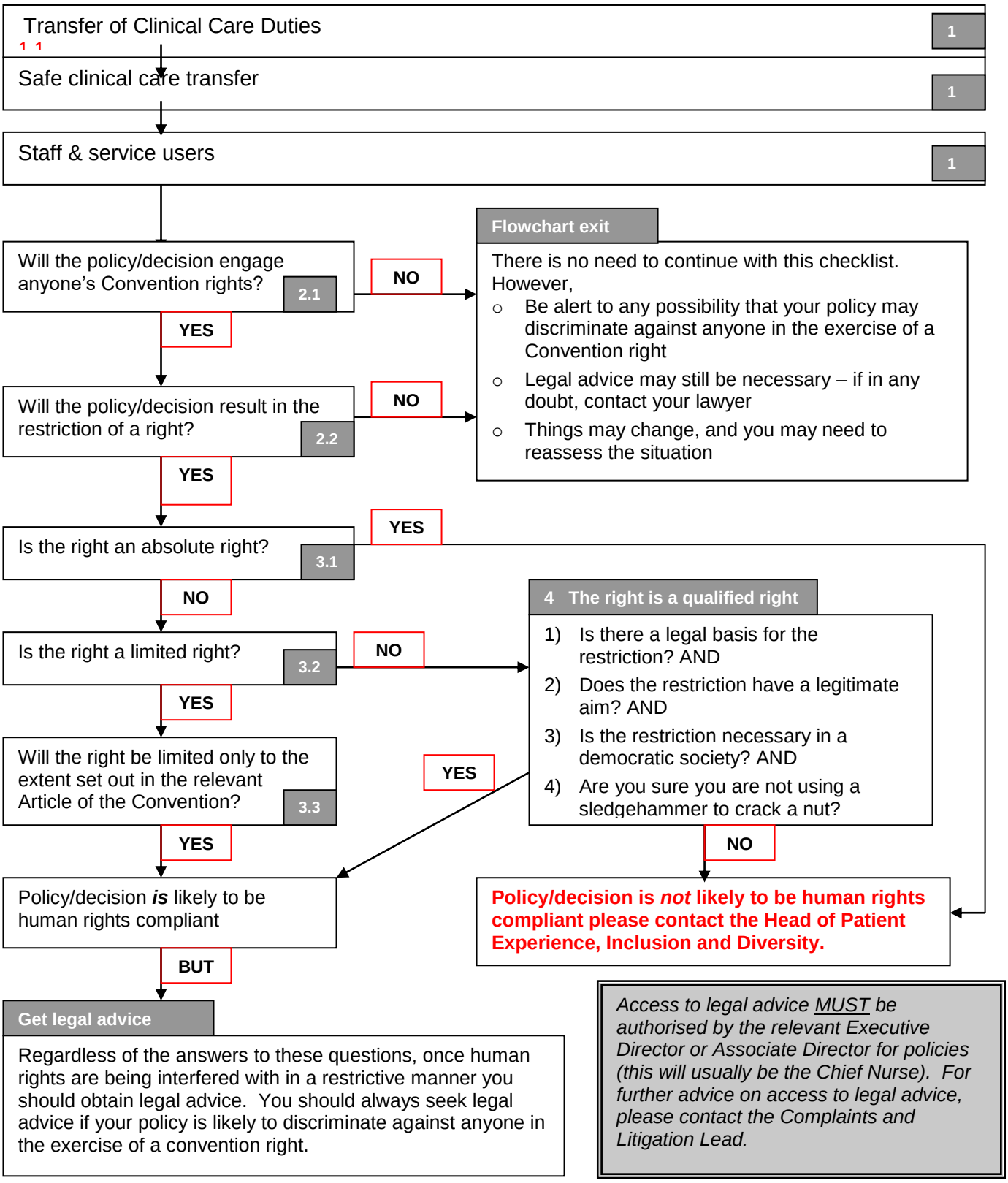
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix E – Development, Consultation and Verification

Policy updated as part of the on-going policy development and revision process. This is version 4 of this policy and replaces the previous version 3 (ratified January 2009). This is a working document with a review date of March 2017.

The policy was verified by the Deputy Chair of the Service Users Safety Group on 14 November 2016.

Appendix F –Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy Document Template which can be downloaded on the intranet.

1. Cover sheet ✓

All policies must have a cover sheet which includes:

- The Trust name and logo ✓
- The title of the policy (in large font size as detailed in the template) ✓
- Executive or Associate Director lead for the policy ✓
- The policy author and lead ✓
- The implementation lead (to receive feedback on the implementation) ✓
- Date of initial draft policy ✓
- Date of consultation ✓
- Date of verification ✓
- Date of ratification ✓
- Date of issue ✓
- Ratifying body ✓
- Date for review ✓
- Target audience ✓
- Document type ✓
- Document status ✓
- Keywords ✓
- Policy version and advice on availability and storage ✓

2. Contents page ✓

3. Flowchart N/A

4. Introduction ✓

5. Scope ✓

6. Definitions ✓

7. Purpose ✓

8. Duties ✓

9. Process ✓

10. Dissemination, storage and archiving (control) ✓

11. Training and other resource implications ✓

12. Audit, monitoring and review ✓

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

13. Implementation plan ✓

14. Links to other policies (associated documents) ✓

15. Contact details ✓

16. References ✓

17. Version control and amendment log (Appendix A) ✓

18. Dissemination Record (Appendix B) ✓

19. Equality Impact Assessment Form (Appendix C) ✓

20. Human Rights Act Assessment Checklist (Appendix D) ✓

21. Policy development and consultation process (Appendix E) ✓

22. Policy Checklist (Appendix F) ✓

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

Statement of Guiding Principles

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

Guiding Principles

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

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

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

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

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

Appendix H – Checklist to assist with any transfer

The transfer plan should:

a. Be person-centred and reflect the service user's choices as far as possible and be made available in a form which can be read and understood by the service user, e.g. in an appropriate language. This may be a print-out from Insight system, an audiotape, a series of pictures, etc.
b. Be consistent with and developed within the Single Assessment Process (SAP), the Care Programme Approach (CPA), and / or other relevant processes and procedures for ensuring effective multidisciplinary, multi-agency, or across-team working.
c. Be developed with the involvement of advocacy services where service users request their help or lack capacity to engage in the process or decision-making.
d. Be provided in a written or other form acceptable and accessible to the service user and their carers.
e. Be considered and commence development as soon as transferred care begins.
f. Consider Statutory (Mental Health Act) provisions, e.g. Section 117.

Checklist

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

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

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

4. Have any specialist care needs been identified?

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

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

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

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

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

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

11. Is an escort required?

    a. If the escort is a member of staff, are the care records and required medication available for them to take with the service user?

    b. If an escort is not required, has this information been communicated to the receiving team/Trust where appropriate?

    c. If an escort is not required, has it been documented in the service user notes with reasons?

d. If an escort is not required, have arrangements been made to convey necessary documents and medication?

e. If an escort is not required, has a comprehensive verbal summary of the service user needs been given to the receiving team/hospital department and subsequently a copy of the relevant transfer documentation communicated in advance of the service user?

f. Has the service user been given documentation / copy of the transfer plan

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

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

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

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

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

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

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

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

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

21. If the risk assessment undertaken by the mental health or learning disability team has not identified a risk that would require an escort to be present and the information necessary for the receiving Team to safely manage the service user on their arrival has been effectively communicated.

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

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

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

Observation levels

The observation level required to ensure that the service user's mental health or learning disability care needs are appropriately met should be identified as part of the risk assessment by the transferring clinical team. This risk assessment should be shared with and agreed by the receiving team. The SHSC Observation Policy should be used to guide this process

Details regarding the level of observation required should be included on the transfer documentation.

Unplanned Transfer and Transfer outside normal hours

There will be occasions where service users need to be transferred and proper care plans cannot be developed or put into place.

In these situations the following must be considered:

a. Appropriate arrangements for medication.

b. Arrangements for communicating as soon as possible with relatives or carers, community services or teams or outside agencies such as Police or accommodation providers who need to be informed.

c. Multi-Disciplinary review at the earliest opportunity to consider further plans.

d. The provision of written information for the client and their carers or relatives if appropriate, regarding arrangements for care.

Disputes

Transfers should not take place until there are clearly agreed arrangements as above which address identified risk. The Resolution of Clinical Disputes Guidance should be consulted and used where there are clear professional disagreements about transfer arrangements.

All teams should raise any concerns or problems relating to the implementation of this policy either generally or in relation to specific service users with their Service or Clinical Directors.

Appendix I – Transfer of Detained Service Users between Trusts

Guiding principles

1.0 General Principles relating to transfer of a service user

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

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

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

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

The care team should also refer to the Mental Capacity Act 2005 Code of Practice.
Section 5 of the Mental Capacity Act 2005 allows staff to carry out certain tasks without fear of liability (see Mental Capacity Act 2005 Code of Practice, chapter 6).

1.5 **In emergency situations** it will almost always be in the best interests of the service user to give urgent treatment without delay. An exception to this is when a member of staff is satisfied that an advance decision to refuse treatment exists. (COP sec.6.37-38, COP chapter 9 and COP chapter 7 concerning Lasting Powers of Attorney)

1.7 These plans will include a comprehensive assessment of the service user'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 and how this would be provided.

1.8 If a service user is subject to detention in hospital under the Mental Health Act 2007, any decision about their care must be made after consideration of the Guiding Principles (see Appendix D) which inform decisions but do not determine them.

The care team should also refer to advice given in the Mental Health Act 2007 Code of Practice.

1.9 Where a service user is transferred to STHFT, overall responsibility for their care will be the responsibility of STHFT.
If the service user is subject to compulsion under the Mental Health Act 2007 the duties of the Responsible Clinician can only be transferred to an appropriate Approved Clinician.

2.0 Unplanned Transfer and Transfer outside normal hours

There will be occasions where service users need to be transferred and proper care plans cannot be developed or put into place.

In these situations the following must be considered:

a. Appropriate arrangements for medication.

b. Arrangements for communicating as soon as possible with relatives or carers, community services or teams or outside agencies such as Police or accommodation providers who need to be informed.

c. Multi-Disciplinary review at the earliest opportunity to consider further plans.

d. The provision of written information for the client and their carers or relatives if appropriate, regarding arrangements for care.

3.0 Disputes

Transfers should not take place until there are clearly agreed arrangements as above which address identified risk. The Resolution of Clinical Disputes Guidance should be consulted and used where there are clear professional disagreements about transfer arrangements.

All teams should raise any concerns or problems relating to the implementation of this policy either generally or in relation to specific service users with their Service or Clinical Directors.