# PCMH Patient Transfer and Special Allocation Scheme (SAS) Policy

October 2023

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|---|---|---|---|---|
| **Policy Number** | | | | |
| **Responsible Committee & Committee approval date** | | Joint Executive Board | | |
| **Policy Lead** | | Melanie Hall | | |
| **Lead Director** | | Lynsey Hughes | | |
| **Peer Review** | | | | |
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| 1 | 18.8.25 | Melanie Hall | update | Updated for the website. |

# Contents



## 1.0 INTRODUCTION/PURPOSE

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 seek to achieve an 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 relevant documentation is completed throughout the transfer process.

Purpose of the policy:

• 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 who 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 healthcare 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, thereby protecting clinicians' safety and maintaining access to care for patients with minimal disruption to their care.

## 2.0 PATIENT TRANSFER TO ANOTHER PCN WITH A FULL MDT

2.1 When a patient moves to another area of the city that has existing provision under PCMH, 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, it 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 the 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 patient's 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 a 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 the Sheffield PCN.

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

## 3.0 PATIENT TRANSFER TO PCN WITHOUT MDT

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

3.2 Should the receiving PCN not have the equivalent profession within MDT i.e. MHP to CBT Therapist, 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 the original PCN, with rationale clearly identified and visible in the patient's record.

3.4 once the patient has completed the treatment within the original PCN no further treatments should be offered by that PCN provision. Any additional treatments/interventions the patient has should be offered from the resources in the new PCN. This may include being added to their waiting list in the new PCN for the intervention. Before a person is added to the list the clinician completed treatment should contact the new PCN MDT to explain rational and seek agreement the patient required another intervention. The clinician who completed treatment is responsible for keeping the patient up to date on next steps.

## 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. video call 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.

## Equality Impact Assessment

| Characteristic / Group | Impact | | Please explain your assessment |
|---|---|---|---|
| Age | Positive | | There is a higher population of students in some parts of the city. They will be more impacted by this policy. They represent an age range of 18-25 typically.<br><br>To mitigate the risk of treatment ending because they move as students, we are using remote appointments to complete the treatment they are offered. By promoting clarity on the policy and publishing the document on the website, we hope to give patients the details of what to expect. |
| | Negative | x | |
| | No impact | | |
| | Impact not known | | |
| Gender Re-assignment | Positive | | |
| | Negative | | |
| | No impact | x | |
| | Impact not known | | |
| Marriage and Civil Partnership | Positive | | |
| | Negative | | |
| | No impact | x | |
| | Impact not known | | |

| | | | |
|---|---|---|---|
| Pregnancy and Maternity | Positive | | |
| | Negative | | |
| | No impact | x | |
| | Impact not known | | |
| Race | Positive | | |
| | Negative | | |
| | No impact | x | |
| | Impact not known | | |
| Religion or Belief | Positive | | |
| | Negative | | |
| | No impact | x | |
| | Impact not known | | |
| Sex | Positive | | |
| | Negative | | |
| | No impact | x | |
| | Impact not known | | |
| Sexual Orientation | Positive | | |
| | Negative | | |
| | No impact | x | |
| | Impact not known | | |
| Other – socio-econ status, employment, carers, migrant status, location, homeless etc | Positive | | People who are students, homeless and others who move accommodation frequently for work or decision processing will be most impacted.<br><br>To mitigate this impact, we have considered their needs to be explicit in this policy. This is to reduce the risk of treatment starting and stopping. |
| | Negative | x | |
| | No impact | | |
| | Impact not known | | |