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 Medical Director
Policy Owner	Head of Mental Health Legislation
Policy Author	Head of Mental Health Legislation

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Ratified By	Mental Health Legislation Committee (MHLC)
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Date for Review	TBC

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 transfers of detained patients meet the legal requirements under Section 19 of MHA 1983.

Target audience	Approved Clinicians; MHA office; ward managers; inpatient nursing staff

Keywords	Detained, Section 19, s19; Mental Health Act 1983, transfer

Storage & Version Control
Version 2 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (V1 July 2020). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log

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.
2.0	Scheduled policy review	10/2023	• Responsible Director changed to Executive Medical Director • Grammatical corrections. • Target audience broadened. • New introduction written. • Scope of policy section reworded; patients who fall outside of s19/s19A added for clarification. • Purpose of the policy refreshed. • Importance of ensuring the patient's Responsible Clinician is involved in decisions about patient transfers added. • Not using bin bags for bagging patient's property added to promote respect and dignity. • Need to incident report highlighted should any problem arise during a transfer. • Section regarding transfers under s136 MHA removed (as s19 does not cover this) • Appendix C (guiding principles) removed and guiding principles placed into Introduction section (to emphasise importance). • Role of Mental Health Legislation Operational Group, and Mental Health Legislation Committee, added.

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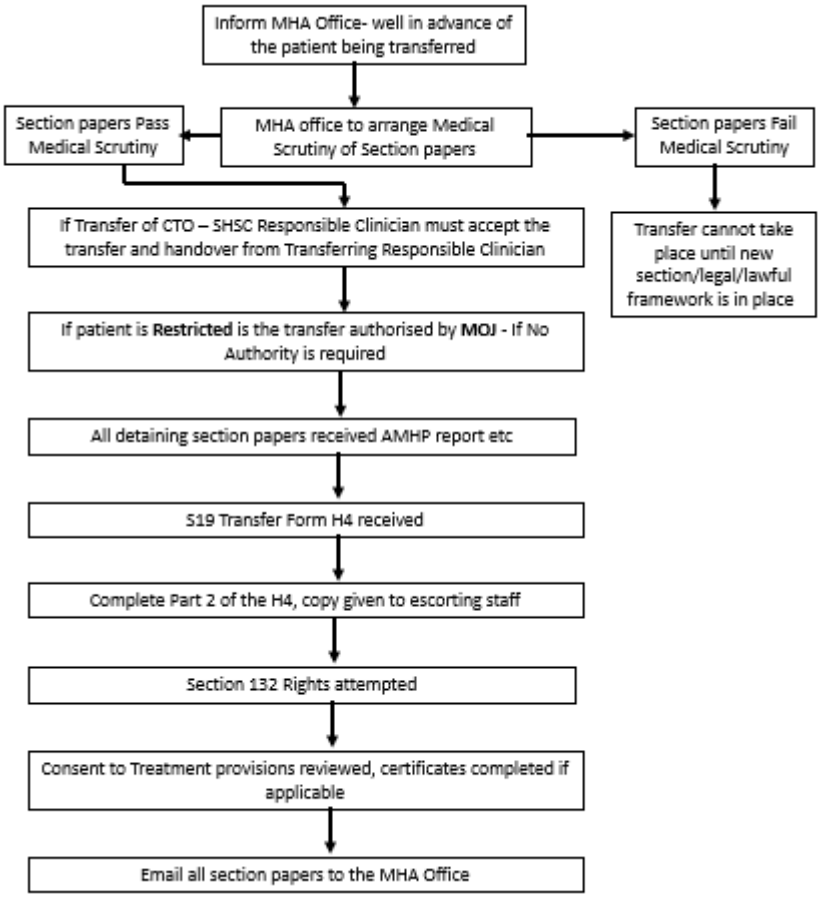
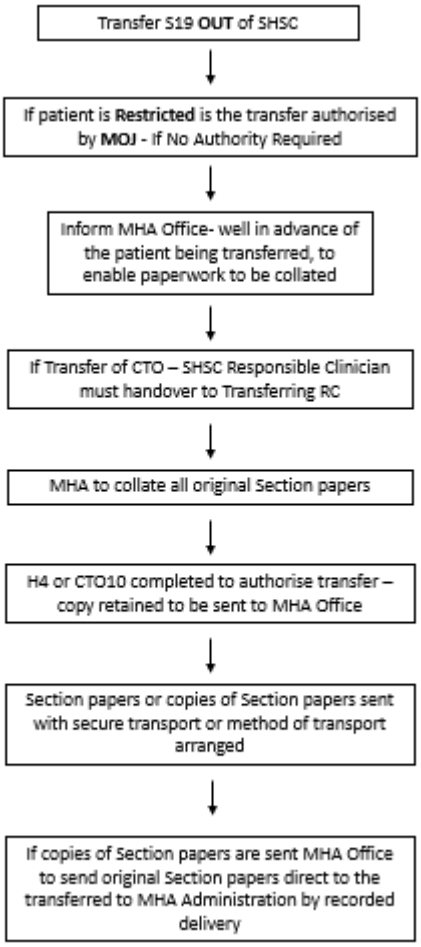
Transfer In Process



Transfer Out Process



1 Introduction

Sheffield Health and Social Care NHS Foundation Trust (SHSCFT) provides a range of adult mental health and learning disability services. This includes providing inpatient facilities which can be used for patients who are detained under the Mental Health Act, and community services that provide support to patients subject to a Community Treatment Order (CTO).

Occasions arise when it is necessary for a detained patient, a patient who is subject to Guardianship, or a patient who is subject to a CTO, to be transferred from one Trust/Authority to another. Such transfers are regulated by s19 and s19A Mental Health Act 1983 (as amended) (MHA83).

It should be noted that when making decisions under the MHA83, which includes making decisions in respect of patient transfers, staff must have regard to the Act's Code of Practice along with the Code's Guiding Principles. These are:

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 patients, promoting their recovery and protecting other people from harm.

Least Restriction Principle
People taking action without the consent of the patient must attempt to keep to a minimum the restrictions they impose on the liberty of the patient, 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 patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the views, wishes and feelings of the patient 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
Patients 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 patient 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 patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

2 Scope

This policy applies to all service areas within the Trust. It applies to all eligible patients who are being transferred from one service to another within our Trust or being transferred to another Trust.

It should be noted that some patients fall outside the scope of s19/s19A. Patients who are subject to the following cannot be transferred under s19/s19A:

S5(4) nurse's holding power
S5(2) registered medical practitioner or approved clinician holding power
S35 remand to hospital for assessment
S36 remand to hospital for treatment
S38 interim hospital order
S135 warrant to search for patient
S136 Police power to remove a patient to place of safety

3 Purpose

The purpose of this policy is to:

a) Ensure that the transfer of eligible patients is only undertaken in accordance with the MHA 83;
b) Provide guidance to staff, when transferring eligible patients, to ensure there is a safe, effective and properly managed transfer.

This policy is not a substitute for the MHA83 or the MHA83 Code of Practice. Staff should ensure they comply with the MHA83, and also have regard to the MHA83 Code of Practice when discharging their duties.

4 Definitions

AMHP – An Approved Mental Health Professional is a registered professional who has received additional training to make certain decisions under the MHA83. Examples include having the power to make an application for a person's detention or to apply for a person to be received into Guardianship. AMHPs are approved by the Local Authority.

Community patient – a person who is subject to a Community Treatment Order

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

Eligible patient means a patient who can be transferred under s19/19A.

Guardianship means a patient who has been made subject to Guardianship (s7 MHA83), or a Guardianship Order by the Court (s37 MHA83). A person who is subject to Guardianship, or a Guardianship Order, will have a Guardian who has three main legal powers ie. to decide where a person lives, to require the person to go to specific places for medical treatment, work, education or training, and to demand that a doctor, AMHP or other specified person is able to visit the person where they live.

Patient – any service user, client or resident. Patient is the preferred terminology within the MHA83

Responsible Clinician – the Responsible Clinician is the Approved Clinician who has overall responsibility for a detained, or community, patient.

S19(1)(a) is the formal transfer of a detained patient to another hospital (which is under the care of a different Trust), or the formal transfer from hospital to the Guardianship of a Local Authority

S19(1)(b) is the formal transfer of a patient under Guardianship to a different Social Services Authority or person or transfer to hospital

S19(3) is the transfer of a detained patient between hospitals within the same Trust

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

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5 Detail of the policy

The detail of this policy aims to facilitate and ensure that patients who are eligible for transfer under s19 and s19A are transferred in a safe, person-centred manner and in a way which complies with statutory requirements.

6 Duties

6.1 Hospital Managers

Whilst the MHA83 uses the term “Hospital Managers”, in NHS Foundation Trusts it is the Trust as an entity which are the “Hospital Managers”. Hospital Managers have certain statutory duties that they must fulfil under the Act and some of these duties, including the transfer of patients under section 19/19A MHA83, can be delegated to Trust staff.

6.2 Responsible Clinician

Responsible Clinicians are responsible for authorising the transfer of eligible patients to other hospitals/units as necessary; and will liaise with the Responsible Clinician at the receiving hospital/unit about the transfer, and the patient’s current proposed treatment plan.

6.3 Medical Staff

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;
- ensure the plan is clearly documented on the Electronic Patient Record (EPR);

- ensure the patient's Responsible Clinician is aware of the transfer and has inputted into this.

6.4 The Senior Leadership 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 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 office needs to be made aware of any planned transfer within office hours and with enough time to request the papers electronically.

7 Procedure

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

Section 19/19A can only be used to transfer patients who are subject to detention under a Section 2, 3, 37, 47 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 19/19A.

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 19/19A 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 MHA83, and to transfer a patient who is subject to Guardianship to another Guardian.

Section 19A is to be used to transfer a patient with a Community Treatment Order to another Hospital.

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 be involved in the decision-making process in respect of a transfer, and agree with it.

- 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 gender 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; 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 and respectful manner and an inventory made. Using black bin bags for the packing of belongings is disrespectful and should not be used.
- 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 Leadership Team and incident reported where necessary.
- 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 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 information provided to them under section 132 MHA83; 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 they 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.
- 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 repeated 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 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

Version 1 of this policy has been disseminated to the Mental Health Legislation Operational Group (MHLOG) and comments invited as to any changes or errors. Feedback was limited. The feedback received was in respect of needing to ensure a patient's Responsible Clinician is always involved in the decision to transfer a patient. This has been emphasised in the policy review.

The policy has been reviewed by the Head of Mental Health Legislation and considered alongside any potential changes in legislation, or significant case law.

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 Legislation Operational Group & Mental Health 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 Legislation Operational Group & Mental Health Legislation Committee.

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. The policy review date will be October 2026.

10 Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove old version	TBC	End Nov 23	
All teams/services to be made aware of policy	Ward/Team Managers	End Nov 23	

11 Dissemination, Storage and Archiving (Control)

The issue of this policy will be communicated to all staff via the Trust Intranet and Trustwide communication email. 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
2.0	TBC	TBC	TBC	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's Mental Health Act training. However, the following staff will need to be familiar with the policy contents:

- Approved Clinicians
- Registered inpatient nursing staff.
- Non-Registered inpatient staff.
- Junior Doctors.
- Mental Health Act Office staff.

Awareness will be achieved via dissemination to operational and non-operational managers at the Mental Health Legislation Operational Group (MHLOG)

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 Safeguards
- Mental Health Act 1983 (as amended)
- 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 1983 (as amended) 2007
- Department of Health, Mental Health Act 1983 Code of Practice, 2015

14 Contact Details

Title	***Name***	***Phone***	***Email***
Mental Health Act Administration Manager	Mike Haywood	27 18102	mike.haywood@shsc.nhs.uk
Head of Mental Health Legislation	Jamie Middleton	271 8110	jamie.middleton@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: Jamie S Middleton, 23.10.23	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - 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 and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy 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	N/A – no potential discrimination identified	N/A – no potential discrimination identified
Disability	No	N/A – no potential discrimination identified	N/A – no potential discrimination identified
Gender Reassignment	No	N/A – no potential discrimination identified	N/A – no potential discrimination identified
Pregnancy and Maternity	No	N/A – no potential discrimination identified	N/A – no potential discrimination identified

Race	No	N/A – no potential discrimination identified	N/A – no potential discrimination identified
Religion or Belief	No	N/A – no potential discrimination identified	N/A – no potential discrimination identified
Sex	No	N/A – no potential discrimination identified	N/A – no potential discrimination identified
Sexual Orientation	No	N/A – no potential discrimination identified	N/A – no potential discrimination identified
Marriage or Civil Partnership	No		

No changes made.

Impact Assessment Completed by: Jamie S Middleton, 23.10.23

APPENDIX B – Prompts and checks to assist with any transfer

The transfer plan should:

1 Be person-centred and reflect the patient's choices as far as possible and be made available in a form which can be read and understood by the patient, e.g. in an appropriate language. This may be a print-out from the Patient's Electronic Record (EPR), a recording, a series of pictures, etc.

2 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.

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

4 Be provided in a written or other form acceptable and accessible to the patient and their carers.

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

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 patient is detained under the MHA83, have the Guiding Principles been considered?

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 patient?

7. If the patient is detained under the MHA83, has the transfer form been completed and signed by a senior member of the clinical team?

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 patient'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 patient?

    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 patient 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 patient needs been given to the receiving team/hospital department and subsequently a copy of the relevant transfer documentation communicated in advance of the patient?

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

12. Have the levels of observation been assessed and included in the transfer documentation?

13. If the patient is detained under the MHA83 and is being transferred to Sheffield Teaching Hospital NHSFT (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 patient's care?

15. Has there been consideration of whether the patient 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 patient is ready for discharge from STHFT, the STHFT Team should advise the Consultant Psychiatrist concerned and/or appropriate SHSC Manager. If the patient is compulsorily detained under the MHA83 or the subject of a Community Treatment Order, the Responsible Clinician – should also be informed.

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

19. If the patient can be discharged back into the community, has 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 patient 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 patient 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 patient 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 patient e.g. copies of necessary transfer documentation passed to the ambulance service if they are transporting the patient via an ambulance.

23. If an escort is not accompanying the patient a comprehensive verbal summary of the patients 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 patient.

24. In certain circumstances the patient 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 patient'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 patients need to be transferred at short notice, and when detailed 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.

e. A patient should not be transferred without the Responsible Clinician's input.

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 patients with their Service or Clinical Directors.

Appendix C

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	✓
2.	Is the local Policy Champion member sighted on the development/review of the policy?	N/A
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	✓
5.	Has the policy been discussed and agreed by the local governance groups?	✓
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	✓
	Template Compliance	
7.	Has the version control/storage section been updated?	✓
8.	Is the policy title clear and unambiguous?	✓
9.	Is the policy in Arial font 12?	✓
10.	Have page numbers been inserted?	✓
11.	Has the policy been quality checked for spelling errors, links, accuracy?	✓
	Policy Content	
12.	Is the purpose of the policy clear?	✓
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	✓
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	✓
15.	Where appropriate, does the policy contain a list of definitions of terms used?	✓
16.	Does the policy include any references to other associated policies and key documents?	✓
17.	Has the EIA Form been completed (Appendix 1)?	✓
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	✓
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	✓
20.	Is there a plan to i. review ii. audit compliance with the document?	✓
21.	Is the review date identified, and is it appropriate and justifiable?	✓