STANDARD OPERATING PROCEDURE: PATIENT TRANSFER & SPECIAL ALLOCATION SCHEME (SAS) PROCESS

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1.0 INTRODUCTION / PURPOSE

Consideration and guidance have been sought from the existing Standard Operating Procedures of Primary Care Sheffield, Sheffield Health and Social Care and MIND, the partner organisations in Sheffield's Primary & Community Mental Health Service (PCMHS).

A review into continuity of care in primary and secondary care, concluded that mortality rates are lower with higher continuity of care, Barker et al. (2020).

This policy applies to the transfer of all service users of the PCMHS. All staff must ensure & achieve effective transfer of service users through good communication between professionals, whether verbal or written, in a planned and structured way. The duties of staff involved in the process should be clear to ensure all risks relating to the transfer of a service

user are identified and discussed so that appropriate risk management plans can be put into place and to ensure that appropriate documentation is completed throughout the transfer process.

Purpose:

- To provide clarity regarding when a patient's treatment will move to another PCN team.
- To provide clarity regarding when a patient's treatment will not move to another PCN team.
- To provide clarity in the circumstance a person has been waiting for treatment from outside Sheffield moves to a Sheffield GP.
- To ensure a consistent, safe, and effective operational process for patient transfer to another Primary Care Network (PCN) within the city.
- To provide a quick efficient pathway for health care professionals to ensure safe and efficient patient flow and minimise any disruption to care.
- To ensure clarity for clinicians supporting patients who have been removed form a GP practice register following alleged violent or aggressive behaviour, to ensure clinician safety and maintain access to care for patients with minimal disruption to their care.

2.0 PATIENT TRANSFER TO ANOTHER PCN, WITH MDT

2.1 When a patient moves to another area of the city that has existing provision under PCMH, then transfer to equivalent clinician, i.e., MHP to MHP, OT to OT, in receiving PCN should be facilitated at the first available opportunity, prior to the patient commencing treatment. If treatment has commenced then treatment should be completed by original PCN. This process should be explained to the patient as soon as possible, when discovering patient has or intends to move out of area.

2.2 Should travel be an issue for the patient and they wish to be seen in person in new PCN then it should be explained that with their consent we could seek to transfer, however they would need to join the waiting list at the bottom if there is a wait.

2.3 Consideration should be given to the progress within the patients care as to whether it would be appropriate to transfer to another clinician i.e., if at session 1 or 2 of 12 sessions then it may be more appropriate to transfer than if at session 10 or 11 of 12, in which case a clinician may wish to end care as planned, following all scheduled interventions. A clinical rationale should be explicitly documented on patient record and agreed with patient prior to such decision being made.

2.4 Full handover should be given to receiving clinician as soon as possible, taking into consideration their existing workload. Dependent upon the progress of the patient

within their care, it may be appropriate to add them to a waiting list for receiving clinician.

2.5 When a patient moves from a PCN outside of Sheffield and the treatment they need is not offered within PCMH then the patient can choose to stay in treatment with their previous PCN or service. If PCMH does offer the same treatment then the patient can either continue treatment with original provider or choose to wait for service under PCMH, however the patient will have to be added to the waiting list from the date they moved to Sheffield PCN.

2.6 It is the clinician's clinical judgement as to whether care should be transferred or remain in original PCN, however an explicit rationale for decision making should be clearly identified in patient record and PCN Network Manager and Clinical Director be made aware of this.

3.0 PATIENT TRANSFER TO PCN, WITHOUT MDT

3.1 The above process should be followed if receiving PCN has equivalent clinician, i.e., MHP to MHP, OT to OT etc.

3.2 Should receiving PCN not have equivalent profession within MDT i.e., MHP to CBT Therapist, then care should continue with clinician in original PCN, to ensure continuity of care.

3.3 PCN Network Managers and Clinical Directors should be made aware immediately if care is to continue in original PCN, with rationale clearly identified and visible in the patient's record.

4.0 PATIENT ADDED TO SPECIAL ALLOCATION SCHEME (SAS)

4.1 When a patient has been added to the Special Allocation Scheme due to alleged violent or aggressive behaviour then there should be no change to their care under PCMH, other than care should be delivered remotely. The rationale for this should be clearly explained to the patient following their alleged behaviour and staff should endeavour to offer remote care in the format they wish to receive it, i.e., videocall or telephone call.

4.2 An alert should be added to the patient's home screen identifying that they are for remote consultations only following being added to the SAS.

APPENDIX 1 – WAITING LIST PROCESS SOP

SOP Final version
waiting list Jan 23 V

AUDITS REQUIRED

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