Essex Partnership University
NHS Foundation Trust

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Related Trust documents (to be read in conjunction with)

CG77 – Guidance to Support Active Engagement including Did Not Attend (DNA) (Disengagement Guidelines)
CLP13 – Safe & Secure Handling of Medicines Policy
CLP28 – Clinical Risk Assessment & Safety Management Policy
CLP30 – CPA Policy
CLP37 – Safeguarding Children Policy
CLP39 – Safeguarding Adults Policy
CP84 – Violence & Abuse Prevention & Reduction (VAPR) Policy
MHA1 – Administration of the Mental Health Act (1983) Policy
MHA21 – Pan Essex MHA Section 117 Protocol

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2.2	I/S Advancing Clinical Practice Lead	Amended 9.2 & 9.3; 13.1 (bullets 4 & 5); 21.4; 21.5; 21.7	01 July 2020
2.3	I/S Advancing Clinical Practice Lead	Added 7.3	01 September 2020
2.4	I/S Advancing Clinical Practice Lead	Amended 7.5 (7 days to 72 hrs'; amended 7.6 (24 hours of discharge)	01 December 2021
2.5	I/S Advancing Clinical Practice Lead	2.5 – 3 month extension	01 September 2022
2.6	I/S Advancing Clinical Practice Lead	2.6 – 2 month extension	01 December 2022
2.7	I/S Advancing Clinical Practice Lead	2.7 - Extension to July 23 & new author approved May 23	01 May 2023
3	I/S	Three year review -High level summary of key points developed -New Appendices (6 & 7)	05 December 2023

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1 Introduction

1.1 The Trust's commitment to high quality care and patient safety is paramount and as such the purpose of this document is to provide clear guidance to staff, patients, relatives and carers when a person is transferred while in the care of Essex Partnership University NHS Foundation Trust (EPUT) services to another service such as an acute trust or, discharged from EPUT services completely.

1.2 The person's discharge will be proactively planned with them and their chosen carer/s from the start of their inpatient stay so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all post-discharge support provided promptly on leaving hospital.

1.3 Transfer of care refers to patients who are transferred between service providers within EPUT and to other service providers.

1.4 Discharge refers to patients whose in-patient and/or community episode has been completed and they no longer require the interventions from EPUT services.

1.5 Throughout this document the term patient will be used throughout and relates to people who use Mental Health, Learning Disability and Community Health services, often referred to as either 'patients', 'service users', 'customers' or 'residents'.

2 Scope

2.1 These guidelines apply to all clinical staff involved in the discharge and transfer of patients in the care of EPUT. It should be noted that elements of the guidance are specific to all service areas, however there are local guidelines and instructions/operating procedures that apply to different services in accordance with commissioning agreements and local arrangements.

2.2 The guidelines identify the process and principles of managing the following:

- Discharge and transfer of care from EPUT services
- Transfer of care and treatment to another service within EPUT

2.3 These guidelines identify the steps that need to be taken within all areas of the Trust.

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3 Duties

3.1 **The Trust Board** has overall responsibility for ensuring:

- That the principles of this guideline and other associated procedures are implemented across the organisation
- The availability for any necessary financial resources

3.2 **Directors and Senior Managers** are responsible for ensuring:

- That any clinical risk issues are addressed with relevant line managers.
- The implementation of national guidance in relation to transfer and discharge.
- Disseminating, implementing and monitoring this guideline within their services via clinical audit and supervision.
- Ensuring that detailed local procedures are in place to manage discharge and transfer of patients.
- Ensuring that EPUT policies and procedures are followed.
- The procedures and principles detailed within this guideline are followed, to meet with all relevant guidance.
- Staff receive appropriate and correct training.
- The monitoring the implementation of this policy via clinical audit and supervision.

3.3 **Ward Managers /Charge Nurses/ Team Leaders/Care Coordinators/Lead Professionals** will ensure:

- Appropriate systems are in place to assess and effectively manage clinical risk through discharge and transfer back into the community.
- That appropriate discharge and transfer arrangements are in place and followed for all patients as set out with related procedural guidelines.
- That employees undertaking discharge and transfer of patients complete the agreed records/documentation as set out within related procedural guidelines.
- That all appropriate documentation accompanies the patient on discharge / transfer
- All appropriate information is provided to the patient on discharge / transfer.
- Where discharge / transfer happens out of hours, arrangements are in place and followed for patients as set out within related procedural guidelines.

3.4 **Individual staff** are responsible for ensuring that they:

- Adhere to all EPUT policies and guidelines.
- Are familiar with these guidelines and associated documents and know where to locate them i.e., the intranet.

4 Patient group definitions

4.1 **Adults**

This includes:

- People of Working Age and Older Adults Mental Health Services (inpatient and community)
- Learning Disability Services
- Secure Services
- Community Health Services

4.2 **Children**

This includes Young People aged 0-17:

- Mental health Services (inpatient and community)
- Learning Disability Services
- Community Health Services

5 General instructions for transfer [All services]

NB: Staff in secure Services should read this Clinical Guideline in conjunction with SSOP4

5.1 Safe and effective transfer of care should be undertaken with minimal disruption and risk. All transfers will be planned and managed in a sensitive way ensuring all communication is clear to the patient, their relative/carer, referrer and receiving service. The patient should be fully informed and if able to do so give agreement to the transfer prior to the transfer taking place. This must be documented in the patient's record. Where appropriate, it will be necessary to consult with those who have parental responsibility.

5.2 Following a decision to transfer a patient, the decision should be documented in the patient records with the rationale and decision to transfer. The transferring team/clinician must ascertain who will take medical responsibility and act as dedicated consultant/medical practitioner.

5.3 The patient will be identified as medically and mentally (where applicable) well/fit for transfer by the medical team with recognised authority to do this.

5.4 Within mental health services, if a patient is to be transferred from one community team to another, full agreement must be sought from both teams and the relevant consultants/medical practitioners. This decision must be planned with explicit dates for transfer to ensure continuation of care. This must be clearly documented within the patient's records and this principle must be applied to both planned and emergency transfers. For patients subject to the Mental Health Care Programme Approach (CPA) the requirements around safe and effective transfer of care as outlined in the Trust CPA Policy and the CPA handbook.

5.5 Where the transfer is from a ward to another ward the form 'MDT Clinical Handover at Point of Transfer from One Ward to Another' (Appendix 4) is completed by the Transferring Ward Staff and signed by the Receiving ward staff. This is to ensure that vital Clinical information has been shared at the point of transfer. Furthermore, the ward qualified staff must ensure that all medicines that have been individually dispensed for the patient must be sent to the new ward along with his other property. This should also include any medication that had been brought into hospital by the patient on admission where appropriate (often medication will change following admission and unrequired medicines may have been destroyed on the ward with the patient's permission) (Refer to sections 9.8 and 9.9 of the Trust's procedures for the Safe and Secure Handling of Medicines).

5.6 The transferring team must ensure a risk assessment is completed prior to every patient transfer to determine the appropriate mode of transport required e.g., secure vehicle, ambulance, taxi. The risk assessment must include number of staff required for escort and band to effectively and safely carry out the role of escort. Staff are required to record in patient's notes that risk assessment has been done prior to transfer.

5.7 Adequate information from the transfer/transport risk assessment must be communicated to the transport provider so they can fulfil their duties under H&S legislation and ensure safety of all parties involved.

5.8 The transferring ward/community team must ensure that relevant health records (for example, section papers, engagement and observation records, medicine charts, etc.) relating to the patient are transferred with the patient. Other record, such as, the assessment, risk assessment, care plan, etc. should be on the electronic health record so that they are published into the Health Information Exchange Portal (HIE).

5.9 HIE is a portal which allows EPUT clinical staff to search for patient information from the North and/or South of the Trust. This information is read only and consists of key documents and a Patient Summary. Managers may request access for their staff by raising a job on the IT Helpdesk. A list of the documents being published is available on the intranet within the quick user guide.

5.10 Verbal and written communication between the ward, department or receiving team/service is necessary so that information may be shared regarding specific requirements: falls risk; mental health risks (including mental capacity); infections; any special equipment required and resuscitation status.

5.11 The staff member accepting the patient must ensure that they have all the necessary information to care for the patient safely and correctly.

5.12 If a patient has or is suspected of having an infection risk the receiving ward/department must be notified in advance of the transfer and the transferring staff member must complete the inter-healthcare infection control transfer form for all patients.

5.13 The time of transfer will be agreed with the receiving ward/team/department where possible avoiding out of hours transfers.

5.14 The patient's property will be checked and accounted for, returning any valuables which have been held in welfare for safe keeping.

5.15 In the majority of cases the decisions regarding the transfer of patients between wards in EPUT services will occur with the involvement of the ward MDT, the patient and those involved in their care. Patients will be provided with a nurse escort in line with their identified need to ensure that their transfer occurs safely.

5.16 Clinical information will be communicated to the receiving team, ensuring that the care transfer process is safe, effective, timely and maintains continuity of care for the patient.

5.17 The receiving team will also access patient's information on Mobius/Paris depending on geographical area of the patient.

5.18 If Mobius or Paris is not accessible due to geographical area, then the information will be accessed via HIE.

5.19 If patient information is not found on HIE, such as in the case of returning a person admitted to an out of area placement to EPUT, then staff should ring the ward or community team where the patient is coming from for information. This process should also be followed if the patient is coming from outside the Trust.

5.20 Repatriation of EPUT Patient from an Out of Area Placement (OoAP) to EPUT:

a. Bed Management team and Clinical Flow Lead (CFL) will be notified of Individuals who have been prioritised for repatriation to EPUT by the Discharge Coordination Team (DCT).
b. These individuals will be recorded on the bed handovers and discussed during the daily safer staffing and bed occupancy sit rep where the most suitable ward to facilitate the transfer of care will be identified.
c. A comprehensive suite of documents outlining the care and treatment of the person whilst in OoAP will be requested by Bed Management Team from the OoAP Provider and forwarded to the identified EPUT ward for review.
d. Ward Consultant and Team will review documentation from OoAP provider and inform bed management if they are able to accept admission to the next available bed.
e. If patient accepted, this is to be recorded on bed needed record and discussed on daily safer staffing and bed occupancy sit rep lead by Chair / Clinical Flow Lead with identified date for transfer of care.
f. On confirmed day of transfer, bed management to liaise with OoAP provider and make necessary transport arrangements.
g. If identified ward decline transfer of care, this is to be reviewed on daily sit rep and alternative identified.

6 General instructions for discharge (all services)

6.1 Discharge planning is a continuous process which should begin at the point of admission, ensuring that patients and their carers/relatives understand and are able to participate in care planning decisions. The process should continue until the patient is formally discharged from services.

6.2 The process of discharge planning should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the patient journey. It should involve the development and implementation of a plan to facilitate the discharge from EPUT services to an appropriate setting, and include the relevant onward community team/service, the patient, and their carers and relatives.

6.3 In line with Section 91 of the Health and Care Act (2022), discharge planning should involve the person and their chosen carer/s.

6.4 As part of discharge planning, it is important to identify early what needs to happen for the person to feel practically and psychologically ready for discharge (while recognising that this may change over the course of the person's time in hospital). The person and their chosen carer/s should be given information about their discharge options, the opportunity to ask questions about these options and should be involved in co-developing a discharge plan.

6.5 In the majority of cases, people are expected to return to their home or alternative accommodation in the community when they are discharged from hospital, with any further assessments and ongoing interventions, treatment and support that they require provided in their home or local community. Services need to work together to make the transition from hospital to home as joined up as possible, with the support outlined in the person's discharge plan provided according to agreed timelines.

6.6 Discharge planning should begin at the start of a person's admission, or a soon as practically possible afterwards. In line with Section 91 of the Health and Care Act (2022), discharge planning should involve the person and their chosen carer/s. It should also involve any services that may be involved in a person's care after discharge, including social care. As part of discharge planning, it is important to identify early what needs to happen for the person to feel practically and psychologically ready for discharge (while recognising that this may change over the course of the person's time in hospital). The person and their chosen carer/s should be given information about their discharge options, the opportunity to ask questions about these options and should be involved in co-developing a discharge plan.

6.7 Some key areas that should be proactively considered and addressed as part of discharge planning, include:

- Understanding what the person's chosen carer/s are able and willing to do once the person they care for is discharged (e.g., whether they are happy for the person to live with them) and what support the chosen carer/s needs to be able to fulfil this role. This is particularly important when considering young carers and people with other caring responsibilities. Where a carer's assessment is needed, this should be organised in a timely way so as to not delay discharge.

Alternatively, the assessment may be completed after discharge, as long as it is not a new caring duty or there are increased care needs.

- Housing – assessing whether the person can return to the place they lived before they were admitted to hospital, and if so, what steps need to take place to make this possible (e.g., securing their tenancy, making any repairs or adaptations). If it is no longer possible or suitable for the person to live there, then prompt contact and referral should be made to the local authority housing services (including the homelessness team if the person is homeless or at risk of homelessness) and proactive action taken to secure a suitable home that meets the person's individual needs (including preferences in terms of location). In some cases, interim or step-down accommodation may be arranged ahead of permanent accommodation being identified.
- Funded packages of care – identifying any care needs that may require ongoing support within the home, in supported / sheltered accommodation or a care home. This is particularly relevant in relation to older adults, who have longer lengths of hospital stay on average, which can be the result of delays in securing appropriate social care. Once ongoing care and support needs are identified, referral should be made promptly to the relevant agency (e.g., the local authority) and assessments should be arranged early, so that funding can be agreed and a package of support can be put in place as soon as the person is ready to leave hospital. Where someone is entitled to Section 117 aftercare, there should be early liaison with the local authority to begin planning the aftercare that is needed.
- Mental capacity and liberty protection safeguards for people who lack mental capacity and meet the criteria for being deprived of liberty.
- Medicines and equipment – some medicines, e.g., opiate substitutes, need to be arranged well in advance of discharge to avoid delays to discharge.
- Travel home/to the discharge location – especially if this is in a rural location. Travel may be through a carer picking the person up, a VCSE sector service, or where relevant eligibility criteria are met, via non-emergency patient transport services. Consideration should also be given to whether a person needs to be accompanied and who can do this, if a carer is not available.
- Immediate needs at the point of discharge, e.g., completing deep cleans of the person's home, having keys to gain access, food, electricity and gas, and any other 'settle in' support required.

6.8 Where there are safeguarding concerns, or a person is subject to a safeguarding investigation the patient should not be discharged or transferred without a review of the safeguarding issues and any discharge plans should reflect the safeguarding action plan where appropriate in accordance with the Trust Safeguarding Policy and Procedure.

6.9 With regard to secure services, restricted patients under Part 3 of the Mental Health Act 1983 will require Ministry of Justice approval before transfer or discharge (refer to Discharge of Patients from Secure Services Procedure).

6.10 The point at which someone is Clinically Ready For Discharge (CRFD) is reached when the MDT conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting.

- There must be a clear plan for the ongoing care and support that the person requires after discharge, which covers their pharmacological, psychological, physical health, social, cultural, housing and financial needs, and any other individual needs or wishes.
- The MDT must have explicitly considered the person and their chosen carer/s' views and needs about discharge and involved them in co- developing a discharge plan.
- The MDT must have involved any services external to the provider in their decision-making, where these services will play a key role in the person's ongoing care, e.g., social care teams and housing teams.

6.11 The point at which it is possible to discharge someone is reached when the person is considered CRFD, and the ongoing care and support agreed in the person's discharge plan can be delivered according to the agreed timescales following discharge. To make this decision, the person's discharge plan needs to have been reviewed and updated with the person and their chosen carer/s, and the role of each party in providing post-discharge support clearly articulated.

6.12 In situations where someone is deemed CRFD, but it is not possible to discharge them, the person must continue receiving interventions, activities and other support in hospital, so that they remain CRFD and can be discharged as soon as the appropriate support has been put in place for them.

6.13 Once the final decision has been made that it is possible to discharge someone: At least 48 hours' notice of this discharge date should be given to the person, their chosen carer/s and any services (both NHS and non-NHS services) that will be involved in the person's ongoing care.

6.14 The person's risk assessment should be updated, to include information on how any risks to self or others will be managed in the community or less restrictive discharge location. In line with NICE guidance on self-harm, risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm, or to decide who should be discharged. Instead, person-centred approaches to safety planning should be used that involve the person and their nominated carer/s and consider individual needs, risks and contexts and personal feelings of safety. Once updated, the risk assessment should be uploaded to a clearly accessible place on the person's clinical record.

6.15 Unless the patient is discharged under the Zero Tolerance policy the patient and their carers/relatives/advocates must be fully informed of the discharge prior to the discharge taking place. This must be documented in the patient's record. If relatives have not been able to be contacted the receiving ward/team (where appropriate) must be notified. If the person does not have capacity to make a decision regarding

discharge, then a capacity assessment must be completed and if they do not have capacity and do not have friends or relatives then an advocate can be requested.

6.16 The nurse in charge must ensure that all medication required has been dispensed and given to the patient. In addition, staff must ensure any medication that had been brought into the ward by the patient on admission have been returned to the patient where appropriate. Planning for medication on discharge should begin sufficiently prior to the discharge date to allow all necessary medicines to be provided by the pharmacy. If the patient requires compliance aid to enable them to self-administer medicines safety and effectively at home, this will require additional time and liaison with other organisations about continued supply. Refer to Trust procedures for the Safe and Secure Handling of Medicines.

6.17 The patient's property will be checked and accounted for by ward staff, returning all property and any valuables which have been held for safe keeping and the required records completed.

6.18 The nurse in charge at the time of discharge must ensure discharge records are kept in line with local operational procedures.

6.19 On discharge a summary of the patient's admission, continuing treatment requirements/medications must be completed by medical staff and a copy forwarded to the GP within 24 hours of the patient leaving the ward, another copy given to the patient and a further copy should be within the electronic record of patient. A more detailed discharge letter must be sent to the GP within five working days of the patients discharge and a copy has to be in the patient electronic record too. Where a patient has indicated that they would like to receive copies of letters relating to them a copy will be provided to them. Refer to policy for copying letters to patients.

6.20 The nurse in charge will ensure ongoing services and equipment (where appropriate) are in place prior to the discharge.

6.21 The majority of patients will make their own transport arrangements, but the nurse in charge of the shift needs to check that this is the case and that the arrangements are appropriate. For some patients, particularly within older peoples services transport may need to be provided. Staff should refer to their local arrangements and refer where necessary the policy on the use of taxis.

6.22 Where the person requires mainstream accommodation and this is not available, please refer to the Protocol for the effective use of temporary (B&B/ Hotel) accommodation to support alternatives to admission and timely, safe patient discharge from EPUT Mental Health Inpatient Services.

6.23 Where the person is a Foreign National with No Recourse To Public Funds, please refer to the Guidance for enabling and supporting discharge from mental health inpatients services for patients with NRP.

7 Transfer between mental health inpatient and community mental health services

7.1 When a patient is transferred to a mental health inpatient setting (including those people placed in Out of Area Placement) and there is an existing care coordinator, the role of the care coordination remains within the community. During the inpatient episode, the ward team will work collaboratively with the existing care coordinator. Please refer to the CPA Policy and CPR Handbook for full details of the role of the care coordinator.

7.2 The care coordinator must work collaboratively with ward staff and the consultant psychiatrist to develop and agree the care plan, taking into account the needs of the service user and their family/carer's wishes. It is the responsibility of the care co-ordinator (in conjunction with the unit and others involved in the care package) to oversee all arrangements for discharge from inpatient care.

7.3 When planning discharge from inpatient services, the family of the person being discharged must routinely be contacted and informed unless there is an explicit instruction not to contact the family from the person being discharged. If this explicit instruction is given for the family not to be contacted, then the reasons for this must be fully explored with the patient and documented in their clinical notes.

7.4 A follow up telephone call must be made within 24 hours of discharge by the ward manager or by a delegated clinical member of staff to all patients discharged.

7.5 Every person discharged from an adult mental health inpatient service (excluding specialised services commissioned by NHS England) should be followed-up by a CRHTT or community-based mental health team within 72 hours. This is because the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) has found that there is an increased risk of dying by suicide within three days of discharge from hospital. Follow-ups should be arranged pre-discharge (including providing written details of when, where and who the follow-up will take place with) and should take place face-to-face wherever possible. If the follow-up indicates that the person needs additional support, action should be taken promptly to put this in place.

7.6 When a person is discharged, they may receive short-term intensive home treatment from a CRHTT to facilitate discharge, and it is expected that they will receive ongoing support from a community-based mental health team. Support should commence within the timescales stated in the person's discharge plan (**in** the case of discharge supported by a CRHTT, a first visit should happen within 24 hours of discharge).

7.7 Best practice indicates a further follow up within 7 days of discharge be provided by the Care Coordinator/CRHT/ Home First Team where clinically indicated.

7.8 When someone leaves adult acute mental health inpatient care, they should receive: If not already included in a person's discharge plan or clinical record, the CRHTT and/or the community-based mental health team are expected to support the person to:

- Develop advance choices, which set out any preferences that the person has for their care and treatment, should they be admitted to an inpatient mental health setting again. This may involve signposting the person to access additional support from an advocate or a VCSE organisation, which can help with the development of advance choices. Advance choices should be recorded and uploaded to a clearly accessible place in the person's clinical record.
- Create a crisis plan that is uploaded to the person's clinical record, containing information about the signs that the person is experiencing or approaching a crisis, where and how they can seek help (including outside standard working hours), and information on their support and treatment preferences.
- Access other support that will help maintain the person's wellbeing and prevent future crises, such as psychoeducation and peer support.

7.9 According to people's needs, as agreed in a person's discharge plan, some people may receive additional support from services such as drug and alcohol services, community learning disability teams, palliative care, housing services, social care services, specialist autism services and VCSE sector services.

7.10 Where a service user's episode of inpatient care has been discontinued following inappropriate behaviour e.g., use of alcohol or illegal substance whilst on the unit, the care co-coordinator should be informed at the earliest opportunity and prompt a review of care.

7.11 ***Funded packages of care:*** A smaller proportion of people may require and be entitled to a funded care package, in order that that they can access:

- Support for social care needs (including domiciliary care).
- Community-based rehabilitation.
- A short-term placement in a step-down service or supported accommodation.
- A longer-term/permanent placement in a supported accommodation or residential care home.

7.12 This may be funded via:

- Section 117 aftercare – available to people who have been detained under section 3, 37, 47, 48 or 45A, or have been placed on a community treatment order (CTO) or conditional discharge. If someone is entitled to Section 117 aftercare, notification of their admission should be made to the local authority.
- The Better Care Fund
- Personal budgets (which are local authority funded), personal health budgets (which are NHS funded) and integrated personal budgets and personal health budgets (which include funding from both a local authority and the NHS). These budgets are intended to give people greater choice and flexibility in organising

and managing their own care, in line with an agreed care plan. Please note, people eligible for after care services under Section 117 of the MHA have a right to a personal health budget; further details can be found in NHS England's Personal Health Budget Quality Framework. It is important that those eligible are informed of this right.

- NHS Continuing Care
- EPUT NHS trust discharge initiatives

7.13 Members of inpatient teams and independent advocates should make people aware of the different options for funding ongoing care (including personal budgets), and where there are different options available, individuals and their chosen carer/s should be supported to understand how the different options work, so that they can make the best choice for their circumstances (particularly where a person will be self-funding their care).

7.14 Where a person is considered to have No Recourse to Public Funds (NRFP) subject to immigration control please refer to the enabling and supporting discharge from Mental Health Inpatient for patients with NRFP Guidance.

8 Transfers from mental health inpatient care in the absence of the service user

8.1 On occasion a patient may be absent when they are 'discharged' from inpatient care e.g., in cases of not returning from leave or non-engagement or admitted to an acute hospital due to physical reasons. In this instance, a professional meeting should be held to consider therapeutic benefit of admission and an assessment of risks made. The outcome of the professional meeting and risk assessment should be relayed to the service user and documented clearly in the patient's notes.

8.2 For patients who have a community care co-ordinator, the care coordinator is responsible for arranging appropriate follow up if the service user's whereabouts is known and every effort should be made to maintain contact and re-negotiate a new plan of care.

8.3 For more information on the management of patients who disengage please refer to refer to the Trust Disengagement or Non-concordance Clinical Guideline.

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9 Transfers between community mental health services

9.1 All transfers of care between EPUT community services must be carried out in accordance with CPA policy / procedures and any local protocols /operational policies.

9.2 **Transfer of Crisis Resolution & Home Treatment Team patients to community services:**

a) The community teams will be alerted by CRHT/HTT in cases of new individual to the service requiring further ongoing input from the appropriate community teams. This advance planning from both teams can allow time for appropriate and considered allocation of case coordinators from within the community teams.
b) CRHT/HTT Care identifies patient needs as early as possible during the treatment episode (while patients are RED or AMBER) and shares risks, patient/carer needs with community teams as appropriate, as part of anticipated CPA transfer.
c) To promote robust information sharing between CRHT/HTT and community services, CRHT/HTT Care would provide a clear written summary of patients' needs and after care plans on the agreed internal transfer template.
d) Community teams will allocate a care coordinator/key worker within the seven days following the summary provided to community teams. To ensure continuity of care, CRHT/HTT jointly with the appropriate community team would plan a face to face handover of care within the seven days of patient being graded to green on RAG rating.
e) It is anticipated that the community services would prioritise care coordinator allocation to CRHT/HTT to assist the CRHT/HTT to fulfil its function of rapidly taking on and discharging patients when home treatment is no longer indicated. In the event that timely allocation is not achieved the case must be escalated to both the CRHT/HTT and respective CMHT Manager.
f) In circumstance, where CRHT/Assessment/Care MDT views it may be appropriate to discharge straight back to GP – (e.g., Acute Stress Reaction completely resolved) and no significant risk history. In these cases, the MDT will record decision and rationale in the notes and transfer the care to GP/primary care without referring to Community Mental Health Teams.

9.3 **Transfer of patients from community services to home treatment:**

a) Case coordinators in the community teams can alert CRHT/HTT staff of concerns about individuals (prior to crisis). When a crisis occurs, which the community team has not predicted, foreknowledge of concern helps the CRHT/HTT in their assessment and care planning.
b) In circumstances of patients requiring home treatment as an alternative to hospital admission the community team will request a joint review with CRHT/HTT. This joint visit is reassuring to service users and allows the process of sharing key information in relation to risks treatment plan of the proposed home treatment. Alongside the ongoing intervention provided by the community team the CRHT/HTT will continue to provide intensive treatment until the resolution of immediate crisis. Following the resolution of crisis, patient care would be transferred back to community teams via a joint face to face meeting involving the care coordinator/key worker and CRHT/HTT.

c) In circumstances where patients make contact with CRHT/HTT again next day or shortly following conclusion of home treatment and being closed to crisis care; the CRHT/HTT would liaise with the appropriate services, as identified at the time of discharge to share the patient's reasons for contact and request a prompt review from community teams as necessary.

10 Age based transfers

10.1 CAMHS COMMUNTY to AMHS COMMUNITY:

10.1.1 Referral to be forwarded by NELFT SET CAMHS to AMHS once young person reaches 17 years 6months.

10.1.2 Where referral is appropriate for EPUT AMHS a clinician will be allocated to oversee the smooth transition. The identified clinician will actively participate in joint transition meetings with the CAMHS worker, the young person, their family and carers (subject to the consent of the young person) and ECC Childrens service where applicable.

10.2 CAMHS INPATIENT to ADULT COMMUNITY:

10.2.1 Where a young person is 17 years of age on planned discharge from CAMHS inpatient care, conversations regarding transfer of community care from NELFT SET CAMHS to EPUT AMHS Community services will commence.

10.2.2 EPUT CAMHS Inpatient teams will agree with NELFT SET CAMHS who is best placed to complete referral to AMHS Community once young person reaches 17 years and 6 months.

10.2.3 Where a young person is admitted less than 1 month before 18th Birthday, CAMHS Inpatient team will inform AMHS Community team on admission. Community AMHS will allocate a clinician to support smooth transition in AMHS.

10.2.4 The young person, their family and carer are to be included in transition arrangements as far as is possible.

10.3 CAMHS INPATIENT to AMHS INPATIENT:

10.3.1 In situations where the young person will not be ready for discharge at the point of reaching transition age into Adult inpatient care, a full discussion between the treating CAMHS service, the Care Coordinator, the Adult Inpatient care team and the NHS England Case Manager will occur prior to transfer.

10.3.2 AMHS Bed Management team will be notified by the CAMHS Inpatient team about the requirement for transition to AMHS Acute Inpatient Services as early as possible to enable identification of most suitable ward for transfer and to actively participate in ensuring smooth transition.

10.3.3 The young person and their family/carers should receive information about the receiving ward / service in advance of the transfer and be involved in discussions as far as possible (subject to the consent of the young person).

10.3.4 Each Adult acute ward will have a named transition champion to support the young person before, during and after the transition period. The Transition champion will support the young adult (and families/carers) discussing how their care will be trauma informed, compassionate, effective and personalised.

10.3.5 The Care Plan, detailing the purpose and therapeutic benefit of admission and continuing clinical need takes precedence over acceptance criteria of the service. The person should be cared for in the most appropriate environment to meet their clinical needs.

10.3.6 All reviews of care should involve a decision in relation to the appropriateness of the current care setting.

10.3.7 There may be occasions when it is deemed to be appropriate to continue working on a short term basis with a young person beyond the age they would normally be expected to transfer to an adult service. In such cases this should be agreed with the relevant Service Manager.

10.4 **OLDER ADULT:**

10.4.1 Older Adult Functional Wards will provide inpatient episode of care for those aged over 70 years and may also accept patients below this age who are experiencing specific frailty and complexity issues related to their age.

- Presence of 2 or more chronic long term health conditions
- Polypharmacy: more than 5 medications
- Rockwood Frailty assessment

10.4.2 Generally persons with a diagnosis of progressive cognitive impairment will be transferred to the most suitable environment/ service to meet their clinical needs regardless of age.

10.4.3 Where transfer from an Acute Adult ward to an Older Adult Ward (Functional or Organic) may be indicated the treating Adult Ward team will liaise directly with the Older Adult team in the locality in which the person is usually resident.

10.4.4 Service users with a functional illness, who are receiving treatment from the services for adults of working age, will continue to be seen by the adult consultant and adult teams beyond the age of 65 unless there are agreed clinical reasons between Adult Mental Health Service and Older Adult Mental Health Service to transfer.

10.5 Service users should not be transferred between services whilst experiencing a crisis. It is in the service user's best interests to be cared for by those who are already working with the service user unless the environment is unsuitable.

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11 Transfers to other mental health Trusts / private facilities

11.1 For patients subject to the Mental Health Care Programme Approach (CPA) the requirements around safe and effective transfer of care as outlined in the Trust CPA Policy and the CPA handbook section 15.0 must be followed.

11.2 People that are placed in an inpatient service outside their local area have longer lengths of stay on average, poorer clinical outcomes (including increased risk of suicide) and poorer experience of care. This is often due to the negative impact of being out of area on the continuity of their care and reduced contact with people in their support network. When someone is placed out of area, the care they receive should be as close as possible to the care they would have received locally. This includes:

a. The person's named key worker / Care Coordinator staying in contact with the person and visiting the person in hospital as regularly as they would have if the person was in hospital in their local trust.
b. The person receiving support to maintain regular contact with their chosen carer/s and support network. This must include funding the costs of transport and accommodation to facilitate visits, as well as supporting the use of technology to aid remote communication.
c. Supporting the person, as far as possible, to engage in their usual activities and to maintain their responsibilities (e.g., the upkeep of their home).
d. The local hospital team maintaining involvement with the person's care, with the aim of returning the person to their local hospital as soon as a bed becomes available, unless this would be disruptive and unhelpful to the person's recovery.
e. EPUT Discharge Coordination Team (DCT) will make contact with all OoAP providers within 2 working days of admission and facilitate connection to locality community services.
f. EPUT DCT will clarify if each person has an identified care coordinator and make referrals to appropriate team if required. This referral will take place as swiftly as possible to enable prompt allocation.
g. EPUT DCT will maintain regular contact with OoAP provider, attending MDT reviews and seeking to understand any barriers to discharge that require resolution prior to discharge.
h. EPUT DCT will hold oversight of clinical treatment pathway and progression to discharge, escalating where EPUT Clinical Director for Flow support may be indicated.
i. DCT will support community care coordinators to address barriers to discharge such as funding panel submissions and access to funds to support discharge.
j. Discharge planning will commence as soon as possible, and Care Coordinators/ Home Treatment Teams will attend MDT reviews to agree discharge plan and post discharge follow up arrangements.
k. Post discharge follow up (face to face) will be provided by community care coordinator or home treatment team (as agreed) within maximum 72 hours of discharge.
l. DCT will provide minimum weekly update to clinical matron for discharge team on progress for all individuals placed in OoAP and highlight those individuals

where escalation within EPUT or wider system is required including oversight of length of stay and those clinically ready for discharge escalation.

m. DCT will identify individuals who are priority for repatriation to EPUT, this will be informed by progression on treatment pathway and also those whose barriers to discharge will be more easily resolved placed closer to home.

n. DCT Lead will undertake regular audit of the care and treatment prior to admission for those placed in OoAP to inform service improvement.

12 Transfer of detained service users and those subject to supervised CTOs, Guardianship or Conditional Discharge

12.1 Transfer of detained service users to services other than within EPUT should unless exceptional circumstances prevail be a planned event and occur during normal working hours (9-5).

12.2 Transfer of any service user subject to Ministry of Justice conditions e.g., Section 37/41 must be authorised by the Ministry of Justice including transfer between wards, unless the warrant specifies a location e.g., Brockfield House, rather than a specific ward.

12.3 The Act makes provision for the transfer of detained service users between different hospitals, or into local authority guardianship (England), or across borders within the UK and Wales. The rules relating to transfers differ based on the Section a person is detained under. When a person is transferred under the Act the power and responsibility to detain them is transferred to the new hospital (or local authority in respect of guardianship). For further information refer the EPUT Policy for the administration of the Mental Health Act 1983 as amended by the Mental Health Act 2007.

12.4 The Act also provides the power to transfer a detained service user to countries outside the UK. This is used primarily to repatriate a service user who does not have the right to live or remain in the UK. The power authorises the legal transfer of the Service User (for example, in an aeroplane) to the receiving country. Once in the receiving country, it becomes that country's responsibility to apply its own legislation. Repatriation is usually organised by the UK Border Agency in conjunction with the Ministry of Justice if applicable.

12.5 Part VI of the Mental Health Act 1983 as amended by the Mental Health Act 2007 - Removal and Return of Patients within United Kingdom Etc. This part deals with the transfer between the United Kingdom jurisdictions and the Channel Islands or the Isle of Man of patients who are subject to certain compulsory powers. It ensures that the patients remain in legal custody whilst in transit and that they are liable to equivalent compulsory powers on their arrival in the receiving jurisdiction. It also provides in Section 86, powers for moving mentally disordered patients who are neither British Citizens nor Commonwealth Citizens with the right of abode in the United Kingdom from hospitals in England and Wales to countries abroad. The procedure to be followed on the removal of a patient to England under this Part is set out in regulations 15 & 16

of the English Regulations and regulation 29 of the Welsh Regulations' Extract from Mental Health Act Manual - Richard Jones – 13th Edition Page 429 para.1-927.

12.6 When transferring a service user to services user outside England or Wales or those services users subject to Community Treatment Orders, Guardianship or Conditional Discharge advice regarding correct procedure **must** be sought from local Mental Health Act Administrator prior to the transfer.

13 Emergency and out of hours transfers

13.1 It may be in the best interest of a service user to be transferred for urgent treatment without delay and proper arrangements and documentation cannot be developed or put in place. In these instances, the following must be considered, and any action taken in relation must be documented in clinical records:

- Arrangements regarding medication.
- Information for informing relatives, carers, care coordinator and any other external agencies that need to be informed.
- Information to be provided to service user if appropriate regarding arrangements for care.
- Any identified risk, including need for observation, escorts etc.
- Refer to paragraph 9.9 of CLPG13-MH Procedural Guidance for Safe & Secure Handling of Medicine in Mental Health services on transfer of medicines when a patient moves to another healthcare setting. Contact the on call pharmacist for advice if necessary.

13.2 If the service user is subject to detention in hospital under the Mental Health Act 1983 as amended by the Mental Health Act 2007, all decisions about their care must be made in light of Statement of Guiding Principles (Mental Health Act 1983 as amended by Mental Health Act 2007 s118) for further information refer to Code of Practice: Mental Health Act revised 2008.

13.3 For young people under the age of 18 presenting out of hours – requiring either a community team response or inpatient admission please refer to the local CAMHS procedure.

14 Temporary transfers (sleepovers)

14.1 When a service user needs to sleep over in other neighbouring units within the Trust to facilitate bed management the Temporary Transfer Form (Appendix 3) should be completed:

- Transfers after hours after 8:00pm should be avoided wherever possible.
- No Temporary transfer to take place after 11 pm, except in exceptional circumstances i.e., a result of evacuation etc.

14.2 The manager or nominated person requesting the temporary transfer should ensure that the receiving unit can meet the personal requirements of the service user, these may be related to ethnic, religious, gender/sexual orientation, physical disabilities, and/or language issues.

14.3 The reasons for the temporary transfer must be discussed with the patient and their family/carers (where appropriate) and the outcome detailed in their clinical record.

15 Disputes

15.1 This guidance is dependent on the exercise of clinical judgement and good relationships between teams and agencies. It is expected that experienced clinicians/practitioners in both affected services (learning disability services if appropriate) will have early negotiation and a clear hand-over. Even so, there may be instances where agreement cannot be reached and differences remain unresolved, potentially to the detriment of the service user, a meeting to resolve the issue must be held within 15 days. Where this is the case:

- The relevant team leader/ward manager/service manager should inform their relevant Associate Director and Clinical Director
- The Associate Director and Clinical Director must consult with relevant managers and clinicians in an attempt to resolve the dispute.
- Disputes should be resolved quickly but if no resolution seems forthcoming, the Associate Director and Clinical Director will consult with the relevant Directors to resolve the matter.

15.2 Where there is a dispute between the two parties, for example over the operation of this protocol or a difference of opinion with regard to which service should take the lead role, the appropriate local Clinical Manager responsible for the relevant geographical area in EPUT and the relevant Community or Clinical Services manager for the receiving service will be responsible for liaising and reaching the swiftest possible resolution of the dispute after hearing all relevant views. An initial meeting must occur within 15 working days of any dispute and the dispute will be documented by the EPUT staff member and passed to the relevant service director. This should also be incident reported. It is vital that as little time as possible is spent in disputes that affect people using either Trust's services.

15.3 Should the dispute remain unresolved after this; the issue will be referred to the most appropriate Director in both organisations relevant to the nature of the dispute who shall endeavour to agree an appropriate resolution of the relevant dispute within an agreed time.

16 Discharge following initial assessment of a service user who does not need the criteria for secondary mental health services (community)

16.1 If following an initial assessment, the service user is deemed not to require any further intervention from EPUT; they should be discharged back to the referrer/GP with a copy of the assessment outcome and advice on re-direction to other services if required.

In order to meet the requirements of the Care Act 2014, "in parallel with assessing a person's needs, local authorities (in this instance the Trust as carrying out these functions on the LA's behalf) must consider the benefits of approaches which delay or prevent the development of needs in individuals. This applies to both people with current needs that may be reduced or met through available universal services in the community and those who may otherwise require care and support in the future" (Care and Support statutory Guidance). This could involve directing people to community support groups, helping people to access universal services, helping service users identify their own support, helping to promote access to education, training etc. to maintain independence.

16.2 Where the assessor has identified that the service user has no eligible needs for social care, they MUST provide information and advice on what can be done to reduce or meet the identified needs (for example identifying a community support/resource) AND what can be done to prevent or delay the development of needs in the future. This information must be tailored to the needs of the individual with the aim of delaying deterioration and preventing future needs and reflect the availability of local support.

17 Discharge from EPUT mental health community based teams

17.1 The responsibilities of community based teams in discharge planning can be summarised into four key areas:

- Engaging in collaborative discharge planning at an early stage of treatment with the patient, their carer/s, internal and external stakeholders involved in the patient's treatment and care.
- Providing written and verbal treatment and medication related information for the patient being discharged and where appropriate their relative/carer.
- Providing written and verbal treatment-related information for GPs and other service providers involved in the patients care.
- Providing timely communication with patients, carer/s, GPs and other key stakeholders

17.2 The care coordinator/lead professional for the clients' care will follow the operational policy discharge process and must ensure:

- The decision is made at an MDT meeting and is clearly communicated and followed up in writing to the patient and/or carer as appropriate in advance, with clear details as to the rationale to ensure involvement.
- Information is given regarding any ongoing care /follow up by other providers.
- All risk assessments are up to date.

- Information is given to the patient on how to make contact with services in the future if needs change.

17.3 Patients who are subject to CPA and/or Section 117 being discharged to another Trust mental health service or other service the requirements of the Trust CPA Policy (MHA21 for Section 117) must be met with the care coordinator ensuring that a joint handover meeting is arranged with the receiving team which includes the following:

- A review of the care plan and crisis and contingency plan
- Where appropriate the receiving professional/team/service must identify a new care coordinator as a matter of priority
- The decision to transfer or discharge from care must be communicated in writing to the patient, their carer/s as appropriate and the patient's GP.
- Adequate time must be allowed to ensure accurate communication of all risks between care coordinators.

18 Discharge of the non-engaging service user

18.1 Exceptionally, a service user may be absent when they are discharged from EPUT services e.g., as a result of non-engagement. A review should be held so that professionals can evidence the reason for that decision and facilitate any onward planning.

18.2 The decision to discharge in a service user's absence must be based on an up to date assessment of risk (as above) and only when all attempts have been made to re-engage the service user in treatment and re-negotiate a new plan of care.

18.3 For service users on Section 117 (aftercare) or Section 7 (Guardianship) of the Mental Health Act, the care co-ordinator, in consultation with the team, will instigate a formal review with all professionals involved. In the case of Section 7 (Guardianship) the appointed Responsible Clinician must authorise the discharge from EPUT services and notification of discharge must be made in writing to the Essex County Council nominated officer (currently the ECC Head of Mental Health Commissioning). Discharge from EPUT cannot occur whilst the service user remains subject to s117.

18.4 Where there are serious concerns regarding the safety of the patient, the public, liaison with the Police, the Probation Service, MAPPA, the PREVENT lead or other relevant agency may also be appropriate in certain circumstances.

18.5 The decision to discharge and written information as to how to access services for support and in a crisis must be relayed to the patient and their families/carers.

18.6 The care coordinator / case worker is responsible for informing the GP and any other relevant parties. For more information refer to Guidance for Service users who Disengage with Mental Health Services (including non-compliance with treatment), Appointments procedure, Care Programme Approach and Mental Health Act Policies.

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19 Discharge from CPA

Within Mental Health/Learning Disability services, patients can only be discharged from CPA following a CPA Review. At no time should a patient under CPA be discharged from CPA purely on the grounds of disengagement. Full guidance should be followed in the CPA Policy and handbook.

20 Inpatient mental health services

20.1 In mental health units where patients are detained under a section of the Mental Health Act (1983) the Responsible Clinician (R/C) will authorize the removal of the section and sign the appropriate Mental Health Act 1983 (amended by the Mental Health Act 2007) discharge form.

20.2 Prior to discharge there must be explicit plans in place to ensure on-going care.

20.3 Any team or service which is to provide the ongoing community care should where possible be present/or conference call to at/to the discharge meeting and the patients care co-ordinator identified prior to discharge.

NB: Patients without accommodation are not to be discharged at the weekends as these departments e.g., housing is not open to them for advice unless hotel or B&B accommodation funded by the EPUT Discharge fund with the required community Mental Health support is in place and clearly documented. Under no circumstances would children without accommodation be discharged without prior planning involving all relevant specialist services.

20.4 In certain instances on mental health wards it is acknowledged that there are occasions where informal patients may wish to leave at short notice, against the advice of the MDT and/or refuse further service involvement. This will be subject to assessment of the patient's mental and physical state, mental capacity safeguarding circumstances and the risks to self or others and risk of deterioration of physical health. In this circumstance the nurse in charge of the shift will:

- Ask the patient to remain on the ward until seen by a member of their medical team.
- Where possible ask the patients responsible clinician (R/C) to see them prior to leaving the ward.
- If the R/C is not available, contact the junior or out of hours the duty doctor and request that they review the patient prior to them leaving the ward.
- In the event that the patient refuses to remain on the ward for a medical review the nurse in charge should again contact the R/C, or out of hours duty doctor to discuss and determine whether the patient can be classed as on leave and should return to the ward the next working day to be seen by a member of the medical team.
- For patients who are felt to lack capacity to make the decision about leaving the inpatient services and/or the patient is suffering from a mental disorder to such a degree that it is necessary for their health or safety or for the protection of others for them to be immediately prevented from leaving the hospital, an assessment

must be made for possible detention under the Mental Health Act 1983 (amended by the Mental Health Act 2007), in particular use by medical and nursing staff of the powers under sections 5(2) and 5(4) see Trust policy MHA 17 Application in respect of a patient.

- Families and Carers and all relevant persons involved in the patients care will be notified of the fact that the patient has left inpatient services at short notice by the member of staff in charge of the ward at the time.
- Where possible medication to take home will be obtained from pharmacy, determined by the nature of any risks presented by the patient. However, under no circumstances should ward stock medication be issued.

20.5 In addition the patient should be given crisis contact details of how to make contact with services in the future and asked to sign the Self-Discharge against Medical Advice notification form (CG24 Appendix 5) prior to leaving the ward. Where it has been possible to obtain medication from pharmacy a copy of the discharge prescription form will be given to the patient.

20.6 The relevant community team must undertake a face to face post discharge follow up within either 24 or 72 hours (as determined by Section 7.4, 7.5 and 7.6).

20.7 Out of hours advice can be sought from the site officer, on-call manager and on-call consultant.

20.8 The following will be completed by the named nurse or their representative at the time of discharge as a minimum requirement;

- Ensure that the discharge plans are documented in the notes.
- Record possible medical consequences of the patient's decision and that they have been explained to the patient.
- Ensure that if someone is discharging another individual, they have parental responsibility for the child or they have Power of Attorney for health and welfare if the patient has no capacity. Also consider safeguarding in these circumstances.
- Communicate the decision of patient to self-discharge with families and carers (where appropriate) and provide chosen carers information on how to access community and urgent care pathway teams.
- Notify the GP within 24 hours of the patient leaving the ward usually by means of faxing the patients discharge prescription form and posting the white copy with details which will include date of admission and discharge, medications on discharge and main diagnosis.
- Notify the relevant community team/service allocated Care Co-ordinator.
- Ensure that for those with a history of self-harm in the last three months, no more than 7 days medication is supplied.
- Ensure that a qualified nurse gives the patient their discharge medication. The nominated person must ensure that the patient understands the medication given, when it will be taken and when and how to obtain further prescriptions.
- Ensure the patient is given crisis/service contact numbers. All conversations, actions and decisions made must be documented immediately in the clinical notes.

For patients who are going to longer term residential and care home care, a handling strategy must be provided where challenging behaviour and risks are likely to be displayed.

21 Home of choice letter

21.1 To ensure the involvement of patients and their carer's at the earliest opportunity two letters are available which address the following:

- Admission to Hospital – this letter should be given to all patients admitted into hospital and relatives/carers made aware. (Appendix 1)
- Home of Choice letter – this notification letter should be used where the patient may not be able to return home and needs a nursing, residential or alternative placement on discharge. (Appendix 2)

21.2 Where it has been agreed that a place in a residential or nursing home is required and confirmed that the patient has been assessed as eligible for such provision every effort must be made to involve the patient and their carer's in the decision and to place the patient in the home of their choice in the context of an environment that is suitable to meet their needs. This needs to be considered within the local authority purchasing guidance and the required process regarding identification of placements.

21.3 Once identified the individual patient must be assessed by the MDT to determine the type of home most suitable to meet their needs. They must be advised at this stage that their preferred choice may not be available and therefore alternatives will be identified in accordance with their needs. This may necessitate discharge to a temporary placement in an alternative home. In some instances, there may be restrictions as a result of individual circumstances; for example, where a patient is restricted by law from an area of residence.

In some cases, it may not be possible to identify a place in the home of choice to coincide with the planned discharge date. The patient and their carers/relatives must be advised that a temporary /interim placement will be arranged until such time as the placement of choice comes available at which time arrangements will be made to transfer there as quickly as possible.

21.4 A discharge planning meeting will be convened during which a full discussion will take place with the patient and their relatives/carers as appropriate regarding the availability of their preferred home of choice and any alternative homes available. The patient must be reminded at this stage that if their home of choice is not available and or not likely to be available at the point of discharge, then a temporary place in another home suitable for them will be found.

21.5 The care co-ordinator/identified case worker may make the necessary approaches to both locate a placement and to the funding Authority's purchasing panel in order to secure funding for the preferred home.

21.6 A full explanation must be given to the individual and their relatives/carers (as appropriate) regarding the need for the temporary placement and followed up in writing.

21.7 A visit to any identified alternative homes will be arranged prior to discharge from hospital and any written information available will be given to the patient.

21.8 It is the responsibility of the designated care co-ordinator/case worker to monitor the patient's progress, liaise with the home of choice and inform the patient and their relatives/carers (as appropriate) when a place becomes available in the preferred home of choice.

21.9 It is expected that if the patient is discharged to a temporary placement that the review of such placements should occur weekly to ensure patients have their needs met as comprehensively and diligently as a resident on a permanent placement.

21.10 In the event that an individual patient refuses to accept an alternative home placement the matter must be referred to the relevant responsible manager for a review of the case. If the matter remains unresolved after this review the case will be referred to the respective Service Director.

22 Specific transfer and discharge arrangements

Other areas such as those providing community health services will have specific transfer and discharge guidelines as agreed with local Commissioning Care Groups. Additionally, Secure Services have bespoke procedures to ensure the safe transfer of care to mental health teams in the community.

23 Training requirements

23.1 There are no specific training needs in relation to this guideline, but staff must be familiar with its contents and the key points that the guideline covers. Awareness can be through a variety of means such as, local induction, team/one to one meetings/supervision; discussion during other awareness raising and training.

23.2 Staff must ensure that they are equipped with the skills and confidence to carry out risk assessment with patients which is an integral part of managing discharge and transfer the Trust has in place Mandatory practice requirements for staff to receive on-going training as set out within Procedural Guidelines for Procedure for the Assessment and Management of Clinical Risk.

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24 Monitoring and audit

24.1 Discharge and transfer of care are frequent and significant events in in-patient and community settings. The team leader/manager will routinely monitor implementation and compliance with this guideline. A component of management supervision must include the scrutiny of records/documentation relating to the discharge and transfer process.

24.2 All incidents or near misses, related to the discharge and/or transfer of patients should be reported via the Trust Risk Management reporting systems i.e., Datix. Monitoring of this policy will include data collected from any clinical incident reporting.

25 Approval and implementation

25.1 All Clinical policies and guidelines will be approved by the Clinical Governance & Quality Sub-Committee, which is the specialist group with the authority to approve Clinical Policies. These will then be forwarded to the Policy team for submission and ratification by the Policy Oversight and Ratification Group.

25.2 It is the author's responsibility to inform the Clinical Governance & Quality Sub-Committee of the approved documents when they are uploaded to the Trust's Intranet.

26 Preliminary equality analysis

26.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix 8)

27 References

Acts of Parliament (UK Statutes)

Care Act 2014, c. 23. Available at:
https://www.legislation.gov.uk/ukpga/2014/23/contents

Health and Care Act 2022, c.31. Available at:
https://www.legislation.gov.uk/ukpga/2022/31/contents

Homelessness Reduction Act, c.13. Available at:
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Human Rights Act 1998, c.42. Available at:
https://www.legislation.gov.uk/ukpga/1998/42/contents

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Immigration and Asylum Act 1999, c.33. Available at:
https://www.legislation.gov.uk/ukpga/1999/33/contents

Mental Capacity Act, c.9. Available at:
https://www.legislation.gov.uk/ukpga/2005/9/contents

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Mental Health Act 2007, c.12. Available at:
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Mental Health Act Code of Practice. Available at:
https://assets.publishing.service.gov.uk/media/5a80a774e5274a2e87dbb0f0/MHA_Code_of_Practice.PDF

The Care and Support (Eligibility Criteria) Regulations 2015
https://www.legislation.gov.uk/uksi/2015/313/contents/made

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Appendix 1: Admission to Hospital Letter

Click here

Appendix 2: Leaving Letter

Click here

Appendix 3: Temporary Transfer Form

Click here

Appendix 4: MDT Clinical Handover Form

Click here

Appendix 5: Self-Discharge against Medical Advice Letter

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Appendix 6: No Recourse to Public Funds (NRPF): A Guide for Enabling and Supporting Discharge from Mental Health Inpatient Services for Patients with NRPF

CG24 Appendix 6
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Author: Sarah Brazier Associate Director Flow and Operational Transformation.

Contents

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

1. INTRODUCTION

This document aims to outline a series of pathways and processes for application in ensuring that patients considered to have No Recourse to Public Funds (NRPF) are supported in line with legal requirements. A series of pathways, dependent on the needs of the patient and potential hurdles to assessing these needs, has been produced. These pathways discuss common hurdles seen in challenging appropriate, timely discharge of patients with NRPF status.

It is important to view these pathways are indicators and as guidance, rather than as definitive and total. The individual circumstances surrounding patient needs, requirements and challenges will inform the use of these pathways and may indicate the need for pathway collaboration to provide the best care for patients. As such, professional knowledge and experience should be executed alongside the use of NRPF status discharge pathway processes.

2. RATIONALE

Over recent months, there has been an increase in the number of foreign nationals with NRPF status being admitted to the Trust's inpatient mental health units following Mental Health Act (MHA) Assessments. Whilst for the majority the route to discharge is straightforward, offering purposeful admission, therapeutic inpatient care and effective discharge / repatriation, for some patients the route to repatriation is becoming increasingly difficult.

As a result of a multitude of reasons, patients who have NRPF status have the potential to become delayed discharges due to challenges associated with enabling their discharge.

EPUT's location, with its proximity to London and air and seaports, means the Trust has a higher number of patients with NRPF status than other Trusts of a similar geographical size and demographic formulation. Further, the UK's exit from the European Union has increased the amount of individuals with possible NRPF status, increasing resource requirement to enable appropriate discharge.

3. ELIGIBILITY

A person is considered to be of NRPF status when they are subject to immigration control, as defined under Section 115 of the Immigration and Asylum Act 1999. This means that they cannot public funds for benefits or housing, with the following immigration statuses being subject to immigration control:

- Leave to enter or remain in the UK which is subject to a NRPF condition;
- Leave to enter or remain in the UK that is subject to a maintenance undertaking;
- No leave to enter or remain when they are required to have this, such as an individual who overstays their visa or an asylum seeker.

Where individuals have leave to enter or remain that is subject to NRPF condition, this will be stated on the residence permit, entry clearance vignette or biometric residence permit.

Following the UK's exit from the European Union, nationals and their family members from European Economic Area (EEA) countries (EU plus Iceland, Liechtenstein and Norway), are required to obtain leave to enter or remain in order to live within the UK. Those who were living within the UK prior to 31st December 2020 have different residence rights and entitlements to services, and therefore establishing the national's immigration status will be relevant to assessing their entitlement to benefits and housing allowance. Those living in the UK prior to this date are eligible to apply for the UK settlement scheme – although applications are now officially closed, the UK Home Office still accepts applications if the person can show they had a reasonable excuse for missing the deadline.

4. LEGAL

4.1 Care Act

In order to receive assistance under the Care Act 2014, the adult must have care and support needs that arise from, or are related to, a physical or mental impairment or illness. Councils will only have a duty under Section 18 of the Care Act 2014 to meet these care and support needs when these meet the eligibility criteria set out in the Care and Support Regulations 2015, where:

- If two or more of the outcomes listed within the Regulations cannot be completed without significant difficulty due to the physical or mental impairment of illness, then the Council will consider what assistance is required.

If the eligibility criteria is not met, but the adult remains vulnerable, or if they are at risk of exploitation or harm, the Council can use power under Section 19 (1) to meet care and support needs.

4.2 Access to adult care and support generally

Assistance provided by social services is not a public fund and so access is not restricted by an individual's NRPF status alone. An assessment of need cannot be refused on the basis that a person is NRPF, subject to immigration controls or an EEA national from another state. If, following an assessment of need, a person is found to have eligible needs for care and support, the Local Authority has a duty to meet these needs, unless:

- The person is unlawfully present (overstays a visa, entered the UK illegally, refused asylum);
- The person is an EEA national from another EEA state;
- The personal has been granted refugee status by another EEA state previously;
- The person is a refused asylum seeker and has failed to comply with removal directions;
- The person is part of a refused asylum seeking family who has refused to comply with removal directions.

If any of the above categories apply, then an additional Human Rights Assessment is required to determine whether:

- The person should be returned to their country of origin to receive the adult care and support services they require; or
- Adult care and support services should be provided in the UK whilst measures are being taken to remove any barriers and support a return back to the country of origin

4.3 Insurmountable Repatriation

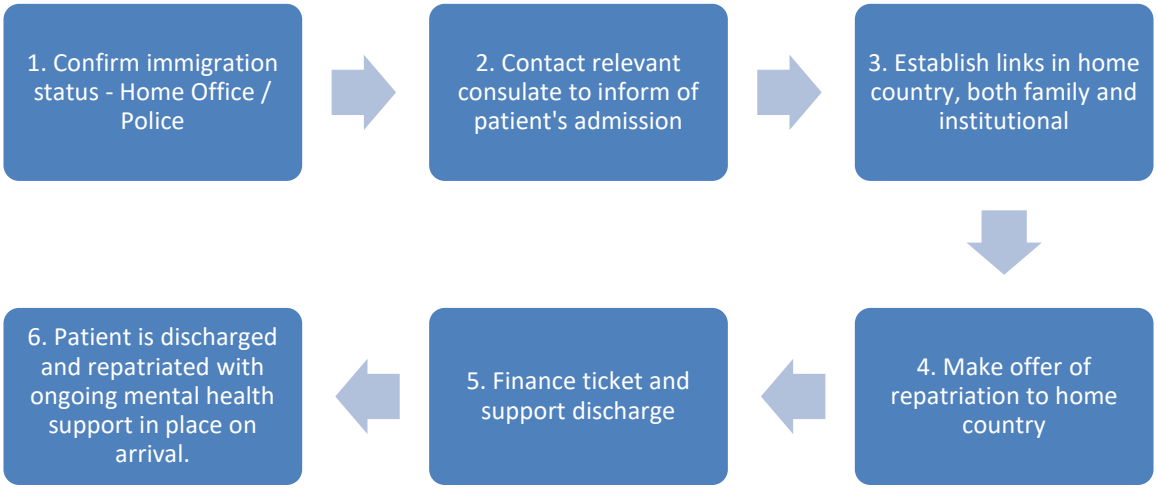
A repatriation to a country of origin is considered insurmountable where the country of origin refuses to provide travel documents to allow the person to return there, or where there is a well-founded fear of persecution. In these cases, the duty to meet care and support needs in the UK applies.

5. PATHWAYS – NO ONGOING NEEDS IDENTIFIED

The formulaic base for ensuring appropriate and efficient discharge of individuals with NRPF status is as follows: The pathways designed attempt to incorporate this core formula into their design, to ensure patient-centred delivery of care whilst maintaining care based on clinical need.

The pathways below focus on those individuals where no ongoing care needs have been identified, and an individual is considered medically fit for discharge.

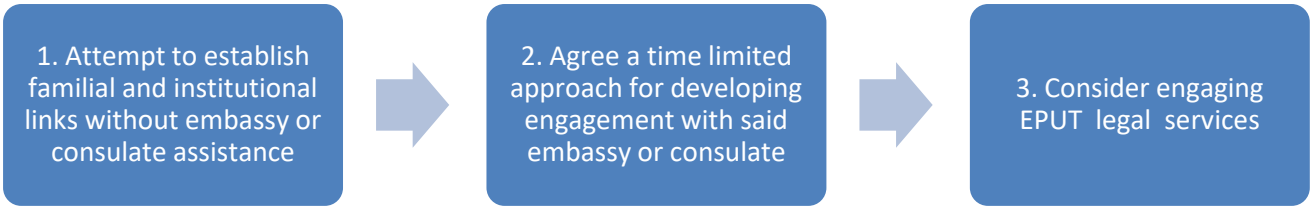
5.1 No Ongoing Needs Identified.



The above flow chart indicates the steps to be taken for enabling discharge and repatriation for individuals who are identified as having no ongoing care needs, following treatment. This pathway assumes that there are no hurdles to any of the steps outlined. Confirmation of immigration status should be sought from the Home Office contact, as described in the stakeholder table. Once nationality is confirmed, the relevant embassy or consulate should be contacted to inform them of their national's medical admission, and efforts made to establish links, both familial and institutional, within the home country. These links can also be sought without assistance from the embassy or consulate. Once links have been confirmed, an offer of repatriation to the home country should then be made, with this financed as appropriate and discharge supported as required. Patient's should then be discharged and repatriated, when appropriate.

For discharge cases where there no ongoing care needs are identified, but challenges are found in the above pathway, consult the pathways below for guidance.

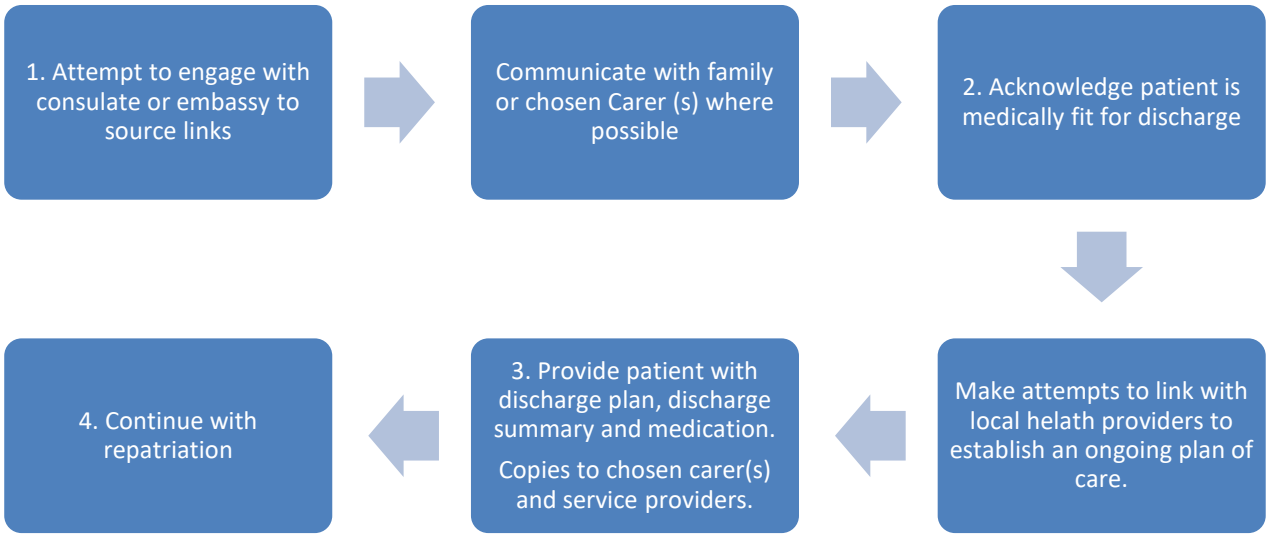
5.2 Disengaged Consulate



The engagement level of individual foreign embassies and consulates will likely vary between both country and office. Dependent on previous experiences, some offices may be more approachable when contacted using email – this should be the first choice for communication, unless alternative means are known to be more successful. Embassies or consulates should be informed that a national of theirs is currently receiving treatment as an inpatient, and the discharge is being coordinated to repatriate them to the home country.

It is advisable that discharge coordinators place a time limit on awaiting for responses from foreign consulates/High Commissions. The delay in receiving information from these foreign consulates should be avoided as a reason for keeping an individual on an inpatient treatment ward.

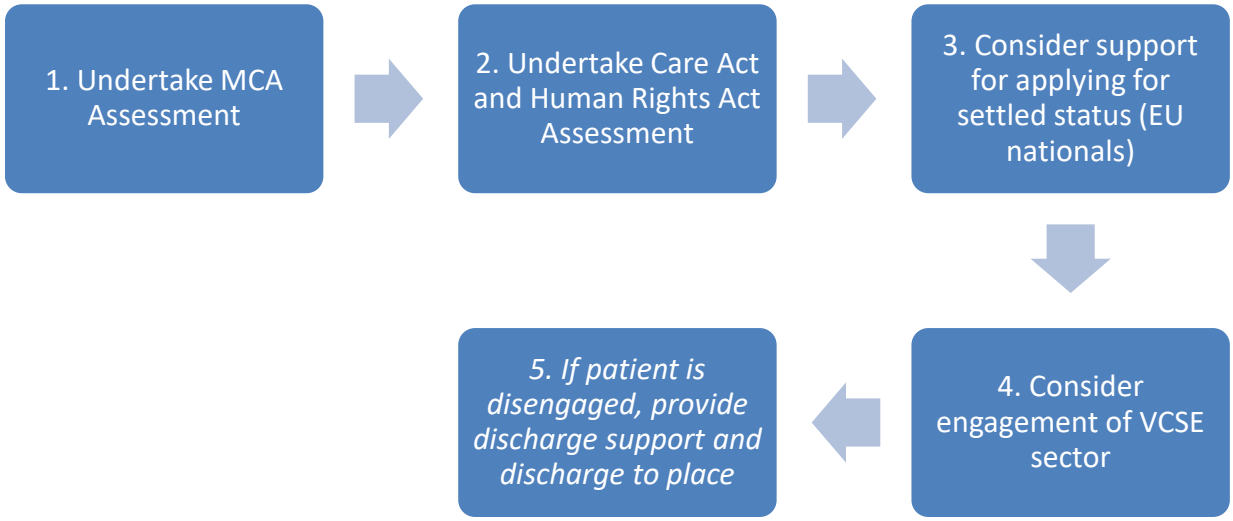
5.3 Unable to Source Links in Home Country



An attempt to engage with the consulate or embassy to source links should be undertaken. Upon acknowledgement that a patient is medically fit for discharge, and here links within a home country; both family and institutional, have not been sourced and confirmed, the patient should be provided with their discharge plan, a discharge summary, and adequate medication. This supports a continuation of care, should the patient follow this route once discharged. Efforts for repatriation back to home country, where appropriate, should continue.

This pathway requires the utilisation of positive risk management to enable discharges of patients, without links being sourced in the home country.

5.4 Refusal of Repatriation



In some circumstances, a patient may refuse repatriation to the home country. The reasons for this should be discussed with the patient, as this may provide insight previously unknown which may be preventing appropriate discharge. A Mental Capacity Assessment should be considered/undertaken, along with a Care Act and Human Rights Act Assessment. This should be based on a patient remaining in the UK or returning to their home country. Where appropriate, and if applicable, patients should be encouraged to apply for settled status within the UK, following the UK's exit from the European Union. The role of the VCSE sector, which have a focus on supporting individuals who have NRPF status, should be explored to consider which assistance may be available if the patient wishes to remain in the UK following discharge.

If a patient has a well-founded fear of persecution in their home country, then repatriation is not an appropriate course of action. In these circumstances, the duty to meet care and support needs in the UK applies.

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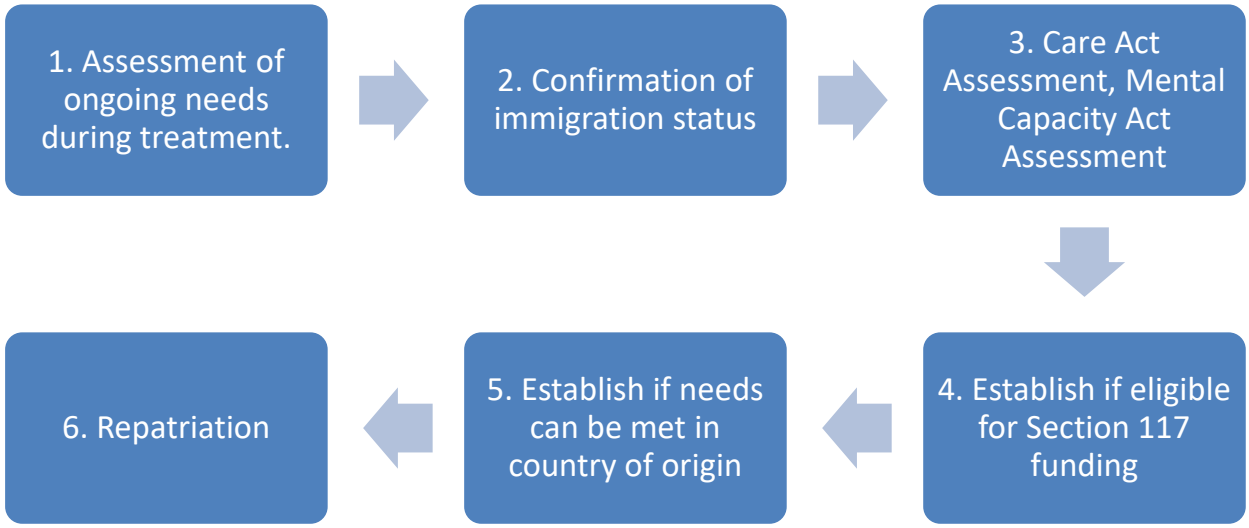
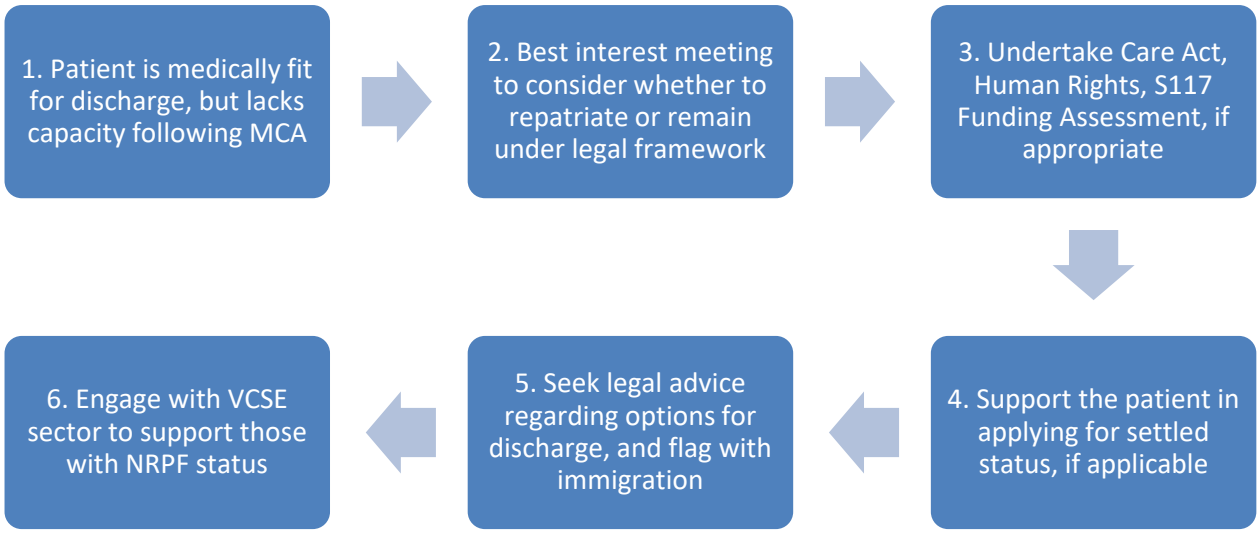
6. PATHWAYS – ONGOING NEEDS IDENTIFIED

6.1 Ongoing Needs Identified (Ideal)



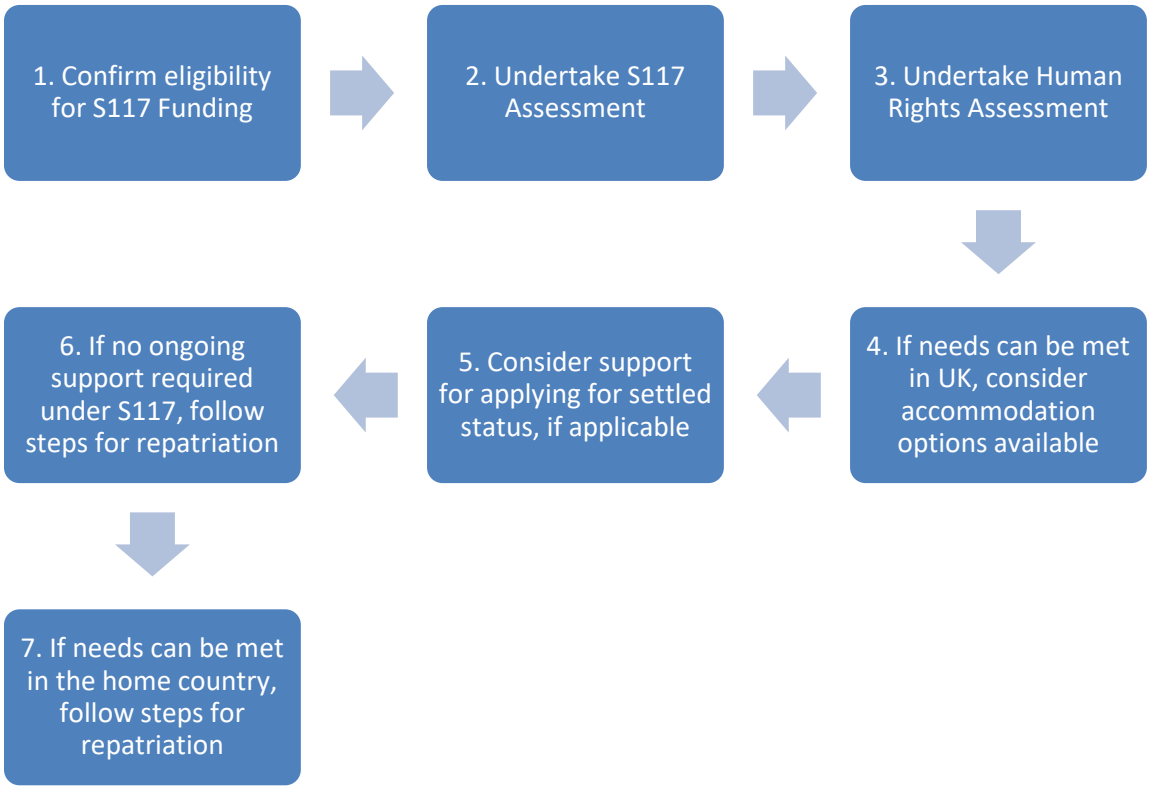
The above flow chart indicates the steps to be taken for enabling discharge and repatriation for individuals who are identified as having ongoing care needs, following treatment. This pathway assumes that there are no hurdles to any of the steps outlined. An assessment of the aftercare needs during treatment, as well as the flagging of possible NRPF status, should be undertaken prior to discharge. A Care Act Assessment and MCA Assessment should be undertaken to establish needs. It should also be considered whether the patient is eligible for Section 117 funding and support following inpatient treatment. Following, it should be established whether these needs can be met in the country of origin. If so, then steps for repatriation should be followed.

6.2 Lack Capacity, Refuses Repatriation



A patient may be identified as lacking capacity following a MCA, but be medically fit for discharge and refuse the offer of repatriation back to the home country. A best interest meeting should be organised to consider whether repatriation or remaining under legal framework is in the best interest of the patient. A Care Act and Human Rights Act Assessment should be undertaken to assess the patient's requirements and potential challenges. A MHA Section 117 funding assessment should also be completed, if appropriate. Where appropriate, and if applicable, patients should be encouraged to apply for settled status within the UK, following the UK's exit from the European Union. If settled status is not applicable, or appropriate, legal advice should be sought from the Trust's legal department surrounding options for appropriate discharge. The case should also be flagged with immigration, and potential support from the VCSE sector considered.

6.3 Patients with 117 Rights and Funding



Patients who have been detained under Section 37 (41), Section 3, amongst others, may be eligible for ongoing support under Section 117 of the Mental Health Act, relating to aftercare services that:

- Meet a need that arises from or relates to a patient's mental health problem; and,
- Reduces the risk of the mental condition getting worse and the patient having to return to hospital

If, following assessment, a patient is deemed as requiring MHA S.117 aftercare services, then a Human Rights Assessment should take place to consider whether this need can be met in the home country or in the UK. If the need can only be met in the UK, then accommodation options should be sourced, considering the limitations on accommodation provision due to the NRPF status. Where appropriate, and if applicable, patients should be encouraged to apply for settled status within the UK. If no ongoing support is required under Section 117, then steps for repatriation should be followed.

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7 FINANCING OF REPATRIATION

Patients should be asked in the first instance if they have adequate funds to support their own repatriation back to their home country (buying flights etc.). Where appropriate families and carers to be approached. If patients or their family/carer(s) indicate that they do not have adequate funds, then the Trust *may* cover the costs incurred by the repatriation, such as purchasing a flight ticket back to the home country. Currently, this is funded through the Winter Discharge Monies, and organised by contacting arrangeMy. It is important for the Trust to weigh up the cost of flight ticket against the cost of continued care within an inpatient treatment unit.

Consideration to the Trust funding the costs of repatriation must be escalated to Mental Health and Urgent Care operational Director/ Associates for authorisation to proceed. Required purchase order numbers to enable booking will be provided at time of authorisation.

8 CONTACT INFORMATION GLOSSARY

A contact glossary has been collated and produced, in which contact details for organisations external to the Trust which may be sources of information, or who support patients with NRPF, can be found.

Purpose	Organisation	Name	Contact Details
Organisation of travel arrangements	arrangeMy		bookings@arrangemy.com 01905 610016
Accommodation Support	No Accommodation Network (NACCOM)	-	office@naccom.org.uk
Advice / Resources	NRPF Network	-	nrpf@islington.gov.uk
Advice / Resources	East of England Local Government Association	I/S – Senior Manager Strategic Migration Partnership	I/S @eelga.gov.uk
Advice / Resources	Islington Council	I/S	nrpf@islington.gov.uk
Confirming Immigration Status	UK Home Office		www.gov.uk check immigration status
Domestic Abuse Victim Support	Support for Migrant Victims Scheme	Southall Black Sisters (London and South of England)	020 8571 0800
Translation Services	Language Empire (EPUT contracted)	-	https://www.language-empire.net/site/index.html New Account: bookings@empire-groupuk.com 0330 20 20 270

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Appendix 7: Protocol for the effective use of temporary (B&B/hotel) accommodation to support alternatives to admission and timely, safe patient discharge from EPUT Mental Health Inpatient Services

SOP Summary

This protocol serves to support the delivery of a consistent approach across services in EPUT.

Optimising flow throughout the system and ensuring consistent gatekeeping for admission means admitting the right patients, to the right beds, at the right time and for the right duration.

The person's discharge will be proactively planned with them and their chosen carer/s from the start of their inpatient stay so that they can leave hospital as soon as they no longer require assessments, interventions or treatments that can only be provided in an inpatient setting, with all post-discharge support provided promptly on leaving hospital.

This Protocol is informed by national guidance and details the whole system response to an escalation in operational pressures.

Process for accessing new funding available to support alternatives to admission and support discharge.

Access to time limited B&B accommodation to facilitate alternatives to admission and earliest safe discharge where clinically appropriate.

Access to funds to resolve barriers to discharge and support community alternatives to admission.

The aim of this document is to support Essex Partnership University NHS Trust, Local Authorities, Councils and the voluntary sector, working in partnership to support people who do not require inpatient mental health support and do not have accommodation.

The over- arching aim of this protocol is to ensure:

- That no one is admitted to mental health hospital where lack of housing is the priority need.
- To support timely, safe discharge from hospital.
- Reduce readmission.

Background information

Identifying a person's housing status on assessment is essential for implementing alternatives to admission and successful discharge

Most homeless people – in particular rough sleepers or those with a chaotic lifestyle – have poorer health than the rest of the population. People living in temporary or insecure accommodation may have difficulty accessing primary care which means they often do not seek treatment until the problem is at an advanced stage. Once admitted to hospital, they can present a complex medical and social picture.

Some homeless people will be known by a homeless service, such as a street outreach team, or primary care or mental health team and may have a keyworker who can provide background information and support to the patient both during admission and following discharge. Identification of a patient's housing status, key working arrangements (if any) and special vulnerabilities at an early stage in the admission is vital to achieve an appropriately planned and timely discharge.

Many of these patients will be discharged from mental health assessment units or treatment wards. Length of stay in hospital does not determine whether a patient has simple or complex discharge needs. The key criterion is the level of ongoing care required – and therefore the complexity/ simplicity of the discharge arrangements.

Patients and carers are at the centre of care and should be involved in discharge plans early in the patient's stay. It is important that they are confident they will be in hospital for an appropriate length of time. They also need information about how their treatment will be managed, when they should be discharged and what they can expect after they leave hospital.

The multiple and complex needs and lack of settled accommodation of some patients means that it can take time to identify and secure appropriate housing and services for people often delaying discharge.

Each local housing authority is required to have a homelessness strategy which must be kept under review providing an opportunity to involve all system partners working together to meet the needs of people in the borough/ district who are homeless or at risk of homelessness. This is in accordance with the principle of patient- centred care and the aim of reducing health inequalities.

Due to the potentially complex needs of some homeless people, patient discharge is most effective when supported in partnership by the inpatient ward, community care providers, the voluntary sector and the local authority housing and social care.

Organisational ownership of this protocol is important. All organisations and Services are required to be engaged with the need to promote good practice by supporting alternatives to admission and timely safe discharge.

The protocol contains the following procedures:

If the person is or may be homeless or at risk of homelessness:

- If sleeping rough, gatekeeping assessors to contact street outreach/ Homelessness providers in the area who may already be working with the individual, and who may have an accommodation plan for the individual concerned.
- If not sleeping rough, care coordinator/ clinical team to liaise with the local housing authority to ensure that an application for housing assistance can be considered.

If the person is in a hostel or other supported housing:

- If in supported housing, care coordinator to contact the person's housing/support provider and take steps to ensure they are able to maintain tenancy and do not lose their accommodation during the period of inpatient admission.
- The process for assessing need and evaluating whether the accommodation will be appropriate for them on their discharge from hospital is in place.
- Relevant local housing authority to be informed of the hospital admission if appropriate.

Process for accessing B&B/ Hotel or discharge funds to support alternative to admission:

- Home First face to face gatekeeping identifies lack of suitable accommodation as priority need.
- Community Mental Health care plan (to include Voluntary & Statutory Service) implemented to support alternative to admission.
- Liaison with locality housing provider to clarify available opportunities for emergency accommodation.
- Mechanism for referral to locality housing for further assessment of housing / accommodation. Assessor to complete 'duty to refer' to locality housing provider.
- Consider use of EPUT discharge funding for B&B/ Hotel
- EPUT authorisation for access to discharge funds to support discharge to B&B/Hotel to be sought from Mental Health and Urgent Care Director/Associates.
- In hours: Escalate to Daily safer staffing and bed occupancy sit rep for authorisation.
- Out of Hours: Escalate to On Call Manager for authorisation.
- Authorisation will only be provided once assurance given that there is a clear discharge plan for ongoing community intervention during the period which details steps to be taken and by whom to resolve the accommodation issues.
- Identification of suitable B&B/ Hotel.
- Once authorisation approved, arrangeMy to be contacted to make booking arrangements. Required purchase order numbers to enable booking will be provided by Director/Associate at time of authorisation.
- Identification of suitable B&B / Hotel.
- Time period of EPUT B&B funding in place to be shared with housing organisation (up to 5 days initially with flexibility on presentation of clear plan for resolution).

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Process for accessing B&B/ Hotel or discharge funds to support earliest safe discharge:

- Ward and Discharge Coordination team complete screening for barriers to discharge on admission and if circumstances change.
- Lack of accommodation identified.
- Liaison with locality housing provider to clarify available opportunities.
- Consider use of EPUT discharge funding for B&B/ Hotel
- Clarification of Mental Health discharge support (HF/Care Co/ Voluntary orgs/ Samaritans partnership etc.)
- Post discharge follow up arrangements in line with CG24: Transfer and Discharge Guidance to be clearly documented and provided to individual prior to leaving ward.
- Clinical team to complete 'duty to refer' to local housing provider.
- EPUT authorisation for access to discharge funds to support discharge and for B&B / Hotel accommodation:
- In hours: Escalate to Daily safer staffing and bed occupancy sit rep for authorisation or Mental Health Inpatient and urgent care unit Director/Associates.
- Out of Hours: Escalate to On Call Manager for authorisation.
- Authorisation will only be provided once assurance given that there is a clear discharge plan for ongoing community intervention during the period which details steps to be taken and by whom to resolve the accommodation issues.
- Identification of suitable B&B/ Hotel.
- Once authorisation approved, arrangeMy to be contacted to make booking arrangements. Required purchase order numbers to enable booking will be provided by Director/Associate at time of authorisation.
- Time period of EPUT B&B/ Hotel funding in place to be shared with housing organisation. (5 days initially, with flexibility on presentation of clear plan for resolution).

There is broad scope for use of available new funding and it is to be made available to support alternatives to admission or resolve barriers to discharge.

Examples (although not limited to):

- Payment of B&B/ Hotel accommodation (up to 5 days with additional 7day flexibility if demonstrated plan in place.)
- Funding for essentials (electricity, food etc.)
- Funding for essential repairs to property (e.g. Door/ Keys/ clean etc.)
- Funding to aid communication with services (Pay as you go mobile phone)
- Funding for immediate care package pending panel decision for intensive enablement/ residential care / home care support/personal budget.

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Guidance for funding amounts:

Whilst there is no clearly defined funding cap for immediate essentials such as food and electricity for all amounts in excess of £50 per item approval to be sought from budget holder. Essential food items are to be provided and not offered as a cash alternative and should not include alcohol and/or tobacco products. It will be necessary to ensure individual is connected to local food banks for ongoing support beyond the first week if required.

Essential food boxes are available for delivery at major supermarkets at £35 which can be purchased by budget holder using credit card supplied for discharge funding.

Essential repairs: Budget holder will be able to authorise payments up to the value of £100. For essential repairs in excess of £100 approval to be sought from Locality Operational Associate Director.

Communication: Basic pay as you go mobile phones are available from all major supermarkets. Inclusive of initial £10 top-up budget holder can authorise up to £50. This can only be provided as a single one off and not replaced if damaged or lost.

Consideration of use for discharge funding outside of noted parameters (above) escalate to Operational Service Managers /Associate Director for decision.

Approval for funds to be raised on daily safer staffing and bed occupancy sit rep by:

- Home First/ Crisis Team Lead
- Discharge Coordination Team Lead
- Ward Manager
- Social Care Leadership Team
- Clinical Manager

Out of hours approval to be provided by:

- On Call Manager

Budget Holder: Associate Director Social Care – James Sawtell

Mental Health Directors / Associates to be notified of all authorised use of funding.

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Annex 1: Contact information and weblinks to guidance documents.

Duty to Refer e-mails for each LHA

District:	Duty to Refer Email:
Basildon	housing.solutions@basildon.gov.uk
Braintree	housingoptions@braintree.gov.uk
Brentwood	housingneeds@brentwood.gov.uk
Castle Point	Housingoptions@castlepoint.gov.uk
Chelmsford	housing.adviceemail@chelmsford.gov.uk
Colchester	housing.solutions@colchester.gov.uk
Epping Forest	homelessness@eppingforestdc.gov.uk
Harlow	housing.options@harlow.gov.uk
Maldon	housingoptions@maldon.gov.uk
Rochford	housingoptions@rochford.gov.uk
Southend	housingsolutionsteam@southend.gov.uk
Tendring	housingoptions@tendringdc.gov.uk
Thurrock	HousingOptions@thurrock.gov.uk
Uttlesford	Housingoptions@uttlesford.gov.uk

Operational lead contact details for each participant organization

District:	Operational Lead:	Contact:
Basildon	I/S	I/S @basildon.gov.uk
Braintree	I/S	I/S @braintree.gov.uk
Brentwood	I/S	I/S @brentwood.gov.uk
Castle Point	I/S	I/S @castlepoint.gov.uk
Chelmsford	I/S	I/S @chelmsford.gov.co.uk
Colchester	I/S	I/S @cbhomes.org
Epping Forest	I/S	I/S @eppingforestdc.gov.uk
Harlow	I/S	I/S @harlow.gov.uk
Maldon	I/S	I/S @maldon.gov.uk
Rochford	I/S	I/S @rochford.gov.uk
Southend	I/S	I/S @southend.gov.uk
Tendring	I/S	I/S @tendringdc.gov.uk
Thurrock	I/S	I/S @thurrock.gov.uk
Uttlesford	I/S	I/S @uttlesford.gov.uk

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Dispute resolution contact details (only to be used where agreement cannot be reached between operational leads)

District	Contact	Dispute Resolution Contact
Basildon	I/S	I/S @basildon.gov.uk
Braintree	I/S	I/S @braintree.gov.uk
Brentwood	I/S	I/S @brentwood.gov.uk
Castle Point	I/S	I/S @castlepoint.gov.uk
Chelmsford	I/S	I/S @chelmsford.gov.uk
Colchester	I/S	I/S t@cbhomes.org.uk
Epping Forest	I/S	I/S @eppingforestdc.gov.uk
Harlow	I/S	I/S @harlow.gov.uk
Maldon	I/S	I/S @maldon.gov.uk
Rochford	I/S	I/S @Rochford.gov.uk
Southend	I/S	I/S @southend.gov.uk
Tendring	I/S	I/S @tendringdc.gov.uk
Thurrock	I/S	I/S @thurrock.gov.uk
Uttlesford	I/S	I/S @uttlesford.gov.uk

- The Duty to Refer (DtR) should be sent to the local authority as early as possible as they will aim to prevent homeless on discharge. The Homelessness Reduction Act (HRA) asks that referrals are made 56 days prior to a patient either becoming homeless or believed to become homeless. The districts though are happy for these DtR's to come in as soon as possible even if this is greater than 56 days. This means they have a longer amount of time to find accommodation for the individual. https://www.gov.uk/government/publications/homelessness-duty-to-refer/a-guide-to-the-duty-to-refer
- Generally the LA's would accept a DtR with the following information. Name, address, DOB, contact details of the patient, contact details of the health worker referring and a quick summary of the patient.
- StreetLink referral is via the StreetLink website https://www.streetlink.org.uk/
- The following rough sleeper outreach teams may be of use too but please make referrals via StreetLink first

Braintree, Chelmsford, Epping Forest, Maldon & Rochford – Managed by CHESS 01245 281104
Colchester – I/S cbhomes.org.uk
Basildon – I/S basildon.gov.uk
Harlow – I/S harlow.gov.uk

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Appendix 8: Initial Equality Impact Assessment analysis

This assessment relates to: Discharge and Transfer Clinical Guidelines
(Please tick all that apply)
Link to Full Equality Impact Assessment can be found in InPut Here:

Does this Policy/Service/Function effect one group less or more favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Race, Ethnic Origins, Nationality (including traveling communities)		
Sex (Based on Biological Sex; Male, Female or Intersex)		
Age		
Sexual Orientation Including the LGBTQ+ Community		
People who are Married or are in a Civil Partnership		
People who are Pregnant or are on Maternity / Paternity Leave		
People who are Transgender / who have had gender reassignment treatments As well as gender minority groups		
Religion, Belief or Culture Including an absence of belief		

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Does this Policy/Service/Function effect one group less or more favourably than another on the basis of:	Yes / No	What / where is the evidence / reasoning to suggest this?
Disability / Mental, Neurological or Physical health conditions Including Learning Disabilities		
Other Marginalised or Minority Groups Carers, Low Income Families, people without a fixed abode or currently living in sheltered accommodation.		

Guidance on Completing this Document

This screening tool asks for evidence to ensure that these considerations are done in collaboration with groups that may be affected. Listed below are the ways that this evidence can be gathered to support this decision:

- Reviews with Staff who may be impacted by these changes
- Service User / Carer feedback or focus groups
- Guidance from national organisations (CQC / NHS Employers)
- The Equality and Inclusion Hub (on the Staff Intranet)
- Input from Staff Equality Networks or the Equality Advisor
- Reviewing this against good practice in other NHS Trust

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Initial Screening Question	Response
If you have identified no negative impacts, then please explain how you reached that decision. please provide / attach reference to any reasoning or evidence that supports this: (Nature of policy, service or function, reviews, surveys, feedback, service user or staff data)	
Is there a need for additional consultation? (Such as with external organisations, operational leads, patients, carers or voluntary sector)	
Can we reduce any negative impacts by taking different actions or by making accommodations to this proposed Policy / Service / Function?	
Is there any way any positive impacts to certain communities could be built upon or improved to benefit all protected characteristic groups?	
If you have identified any negative impacts, are there reasons why these are valid, legal and/or justifiable?	

Please complete this document and send a copy to EPUT's Compliance, Assurance & Risk Assistant / Trust Policy Controller) at I/S @nhs.net as part of the Approval Process, if this proposal / policy etc. has no positive or negative impacts on protected characteristic groups, a Full Equality Impact Assessment will not need to be completed

To be completed by the Trust Policy Controller				
Is a Full Equality Impact Assessment Required for this Policy, Service or Function?	**Yes**		**No**	
Name:				
Date:				