Policy:

NP 032 - Section 19: Procedure for the Transfer of Patients Detained under the Mental Health Act 1983 to another Hospital/Unit

Executive Director Lead	Executive Director of Nursing and Professions
Policy Owner	Deputy Chief Nurse
Policy Author	Deputy Chief Nurse

Document Type	Policy
Document Version Number	Version 1
Date of Ratification	22/06/2020
Ratified By	Quality Assurance Committee
Date of Issue	01/07/2020
Date For Review	30/06/2023

Summary of policy
This policy is to provide a framework for all staff to ensure the safe and efficient transfer for all patients detained under the MHA 1983. The policy aims to ensure that all the transfer of detained patients and to meet the legal requirements under Section 19 of MHA 1983.

Target audience	Clinicians, Medics

Keywords	Detained, Section 19, Mental Health Act 1983, transfer

Storage

Version 1 of this policy is stored and available through the SHSC intranet/internet This version of the policy supersedes the previous version (Vx Insert month date). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
0.1	New draft policy created	04/2020	New policy commissioned by EDG on approval of a Case for Need.
1.0	Approval and issue	05/2020	Amendments made during consultation, prior to ratification.

Contents

1 Introduction

Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) provide mental health, learning disability, substance misuse and primary care services. This policy applies to the transfers of detained patients under the Mental Health Act 1983 (MHA) within our Trust. All staff must ensure and achieve effective transfer through good communication between professionals, family and carers, whether verbal or written. The duties of the staff involved in the process should identify all risks relating to the transfer of the patient and discussed to ensure that an appropriate risk management plans can be put in place and the appropriate documentation is completed throughout the transfer process.

Section 19 of the Mental Health Act 1983 (MHA) 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' holding power;
- Section 35 remand to hospital for assessment;
- Section 36 remand to hospital for treatment;
- Section 38 interim hospital order

2 Scope

This policy applies to all service areas with our Trust and covers all staff and all patients being transferred from one service to another within our Trust or being transferred to another Trust.

3 Purpose

The purpose of this policy includes the provision of guidance to staff when transferring detained patients to ensure a safe, effective and properly managed transfer and re-iterates the key points of the MHA1983. It is essential that this policy is read in conjunction with the Mental Health Act Code of Practice 2015 as it is statutory guidance and provides detail not contained in this policy.

4 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

Patient – any service user, client or resident. Patient is the preferred terminology within the MHA 1983

Transfer – care of patient, service user, client or resident being removes between any service, team or Trust.

Discharge – refers to the end of an inpatient care spell within our Trust.

Responsible Clinician – the Responsible Clinician is the Approved Clinician who has overall responsibility for the care of a detained patient under the MHA 1983 and the Mental Health Act code of Practice 2015.

5 Detail of The Policy

This policy is to provide a framework for all staff to ensure the safe and efficient transfer for all patients detained under the MHA 1983. The policy aims to ensure that all the transfer of detained patients and to meet the legal requirements under Section 19 of MHA 1983.

6 Duties

6.1 Hospital Managers

Whilst the MHA 1983 uses the term “Hospital Managers”, in NHS Foundation Trusts the Trust themselves are defined as the “Hospital Managers”. They have certain statutory duties they must fulfil under the Act and some of these duties, including the transfer of patients detained under section 19 of the Act, can be delegated by the Hospital Managers.

6.2 Responsible Clinician

- Authorise the transfer of detained patients to other hospitals/units as necessary; and

- Liaise with the Responsible Clinician at the receiving hospital/unit about the transfer and the current /proposed treatment plan for the patient.

6.3 Medical Staff

- Must determine whether the patient is ‘medically fit’ for transfer and that the benefits of the transfer outweigh the risks.

- Agree a detailed plan for the transfer of the patient 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 patient and their carers or relatives

- The plan must be clearly documented on the Electronic Patient Record (EPR) systems, Insight, System-one and paper records.

6.4 The Senior Management Team

Will identify the duties of different staff groups within the multidisciplinary teams with respect to transfer/discharge according to the needs of individual patients. The Care Programme Approach (CPA) must apply and a collaborative care planning processes to ensure all risks are identified in the Detailed risk Assessment Module (DRAM) are taken into account to maintain safety of the patient during the transfer. This includes identifying a **named person to co-ordinate transfer arrangements for the patient.**
(Appendices C and D)

6.5 Independent Mental Health Advocates

The role of the IMHA is to help qualifying patients (those detained under the MHA, conditionally discharged, subject to guardianship or a Community Treatment Order but **not** those detained under Section 4, Section 5, Section 135 or 136) understand the legal provision to which they are subject under the MHA 1983 and the rights and safeguards to which they are entitled

6.6 Mental Health Act Office

The original MHA detention papers and any other statutory documentation must be provided to the receiving hospital. For transfers out of SHSC, these documents are maintained in the MHA Office. The Office must be contacted within office hours and with enough time prior to transfer so that the papers can be prepared and provided to ward before the patient's departure.

To avoid the transfer in of an unlawfully detained patient, copies of the original papers for a patient being transferred into SHSC must be obtained from the transferring hospital BEFORE the patient is transferred so that the papers can be scrutinised. The MHA needs to be made aware of any planned transfer within office hours and with enough time to request the papers electronically.

6.7 Hospital Managers

Whilst the MHA 1983 uses the term "Hospital Managers", in NHS Foundation Trusts the Trust themselves are defined as the "Hospital Managers". They have certain statutory duties they must fulfil under the Act and some of these duties, including the transfer of patients detained under section 19 of the Act, can be delegated by the Hospital Managers.

7 Procedure

7.1 Under which detaining sections can a Section 19 be used to transfer a patient?

Section 19 can only be used to transfer patients who are subject to detention under a Section 2, 3, 37, 47 of the MHA 1983, or, are on a community treatment order and subject to recall or, are subject to guardianship. For any other Section there is no power of transfer under Section 19.

It must also be noted that for patients detained under a 37/41 or 47/49, a transfer under Section 19 can only take place with prior approval from the Home Secretary and with a transfer direction issued by the Ministry of Justice. In these circumstances staff should refer to the Ministry of Justice Guidance for Transfers between Hospitals in England and Wales.

7.2 When should section 19 be used?

Any detained patient who is transferred to a Hospital/Unit in another Trust (i.e. one which comes under the authority of different Hospital Managers) must do so under the provisions of section 19.
Section 19 can also be used to transfer a patient to a Nursing Home which is registered to accept patients who are detained under the MHA 1983.

7.3 Action To Take When Transferring Under Section 19

- The patient and their nearest relative/carer/friend (subject to the patient's consent) are to be involved in any discussions about the proposed transfer.

- Patients are to be reminded that they can have support from the Independent Mental Health Advocacy services.

- The patient's Responsible Clinician must refer them to a Responsible Clinician at the receiving Hospital/Unit.

- The receiving Hospital/Unit must agree to the acceptance and subsequent transfer of the patient.

- In the event of a patient requiring transfer to Scotland, Northern Ireland or the Channel Isles, staff should seek advice from the Mental Health Act Office.

- In the case of patients who are subject to a restriction order e.g. Section 37/41 or 47/49, the Responsible Clinician must obtain authority to transfer from the Secretary of State. This authority is requested via the Ministry of Justice. Without this authority no transfer can take place. Refer to the Ministry of Justice Guidance on Transfers between Hospitals in England and Wales.

NB: This is also the case when transferring restricted patients between different SHSC sites.

7.4 Action Once The Patient Has Been Accepted For Transfer Out Of SHSC

- Wherever possible, any such transfer should be planned well in advance.

- The following people must be notified and given details of why, to where and when the patient is to be transferred (if not already aware):

  - The patient;
  - The patient's nearest relative/carer/friend (if the patient consents);
  - The patient's Care Co-ordinator; and
  - The Mental Health Act Office so the papers can be scrutinised for lawfulness prior to transfer

- A risk assessment must be undertaken in relation to the transfer and a care plan completed. These should detail:

  - What transport is to be used for the transfer?
  - How many staff will be needed to undertake the safe transfer of the patient;
  - What training the staff have had in the control of violence and aggression;
  - The need for at least one staff member to be of the same sex as the patient;
  - That one of the staff must be a qualified nurse as they will be responsible for handing over the patient at the receiving hospital;
  - The estimated length of the journey and the need for comfort breaks;
  - Any specific risk issues relating to the patient; and
  - Administration of any medication due whilst travelling.

7.5 Information For The Receiving Hospital

- As much information about the patient as possible should be provided prior to transfer and this can either be done by letter or secure email (dependent on time constraints); and

- They must also be notified of the expected time of arrival for the patient

7.6 On The Day Of Transfer

- The patient's belongings must be packed in a suitable manner and an inventory made.

- The original detention papers must be obtained from the Mental Health Act Office and these must accompany the patient (copies must be retained for our records) ideally this should occur prior to the day of transfer.

- A Form H4 (Section 19) (Form H4 Regulation 7(2)(a) and 7(3) MHA 1983) will be provided by the Mental Health Act Office and part one of the form must be completed prior to leaving. The receiving hospital will complete the second part of the form to accept the patient into their authority. The

original Form H4 will be kept by the receiving hospital but the escorting nurse must bring back a photocopy for the Mental Health Act Office for our Trust's records. For those patients on a Restriction Order (S37/41 or S47/49) a copy of the Ministry of Justice transfer direction must also accompany the papers.

- Photocopies of the patient's medical notes, nursing notes and drug card are to be taken on the day of transfer to the receiving hospital.

- A transfer letter from the patient's Responsible Clinician should also be taken (if not already sent).

- Any medication the patient is receiving should be obtained as TTOs for an appropriate period and taken with the patient.
  Staff should refer to the Trust Policy for the Transfer of Clinical Care Duties patients for full guidance on the safe transfer of patients.

7.7 Action By Staff On Return To Their Hospital/ Unit Following Transfer

- The photocopy of the completed Form H4 is to be forwarded to the Mental Health Act Office;

- Any problems encountered during the transfer should be reported to the Senior Management Team

- If the patient has been transferred to a Non NHS Psychiatric Hospital or Private Psychiatric Hospital, then staff must follow the CPA 7 day Follow up Guidance, please refer to CPA policy

7.8 Section 19 Transfers From Outside Hospitals/Units Into The Trust

Any detained patients who are to be transferred into any of the Trust services will do so under section 19 and:

- The transfer is to be planned.

- There is to be agreement as to who their Responsible Clinician will be within the Trust. For those patients who transfer in on a Restriction Order the decision to accept the transfer should be have been agreed in advance via the Restricted Patient's Panel (refer to the Trust Policy for the acceptance of patients on a restriction order into Trust services).

- The patient must have a Form H4, part one of which will already have been completed by the previous hospital and will be received by the nurse in charge of the ward who will complete the second part of the form. For patients on restriction orders there should be a copy of the Ministry of Justice transfer direction.

- The patient will only be accepted with the properly completed original relevant detention papers. Patients with faulty papers should not be accepted.

- The Form H4 is to be completed, photocopied and a copy given to the escorting staff.

- The nurse in charge of the ward will at the earliest opportunity make arrangements for the patient to:

    - have their legal rights under section 132 explained to them; and
    - have their consent to treatment provisions reviewed by the Responsible Clinician.

7.9 Transfers to Another Hospital/Unit Within The Trust

- Detained patients who are to be transferred to another Hospital or Unit within the Trust remain under the same Hospital Managers and so **DO NOT** need an authority under section 19 to be transferred. However, staff are still to follow the guidance provided in this procedure.

- In these circumstances, if the detention papers state a specific unit/ward within the Trust, the transfer is allowed as if he had been admitted to the original hospital based on the original application. However, in order that the patient can be transferred to the new unit/ward a section 17 form will be required to authorise the leave of absence to provide authority for the journey between sites.

- In these circumstances for those patients on a Restriction Order (Section 41 or Section 49) the permission to transfer the patient will need to be sought via the Ministry of Justice in advance as the order usually prescribes the specific ward/unit where the patient is to be detained.

- The Mental Health Act Offices will liaise between localities about any planned internal Trust transfers of detained patients and arrange for the transfer of the relevant documentation between offices. (**This only applies to transfers out of the Trust)**

- The Mental Health Act Offices will notify each other of the dates for any Mental Health Tribunal or Hospital Managers Hearing which may be planned. (**This only applies to transfers out of the Trust)**
  • Whenever a detained patient is transferred to another locality within the Trust, their legal rights under section 132 should be re-read by the receiving ward/unit.

- Any patients, who are subject to consent to treatment provisions under a form T2, are to be seen by their new Responsible Clinician and a new T2 completed upon arrival at the new ward/unit.

7.10 Transfers under Section 136

There are provisions within the Mental Health Act to allow for the transfer of people subject to assessment under section 136. This means that during the 24 - hour period of assessment (or during any lawful extension) a transfer can be made to another place of safety. Staff should refer to the Trust Section 136 policy for full details.

7.11 Additional Requirements For The Transfer Of Patients Subject To Community Treatment Orders Who Are Recalled

- For any patients who are recalled from their Community Treatment Order, the Hospital Managers can authorise their transfer to another Hospital/Unit.

- The maximum 72-hour period of detention in Hospital on recall will continue to run from the original time that the patient was detained.

- Either prior to, or at the time of the transfer taking place, the receiving Hospital/Unit is to be provided with a copy of the Form CT04 which records the time of the patient's detention following recall.

- Ward staff will complete a Form CT06 which is to accompany the patient to the receiving Hospital/Unit.

8 Development, Consultation and Approval

Brenda Rhule, Deputy Chief Nurse and Tony Bainbridge, Deputy Director Nursing (Operations) were involved in the review and development of this new policy.

Consultation took place with Dr Peter Bowie, Clinical Director, Care Networks and Anne Cook, Head of Mental Health Legislation over 2-month period from March 2020 to May 2020.

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
Ward Managers and Senior Management Teams	Supervision, governance meetings, incident reports, complaint and compliments.	Ward managers and Senior Management Teams	Annually	Ward Managers and Senior Management Teams	Ward Managers and Senior Management Teams	Ward Managers and Senior Management Teams
Compliance with Section 19 legislation	Audits of forms, H4, CTO4, CTO6	Ward managers and Senior Management Team, Mental Health Act team	Monthly	Ward Managers and Senior Management Teams, Mental Health Act team.	Ward Managers and Senior Management Teams Mental Health Act Team	Mental Health Act Legislation Committee

All detained patients are transferred into the Trust under section 19 given an explanation of their legal rights under section 19 following transfer	Audits	Ward managers and Senior Management Team, Mental Health Act team	weekly	Ward managers and Senior Management Team, Mental Health Act team	Ward managers and Senior Management Team, Mental Health Act team	Mental Health Act Legislation Committee

This policy will be reviewed every three years or earlier where legislation dictates or practices change. This policy will be reviewed by 30 June 2023.

10 Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove old version	Executive Director of Nursing and Professions	July 2020	
All teams/services to be made aware of policy	Ward/Team Managers	July 2020	Team briefings

11 Dissemination, storage and archiving (Control)

The issue of this policy will be communicated to all staff via the Trust Intranet and Connect. 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.

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0	July 2020	July 2020	July 2020	N/A

12 Training and other resource implications

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

- Inpatient Consultant Psychiatrists.
- Qualified inpatient nursing staff.
- Non- Qualified inpatient staff.
- Junior Doctors.
- Mental Health Act Office staff.

Awareness will be achieved through a presentation of the updated policy at the Consultants Meeting, ward meetings, team briefing meetings and via the MHA Manager to the MHA Office staff.

13 Links to other policies, standards (associated documents)

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

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).

14 Contact details

Title	***Name***	***Phone***	***Email***
Deputy Chief Nurse	Brenda Rhule		brenda.rhule@shsc.nhs.uk
Deputy Director of Nursing (Operations)	Tony Bainbridge		anthony.bainbridge@shsc.nhs.uk

Appendix A – 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) Brenda Rhule 5th May 2020

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) Brenda Rhule 5th May 2020

Appendix B - 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.**

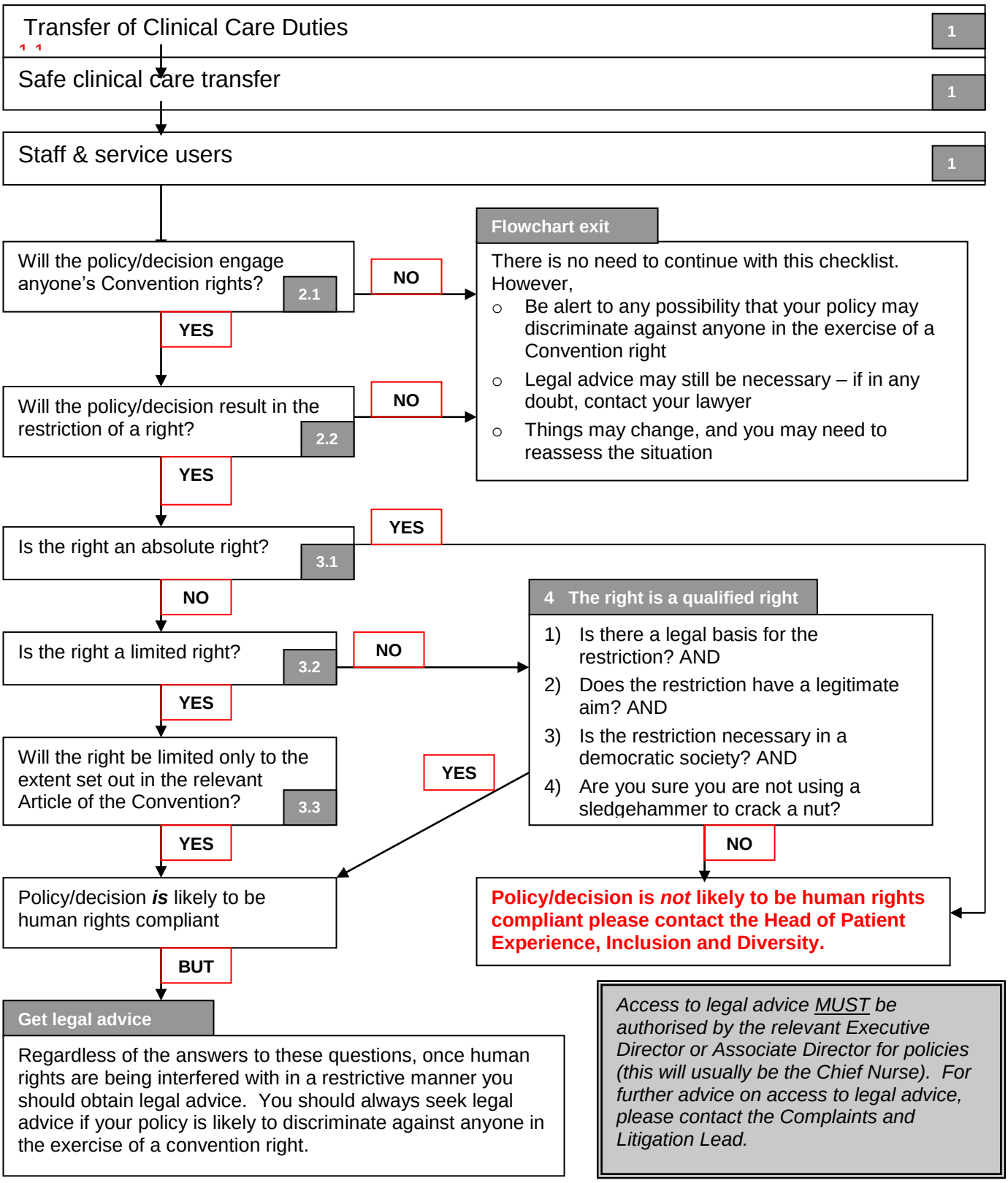
3. Complete the table below to provide details of the actions required

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

Statement of Guiding Principles

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

Guiding Principles

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

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

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

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

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

Appendix D – Checklist to assist with any transfer

The transfer plan should:

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

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

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

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

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

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

Checklist

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

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

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

4. Have any specialist care needs been identified?

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

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

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

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

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

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

11. Is an escort required?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.