

<b>Reference Number:</b> UHB 551 <b>Version Number:</b> 1	<b>Date of Next Review:</b> 22/11/2027 <b>Previous Trust/LHB Reference Number:</b> <i>n/a</i>
<b>CMHT Standard Operating Procedure - Transfers</b>	
<b>Introduction and Aim</b>  <p>The following Standard Operating Procedure is devised to set out the transfer arrangements for those individuals allocated to the CMHT caseload as well as those newly resident in areas who may be open to existing clinical teams.</p> <p>It's intention is to enable a seamless transition between local services and advise on relevant individuals, pertinent information sharing and responsible bodies for dispute and resolution.</p>	
<b>Objectives</b>  <p>This procedure is designed to help describe the standard expected processes involved in managing a patient transfer request that is received by the CMHT.</p> <p><b>Not all clinical cases will align with the devised procedure. In instances where this is the case, clinical judgement and informed rationale will be required for actions taken in response to daily working tasks. Each time this is the case, safe care and individual service user need must be prioritised. Documentation of clinical rationale that has informed your decision making must be recorded in the case record.</b></p>	
<b>Supporting Procedures and Written Control Documents</b>  <p>Referrals SOP          117 Policy</p>	
<b>Scope</b> <p>This document defines the procedure for the transfer of care, (including the “re sectorisation”), of adults of working age between secondary care Community Mental Health Services in Cardiff and the Vale of Glamorgan. As well as process to follow when transferring in/out of Cardiff and Vale.</p>	
<b>Equality Impact Assessment</b>	<p>An Equality Impact Assessment (EQIA) has not been completed as there were no identifiable impacts of this policy review/update.</p>
<b>Policy Approved by</b>	<p>Mental Health Clinical Board Control Document Oversight Group</p>

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<b>Group with authority to approve procedures written to explain how this policy will be implemented</b>	Mental Health Clinical Board Control Document Oversight Group
<b>Accountable Executive or Clinical Board Director</b>	Mark Doherty, Director of Nursing

**Disclaimer**  
**If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the [Governance Directorate](#).**

Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	22/11/2024	18/12/2025	<i>New document, approved</i>
2			

## 1. Introduction

The population of Cardiff and Vale is varied with communities often sitting across Gp and CMHT boundaries. Individuals responsible CMHT's is determined by an individuals registered Gp. With movement across Cardiff and the Vale it is a frequently the case that clinically cases require transfer between CMHT's.

Reasons for a required transfer can occur for many reasons including:

- Individual changing Gp Practice

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- Individual changing home address
- Changing needs of individuals
- Individual requesting to transfer team
- Individual being placed in a commissioned care setting by Cardiff and Vale Complex Care and Commissioning team.

## 2. Request

The transfer of care or re - sectorisation request will be made by the Care Coordinator via a PARIS transfer request, unless the individual concerned is subject to a Community Treatment Order where the Responsible Clinician should make the transfer request.

The request will be addressed to the Manager and Administration Manager of the team requested to take over the individuals care and treatment.

The request will include.

- Reason for transfer of care/ re-sectorisation request.
- An indication of which professional groups need to be involved with the individuals Care and treatment
- A brief summary of the history of the client: including diagnosis, treatments/interventions undertaken in the past
- A description of current care and treatment being undertaken, goals outlined in the care plan, social situation
- Commissioned care package and funding arrangements where appropriate
- Current 117 responsibility

The accepting CMHT will process request via their referrals process. It is expected that liaison with the Care Coordinator or RC making the request will take place to arrange a CTP/117 handover meeting

## 3 Documentation

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The Care Coordinator making the request for transfer will ensure that the following documentation is up to date on the PARIS system, *before* making the sectorisation request.

- Assessment Form 1a,
- Care and Treatment Plan
- Risk Assessment/WARRN with risk management plan where the risk assessment indicates this is appropriate
- Relapse Prevention/Management Plan
- For individuals placed in a funded placement who are 117, Local Authority integrated assessment should be up to date and available
- For individuals who are entirely health funded through Continuing Health Care funding and not 117, the Decision Support Tool to support the decision making around continuing Health Care Eligibility should be in date
- Include details of the individuals current Section 117 eligibility and/or other legal frameworks i.e. Community Treatment Orders, DOLS, Guardianship Orders.

### 3.2 Part 1 - Recovery and Maintenance Programme (RAMP)

- RAMP is considered to be a broad-spectrum Part 1 MHM scheme, as such CTP documentation is not a statutory requirement and therefore not required at point of transfer.
- Transfer of RAMP cases between CMHT's will require a clinical request letter to be completed by the allocated RAMP practitioner to the receiving Team manager for discussion in the appropriate forum.

**4. The transfer of care (or handover) meeting** will be arranged at a time and place convenient for all parties to attend. As a minimum, the hand over meeting should include the current Care Coordinator, the new Care Coordinator, and the service user

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- 4.2** The meeting will be arranged in a timely manner (within a maximum of three months) following the transfer of care request. Patient care should not be affected by any delay in decision making between teams
- 4.3** Until the formal transfer of care meeting has taken place, the referring team will retain responsibility for providing and coordinating care and treatment
- 4.4** Where a transfer of care meeting has been arranged but is not attended by either current Care Co-ordinator/RC or projected newly allocated Care Co-ordinator/RC, then the referring CMHT will retain responsibility for providing and coordinating care and treatment until another meeting can be arranged.
- 4.5** Once the meeting has been held, and the transfer of care formally accepted by the accepting team, the case files will be transferred to the new team on the PARIS system if internal or copies of relevant documentation sent to external CMHT
- 4.6** If individual is in funded placement or has care package the care coordinator should outline the reason for placement/package, expected outcome of placement/package, and anticipated timescale of improvement (if expected). From this agreement should be made on robust monitoring arrangements including review periods and commitment from transferring team to attendance of these.
- 4.7** If an individual is prescribed Clozapine medication, good practice will involve liaising with pharmacy. It is essential for seamless transfer to manage registration with a new clozapine provider, facilitate monitoring and supply.
- 4.8** Agree arrangements in event of deterioration, including if admission is indicated in future. Discuss relapse indicators and any current crisis plans in place

## **5 Disputes regarding responsibility for care and treatment**

- 5.1** Patient care should not be affected by disputes about responsibility for care and treatment. Decisions taken must be taken with the patients interest and health outcomes in mind. Where a dispute between teams arises, the referring team will retain responsibility for care and treatment until the dispute is resolved, and the transfer of care process completed

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- 5.2** Resolution of any dispute should be facilitated by the Managers of the teams concerned.
- 5.3** If resolution cannot be reached at a local level, the case should be escalated to the Clinical Director for Adult Mental Health Senior Managers who will facilitate a decision
- 5.4** Out of Area requests for transfer are to be managed by the responsible team manager or appropriately delegated team member. Complex Care and Commissioning should be notified of all OOA transfer requests.
- 5.5** Should dispute arise following OOA requests this is to be escalated to the Clinical Director, Senior Nurse Manager, Service Manager and Directorate Managers.

## **6. Transfer out of Cardiff and Vale UHB/LA**

- 6.1** If possible best practice would be that team is aware of forthcoming move and have planned review CTP/117 prior to move
- 6.2** Once detail of new address, GP and local mental health team is known transfer request as outlined in Section 2 is to be sent.
- 6.3** Proportionate to the individuals need a handover meeting (Section 4.) should be arranged, this may depend on complexity of care/treatment and funding arrangements
- 6.4** The receiving Health/Local Authority may have local, pre-determined process for such transfers and so clarity should be sought at point of transfer request to mitigate potential delay.
- 6.5** Should a dispute arise with the individuals new Local Authority and Responsible Health Authority, if not resolvable locally, should be escalated to the Clinical Director and Directorate Managers.

## **7. Commissioned care placements or packages**

- 7.1** Individuals placed in commissioned care settings by Health Authorities outside of Cardiff and Vale are eligible for Crisis and Emergency care only; Referrals into CMHT's should be dealt with accordingly. The Complex Care and Commissioning service should be advised of such referrals. Disputes should be considered in line the process set out in section 5.

## **8.0 New residents to Cardiff and the Vale**

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**8.1** On occasion whereby an individual relocates to the Cardiff and Vale catchment area independently; who may be under the care of an outside health authority the referral should be approached in-line with the Mental Health Measure's statement of right to access local services.

**8.2** Referrals on occasions such as this should be considered within the Referral Screening Meeting and responded to on a case by case basis, considering the patients level of need with agreement from/with the responsible health authority.

## **9. PARIS process for transfers**

**9.1** Internal PARIS transfers are to be managed by the Administration Team Manager in both the transferring and receiving CMHT's via the Caseload Manager in the following steps:

1. CTP, CPA1a and WARRN documentation to be updated
2. Formal transfer request letter addressed to receiving teams Integrated Manager and Administrator Manager to be completed by the involved clinical team; inclusive of invitation to arranged handover meeting.
3. Transferring CMHT Administrator Team Manager to be sent Paris notification in completion of the transfer request letter. Administrator Team Manager to initiate Transfer Request to receiving Team.
4. Receiving CMHT's Administrator Team Manager to be sent a Paris notification.
5. Receiving team Referral meeting discussion to be documented inclusive of allocated staff to attend arranged handover meeting.
5. Attending clinician to feedback in receiving teams MDT meeting.
6. When transfer agreed, Caseload Manager to be completed by Administrator Team Managers.
7. Particular attention is to be paid to those clients Subject to 117 of the MHA where 1117 reviewing responsibility is being transferred. This process is to be managed by the Administrator Team Managers in conjunction with the MHA Office after the adherence to the previous 6 steps.

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## Appendices

### Appendix 1: Letter Content Template Handover requests

- Reason for transfer of care/ re-sectorisation request.
- An indication of which professional groups need to be involved with the individuals Care and treatment

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- A brief summary of the history of the client: including diagnosis, treatments/interventions undertaken in the past
- A description of current care and treatment being undertaken, goals outlined in the care plan, social situation
- Commissioned care package and funding arrangements where appropriate
- Current 117 responsibility

## **Appendix 2: Letter Content Template Confirmation of Transfer**

- Date of Transfer request
- Date of handover meeting
- Agreement of what care will be provided by receiving team
- Outline of any remaining responsibility of transferring team (117/placement reviews)
- If 117- agreed review period; you agreed to inform us of any notable changes to the individuals care needs, if they move out of your area and if you are considering discharge from your service in future