The Tavistock and Portman NHS
NHS Foundation Trust

# Trust Procedure for

# Discharge, Transfer and Closure

# of Clinical Cases

*(paper files and Care Notes)*

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|---|---|
| Version: | 3.2 |
| Bodies consulted: | Management Committee |
| Approved by: | Management Committee |
| Date Approved | 5 March 2019 |
| Lead manager | |
| Responsible Director | Louise Lyon, Director of Quality and Patient Experience |
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**CONTENTS**

## 1 Introduction

The Trust recognises that there are risks to patients at the point that their care is completed and the case closed or they are transferred to the care of another provider. This procedure is designed t o address those risks and set out clear procedures that are designed to minimise risk at this point in the patient's journey. The principles of this procedure are founded on the following

- Excellent communication with and involvement of the patient/carer procedure in plans for transfer and/or discharge
- Excellent communication with professionals who need to know about the patients care at the trust (e.g. GP /referrer)
- Comprehensive record keeping (both paper and electronic) of the process

## 2 Purpose

The purpose of this procedure is to ensure a co-ordinated approach regarding the processes to be followed the transfer or discharge and of a patient and closure of the patient's file following assessment and/or treatment at the trust

## 3 Scope

This procedure and procedure applies to all staff who are involved in the management of patient discharge and closure.

The procedure is relevant for the management of all patients who's core record is held on paper in all Directorates.

In 2011 the Trust is rolling out RIO as an electronic records management system a parallel process document will be available for discharge, transfer and closure of patients' file for patients who's records are on RIO

## 4 Duties and Responsibilities

### 4.1 Trust Director

The Trust Director has overall responsibility for this procedure on behalf of the Management Committee. The Trust Director will assure the Management Committee that local procedures within Directorates comply with this Trust wide procedure.

**4.2 Director of Service Development**

The Director of Service Developments manages the Informatics department who are responsible for providing monitoring data on discharge and closure as part of the Trust's performance monitoring framework and for reporting such data as is required by external monitoring bodies.

**4.3 Clinical Directors**

The Clinical Directors are responsible for ensuring that discharge, transfer and file closure are managed in accordance with this procedure and that any locally developed procedures are in line with this Trust wide approach.

**4.4 Clinical Coordinator**

The Clinical Coordinator is responsible for ensuring all relevant documentation is completed at the conclusion of assessment/treatment at the Trust and that the referrer receives a letter with all relevant information. If care is being given under supervision, the Clinical Coordinator must ensure the trainee completes the full discharge and closure process.

**4.5 Administrative Managers**

Administrative managers are responsible for ensuring that all new administrative staff in the department have this procedure explained to them as part of local induction.

**4.6 Administrative Staff**

Administrative staff are responsible for facilitating the clinical staff in completing the patient's record at closure by providing the relevant documentation for completion. Administrative staff will prepare letters to referrers and others for signature and ensure they are dispatched in a timely manner. Administrative staff will keep CareNotes updated with the discharge/closure data following training.

**4.7 Informatics Staff**

Informatics staff are responsible for training administrative staff in the use of CareNotes and for monitoring, analysing and reporting rates of discharge and closure as part of the Trust's Performance Management programme.

## 5 Discharge and Closure Procedure for Adult Department and Portman Clinic

## 5.1 Procedure at Completion of Assessment

Patients at the end of a period of assessment should be made fully aware of its conclusion and if treatment is not being offered, the reasons for this.

An Assessment form is completed by the clinican at the conclusion of the assessment summarising all aspects of the assessment, which should be signed the clinician and if necessary countersigned by the Supervising Clinican (trainees)

Outcome monitoring data should be recorded on the CORE outcome monitoring form and passed to the outcome monitoring team for data entry and analysis.

A letter should be sent to the GP, recording the main facts of the assessment and the patient, and indicating the reasons for offering or not offering further treatment to the patient. This letter should be sent within 14 days as required by the Trust Case Note Standards

- If treatment is offered details of the proposed care plan should be included in the letter

- If treatment is not offered, advice should be offered on possible alternatives. .

On completion of these records by the clinician, the Unit Administrator will record the outcome on the Care Notes IT system and if no further treatment is to be offered will arrange for the file to be closed on CareNotes, and will arrange for the paper file to be sent to the Records Library.

## 5.2 Procedures on Termination of Treatment

In general a patient's treatment will be concluded at the end of a period agreed in advance or where treatment had been indefinite, with a period of notice. Closure of the case will be accompanied by a review of potential future needs of the patient and where necessary referral to other services. This should be summarised in a letter to the GP.

Patients who fail 3 consecutive appointments should be sent a letter requesting confirmation of further attendance within a defined period. If there is no further response from the patient, the case should normally be closed in accordance with the Trust Case Note Standards within 28 days, unless there are specific clinical reasons for holding the vacancy.

Patients in intensive treatment, more than once weekly, who fail to attend appointments regularly, should be reviewed by a member of the senior staff to decide on the continuation of the treatment.

When patients do not sustain their treatment or make a decision against the advice of the clinician and the case is closed, the GP should be written to summarising the progress of the treatment and its outcome. The letter should also indicate any issues of possible future management, care and risk, including the suitability of the patient for re-referral.

If the clinician makes a decision to end treatment when the treatment has become untenable because of some behaviour on the part of the patient, for example, an unacceptable expression of violence, prolonged absences with no willingness to review its significance, or a deterioration in the patient's condition indicating a need for an alternative treatment intervention, the GP and any associated mental health professional will be informed, with an assessment of the likely risks to the patient or others.

All terminations of treatment should be recorded by clinicians within a period of 28 days by:

- Completion of the CPA closure form
- CORE outcome monitoring form
- GP letter and to referrer if different.

In addition, in cases where the patient has not continued with the treatment that was offered, a letter confirming the closure of their case and advice as to further contact should be sent to the patient.

On completion of the record by the clinician, the administrator should enter the details on the Care Notes IT system and archive the file.

### 5.3 Summary of Clinician Procedures on Closure

- CPA record
- Outcome monitoring data
- GP letter
- Patient confirmation in writing when patient has ended contact.

### 5.4 Summary of Administrator Procedures on Closure

- Ensure completion of clinical record
- Entering data on Care Notes system
- Ensuring that the letter to referrer/GP is dispatched when complete
- Sending a copy of the GP/referrer letter to the patient if the option to receive a copy is marked on the assessment form

## 6 Discharge and Closure Procedure for Child and Family Department

### 6.1 Ending Treatment with Child, Young Person, Family or Carers

By mutual agreement whereby both the therapist and those involved terminate the treatment and the ending is worked towards jointly. This might happen when a treatment process has been judged to come to an end. It might also happen when those involved can no longer continue with the treatment because the clinician leaves the Clinic of the patient/family moves away and a joint decision is taken not to refer the patient for further treatment.

The child, young person or family makes a decision to end treatment, for whatever reason, against the expressed judgement of the clinician. At times such a decision is not expressed directly to the clinician but is communicated through non attendance at appointments.

The clinician makes a decision to end treatment when the treatment has become untenable or an alternative treatment or intervention is indicated.

### 6.2 Procedures on Termination of Treatment

In general treatment will be concluded at the end of a period agreed in advance or where treatment has been indefinite, with a period of notice. Closure of the case will be accompanied by a review of potential future needs of the child, young person and family and where necessary a referral to other services.

Patients who fail 3 consecutive appointments should be sent a letter requesting confirmation of further attendance within a defined period. If there is no further response from the patient, the case should normally be closed in accordance with the Trust Case Note Standards within 28 days, unless there are specific reasons for holding the vacancy. Specific reasons might include child protection concerns or other serious concerns about a child's wellbeing. In these cases contact should be made with other professionals within the network.

Patients in intensive treatment, more than once weekly, who fail to attend appointments regularly, should be reviewed by a member of senior staff to decide on the continuation of treatment.

When patients do not sustain their treatment and the vacancy is closed, the GP/referrer should be written to summarising the progress of the treatment and its outcome. The letter should also indicate any issues of possible future management, care and risk, including the suitability of the patient for re-referral.

All terminations of treatment should be recorded by clinicians within a period of 28 days by:

- Completion of the CPA closure form
- CORE outcome monitoring form
- GP letter and to referrer if different.

In addition, where termination was not mutually agreed between patient and clinician, a letter confirming the closure of their case and advice as to further contact should be sent to the patient.

**Administrator Procedures on Closure**

- Ensure completion of clinical record
- Entering data on Care Notes system
- Ensuring that the letter to referrer/GP is dispatched when complete
- Sending a copy of the GP/referrer letter to the parent/guardian if the option to receive a copy is marked on the assessment form

## 7 Discharge and Clsoure Procedure for Adolescent Department

### 7.1 Assessment

Patients at the end of a period of assessment should be made fully aware of its conclusion and if treatment is not being offered, the reasons for this.

A CPA Assessment form is completed at the conclusion of the assessment summarising all aspects of the assessment, which should be signed and dated by the clinician and the Case Consultant.

A letter should be sent to the referrer and GP where appropriate, recording:

- the date of the original referral
- the date of the first session
- the number of times seen
- the main facts of the assessment and the patient, indicating the reasons for offering or not offering further treatment to the patient.

If treatment is offered the level of CPA should be indicated in the letter along with the essential aspects of the Care Plan.

If treatment is not offered, advice should be offered on possible alternatives.

The letter to the referrer/GP should be sent within 14 days as required by the Trust Case Note Standards.

On completion of these records, the Departmental Administrator, will record the outcome on the Care Notes system.

## 7.2 Procedures on Termination of Treatment

In general, a patient's treatment will be concluded at the end of a period agreed in advance or in treatments where no closing date had been agreed in advance, with a period of notice. Closure of the case will be accompanied by a review of potential future needs of the patient and where necessary referral to other services.

After three consecutive non-attendances, in the context of an ongoing treatment, the clinician will review the case with the clinical supervisor. This may involve discussions with the GP and referrer, as appropriate. A decision as to the most appropriate course of action will be made by taking into account the facts of each individual case.

- **In the event of case closure** the patient, GP and referrer are notified in writing.

- **If the treatment programme continues** a letter is sent to the patient reminding him/her of the importance of contacting the Clinic should s/he be unable to attend the next scheduled appointment.

- **Should the patient in an ongoing treatment continue to non-attend,** the case will be closed after a reasonable and appropriate period, having regard to all relevant facts pertaining to the individual case. The patient, GP and referrer will be informed in writing summarising the progress of the treatment and its outcome. The letter should also indicate any issues of possible future management, care and risk, including the suitability of the patient for re-referral.

There are a number of patients who may take leave during treatment. In such cases the clinician should clarify with the patient the reason for the absence as well as when treatment is to be resumed. It is the responsibility of the clinician to inform the department's receptionist in advance of the period of absence in order for the appropriate appointments to be deleted from Care Notes.

In cases where treatment has broken down and it is not clear whether this is permanent or temporary (e.g. in the context of in-patient admission), the clinician will, as appropriate, maintain contact with the patient, GP, referrer and in-patient provider and be available for Consultation to the network. Only through such contact will the clinician and clinical

supervisor (and/or case Consultant where appropriate) be able to make a judgment as to continued treatment or case closure. It is the responsibility of the clinician to inform the admin staff of treatment breakdown in order for the appropriate appointments to be deleted from Care Notes.

Unless there are clear clinical indications for keeping a file open, which will be recorded in the file by the clinician, all terminations of treatment should be recorded by clinicians within a period of 28 days by:

- Completion of the CPA closure form
- CORE outcome monitoring form
- GP letter and to referrer if different

In addition, in cases where the patient has not continued with the treatment that was offered, a letter confirming the closure of their case and advice as to further contact should be sent to the patient.

**Administrator Procedures on Closure**

- Ensure completion of clinical record
- Entering data on Care Notes system
- Ensuring that the letter to referrer/GP is dispatched when complete
- Sending a copy of the GP/referrer letter to the patient if the option to receive a copy is marked on the assessment form (refer to Copying Letter to Patients Procedure)

### 7.3 Patients Who Fail to Opt-In

Patients accepted by the Intake Team will be contacted inviting them to 'opt-in'. If there is no response within two weeks of the initial letter, a reminder will be sent. If there is no response to the latter within a week, the case should be closed by the administrator.

## 8 Transfer of Care (all Directorates)

If the assessment or treatment result in a clinical decision that it is in the patients best interest for their care to be transferred to an alternative provider the Transfer of Care Protocol is to be followed. This protocol forms part of the Core Service Agreement and is shown at **Appendix A**

## 9 Implementation of Procedure and Training Requirements

This procedure will be available to staff via the intranet. All new clinical staff and administrative staff working with patients should familiarise themselves with the procedures as part of induction. Clinical Directors and administration mangers should monitor adherence to the procedures and arrange for local training and support following any incident/breach of procedure

## 10 Process for Monitoring Compliance with the Procedure

The following arrangements will be made to monitor the effectiveness of this procedure.

- Adherence to this procedure will be monitored as part of the annual case note audit (see Clinical Records Audit Procedure)
- Complaints regarding discharge will be monitored through the Trust Complaints Procedures, and reviewed by the Risk Management Committee.
- Clinical Directors will monitor local compliance through exception reporting via administrative staff when administrative targets are not achieved
- Discharge data will be reviewed quarterly as part of the Performance Reporting schedule, and data with commentary will be submitted to the Board. By the Director of Performance
- The procedure will be reviewed every two years, or earlier if legal or NHS changes to discharge arrangements are introduced.

## 11 Equality Impact Statement

This procedure has been screened using the Trust's Equality Impact Tool and has been found not to discriminate against any group of persons. The EQIA form is included at **Appendix A.**

## 12 References


- Department of Health. (1999). *Guidance on the Health Act Section 31 Partnership Arrangements*. London: Department of Health.
- Department of Health. (1999). *National Service Framework for Mental Health*. London: Department of Health.
- Department of Health. (2001). *National Service Framework – for Older People*. London: Department of Health. Available at: www.dh.gov.uk

- Core

## 13 Associated Documents

Health Records Procedure
Procedure for the Audit of Case notes
Copying Letters to Patients Procedure

Appendix A

## Transfer Protocol

### 1.0 Introduction:

When reviewing the Service User's treatment and care, determine what kind of further treatment and care the Service User may need, and the most appropriate and clinically best service providers available for providing all or part of it under the NHS. The Provider shall involve the Service User and/or their carer(s) in this process and where reasonably possible, seek to reach agreement with the Service User and/or their carer(s).

If this is likely to necessitate a Transfer of Care to another service provider, the Provider shall proceed as follows.

### 1.1 Protocol for Transfer of Care

1.1.1 The Provider shall select one or more services which the Provider judges to be the clinically best and most appropriate providers of the treatment and care needed by the Service User.

1.1.2 Services in or near to the geographic area covered by the Commissioner shall be given preference, unless there are special reasons for which the Service User may have for being treated and or cared for elsewhere (e.g. because they are a public sector employee in the area covered by the responsible commissioner).

1.1.3 If similar referrals have not already been made by the Provider within the last two years, the Provider shall consult the selected service providers, to check whether they are likely to accept the referral and how soon they may be able to see the Service User if referred.

1.1.4 The Provider shall involve the Service User and/or carer(s) when choosing which service provider the Service User should be referred to, by, when reasonably possible, offering two or more Service Providers selected in accordance with Clauses 1.1.1 to 1.1.3, in this Part 2 of Schedule 2. *

1.2 The Provider shall then send a referral letter to the chosen service provider, detailing the Service Users' mental health conditions, medical history, relevant personal circumstances, and the recommended treatment and care. The letter shall include the Service User's NHS number and GP details when known to the Provider, and shall comply with Caldicott principles. Subject to the Service User and/or their carer(s) consent, the referral letter shall be copied to the Service User's GP.

1.3 Responsibility for the Care of the Service User shall transfer to the Service provider to which the patient has been referred. Pending the Service User being seen by that or another Service provider, the responsibility of Care shall automatically return to the GP if they have received a copy of the referral letter. If the GP has not been informed of the Transfer of Care, or the Service User is not registered with a GP, the Provider shall continue to be responsible for the Service User until confirmation has been received that another provider has accepted the Transfer of Care or the Service User has died.

* refers to STANDARD NHS MULTILATERAL CONTRACT FOR MENTAL HEALTH AND LEARNING DISABILITY SERVICES, further Robin Bonner, in the Contracting team

**Appendix B**

**EQUALITY IMPACT ASSESSMENT**

**– INITIAL SCREENING**

1. Name of policy, function, or service development being assessed:
Procedure for Discharge and Closure of Clinical cases

2. Name of person carrying out the assessment: Jane Chapman

3. Please describe the purpose of the policy, function or service development:

The purpose of this procedure is to ensure a co-ordinated approach regarding the procedures required for the discharge and closure of a patient attending any of the following departments/clinics within the Tavistock and Portman NHS Trust:

4. Does this policy, function or service development impact on patients, staff and/or the public? **YES** (*go to Section 5*.)

5. Is there reason to believe that the policy, function or service development could have an adverse impact on a particular group or groups?

**NO**

6. If you answered **YES in section 5,** how have you reached that conclusion?

Note this is a procedural document that sets out administrative steps to ensure effective closure of clinical cases. It is applied on a case by case basis and the procedure is followed for all patients according to Directorate. The procedure should have a neutral influenced by equality issues.

7. Based on the initial screening process, now rate the level of impact on equality groups of the policy, function or service development:

**Low…….(i.e. minimal risk of having, or does not have negative impact on equality)**

Date completed ……14.7.08 (reviewed 2010 no change)

Print name ……Jane Chapman……