# TRANSITION OF CARE BETWEEN WORKING AGE ADULT AND OLDER PEOPLE'S MENTAL HEALTH SERVICES PROCEDURE

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**VALIDITY – Policies should be accessed via the Trust intranet**

**CHANGE RECORD**

| Version | Date | Change details |
|---|---|---|
| *1.0* | *June 2016* | *New Procedure (Ratified 02/03/17 – Operational Management Group).* |
| *1.1* | *May 2021* | *Annotated pathway added (Ratified: June 2021- Practice Network Meeting)* |
| *1.2* | *5 June 2024* | *Reviewed and no changes made. Approved at MH Divisional Practice Network (5 June 2024).* |
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## Contents

## 1. INTRODUCTION

Humber Teaching NHS Foundation Trust aims to provide safe, effective and appropriate care which reflects the individual need; not determined by age or other non-clinical factors. As such the transition of care from services designed for adults of working age to the services designed to meet the specific needs of older people is a key transition point which needs to be sensitively and carefully considered.

This policy helps to ensure that the care provided meets the standards of effectiveness and responsiveness set by the Care Quality Commission:

By effective, we mean that people's care, treatment and support achieve good outcomes, promotes a good quality of life and is based on the best available evidence.

By responsive, we mean that services are organised so that they meet people's needs.

## 2. SCOPE

This policy applies to all clinical staff working within the Trust's Adult Mental Health and Older People's Mental Health inpatient and community teams, and is as relevant for all staff, students and locum clinical staff.

## 3. POLICY STATEMENT

The National Service Framework for Older People was published in 2001 and sought to ensure that older people are not unfairly discriminated against in accessing care services as a result of age. This principle underpins the purpose of this policy and is consistent with criteria for old age psychiatry services in the UK[1], which states:

> *'The expertise of old age psychiatry services lies in the care and treatment of people with complex mixtures of psychological, cognitive, functional, behavioural, physical and social problems usually related to ageing'*

This is particularly important in the Trust as an age based service is used to determine the organisational structure of the Care Groups and can easily be interpreted to imply an age transition point for people in receipt of mental health services. This is not the case and individual need is the basis for clinical decision making regarding the most appropriate service to take a lead responsibility for the delivery of mental health care.

As a Trust we are committed to providing services which are appropriate to the individual irrespective of age and we will use the criteria developed by the Royal College of Psychiatrists to provide staff with the guiding principles to be employed in practice.

In all cases the patient choice should be considered when deciding on the most appropriate service. Patients should generally be transferred between different psychiatric services when stable. Patients should only move between services in acute circumstances by exception, because of patient safety considerations.

[1] Criteria for old age psychiatry services in the UK: Royal College of Psychiatrist Faculty of the Psychiatry of Old Age (2015)

For patients with severe comorbidity, conjoint management should be explored. The principles of conjoint management are that one team takes responsibility for the overall care and treatment of the patient, but draws on support in addition to consultation from other services. People will remain under the care of Adult Mental Health Services until such time as it is agreed that care should transfer under the terms of this policy.

People considered for transfer from Adult Mental Health to Older People's Mental Health services should meet one of the following criteria:

1. People of any age diagnosed with a primary dementia (excluding acquired brain injury and Korsakoff Syndrome).
2. People with mental disorder and physical illness or frailty that contributes to, or complicates, the management of their mental illness. This may include people less than 65 years of age.
3. People with psychological or social difficulties related to the ageing process, or end of life issues, or who feel their needs may be best met by a service for older people. This would normally include people over 70 years of age.

## 4. DUTIES & RESPONSIBILITIES

### 4.1 Lead Professional/Care Coordinator

The patients lead professional is responsible for:

- The ongoing assessment of the patient's needs, and determining when the individual care needs are more appropriately met by specialist older people's mental health services.
- Coordinating the transfer process in line with this policy.
- Keeping the patient and their carers involved in the decision making and informed throughout the process of transfer.

### 4.2 Team/Ward Managers

The Team/Ward Manager is responsible for:

- Making staff aware of the standards within this policy.
- Overseeing the timely transfer of patients.
- Liaising with the Lead Professionals in the event of a dispute arising in relation to the transfer of a patient.
- Notifying the relevant Service Manager/Matron in the event that a dispute cannot be resolved.

### 4.3 Service Manager/Matron

The Service Manager/Matron is responsible for:

- Dealing with any disputed transfers which the Team/Ward Managers have been unable to resolve.
- Notifying the Assistant Director in the event that a dispute cannot be resolved.
- Monitoring the compliance of staff in relation to the standards set out in this policy and procedure.

### 4.4 Consultant Psychiatrist

The Consultant Psychiatrists in both Adult Mental Health and Older People's Mental Health Services are responsible for:

- Providing medical advice and input in relation to patients who are to be transferred under this procedure.
- Providing clinical advice in disputed transfers.

## 5. PROCEDURES

### 5.1 New Referrals

In general requests to mental health services as new referrals will be made in line with the organisational structure with those under the age of 65 years referred to adult mental health services and those aged 65 years and over referred to older people's services. This is to provide for a clear and single referral process ahead of an assessment of need. Following assessment in cases where the needs of the patient are considered more appropriately met by another service the care will remain with the current service and the standard transfer procedures (below) considered.

For people who have been recently (less than 3 months) discharged from Adult Mental Health Services who are re-referred to mental health services the team responsible for the care plan and discharge will resume contact at the point of re-referral to retain continuity and establish any changed need, this will include those who reach the age of 65 between contacts with service.

For people in receipt of Adult Mental Health services the process of planning a transfer of care should begin as soon as the needs of the patient are identified as changing; the good practice principles of the Care Programme Approach (CPA) should underpin all transfer discussions irrespective of the individual patient's CPA status. The Adult Mental Health Service will continue to provide a full package of care until consultation and agreement has been reached with the Older People's Mental Health Services for the transfer to take place.

If there has been a significant length of care with AMH services and the patient is re referred after the 3 month period a joint discussion should be held to establish current care needs of the service user and to identify the appropriate team. A joint period of working could be considered for up to 6 months if required.

### 5.2 Transfer of Care

The Older People's Mental Health Service is intended mainly for people over the age of 65 though reaching 65 is in itself not a reason for transferring to OPMHS as continuity of care should take precedence over automatic transfer for people over 65 who do not have complex physical co-morbidity or dementia. The expectation is that the service with the most appropriate skills in relation to the identified care needs should take responsibility for on-going care.

The needs of adults under the age of 65 who have a diagnosis of early onset dementia are usually best met by OPMH; however for patients who do not have a diagnosis at the point of referral adult mental health services will undertake initial assessment and establish the likelihood of early onset dementia; this should include appropriate cognitive screening (e.g. Addenbrookes). Advice and support will be provided by OPMH if required in the best interest of the patient to provide for specialist skills if required and/or to advise on diagnostic testing and approaches.

Transfer into OPMH is particularly important for people who have increasing physical frailty irrespective of age. Physical frailty is not the same as disability and in determining the appropriateness of a frailty based assessment staff should consider frailty as a clinically recognised state which results from ageing associated with a decline in the body's physical and psychological reserves. Frailty is not an inevitable part of ageing: it is a long term condition[2].

[2] Fit for Frailty; Consensus Best Practice Guidance for the care of older people living with frailty in community and outpatient settings. British Geriatrics Society (2014).

In order to determine the appropriateness of referral for Older People's Mental Health Services it will be necessary to undertake a detailed assessment of frailty; this may be in the form of a structured frailty assessment but as a minimum will consider:

- Presence or absence of co-existing long-term medical condition/s.
- Consideration and resolution of reversible medical condition/s.
- Medication; including polypharmacy.
- Dependence and independence in activities of daily living.
- Changes in impairment and functioning over time.
- Assessment of clinical condition e.g. vital signs, blood tests.

Appendix 1 provides further information published by the British Geriatrics Society to assist staff in the recognition and management of frailty.

Service Users needs should always be the main consideration for admission rather than age (care can often be adequately provided in an adult environment for a patient over the age of 65). An assessment of the risk of placing an older adult service user on an adult unit, due to its activity and other inpatients, is required before a final decision is made.

Should a service user over 65 known or not known to older age services require a bed, care needs should be prioritised rather than their age. The same should be considered for anyone younger than 65 who meets the criteria for transition of care between OPMH services and AMH services and who cannot be safely supported on an adult inpatient unit.

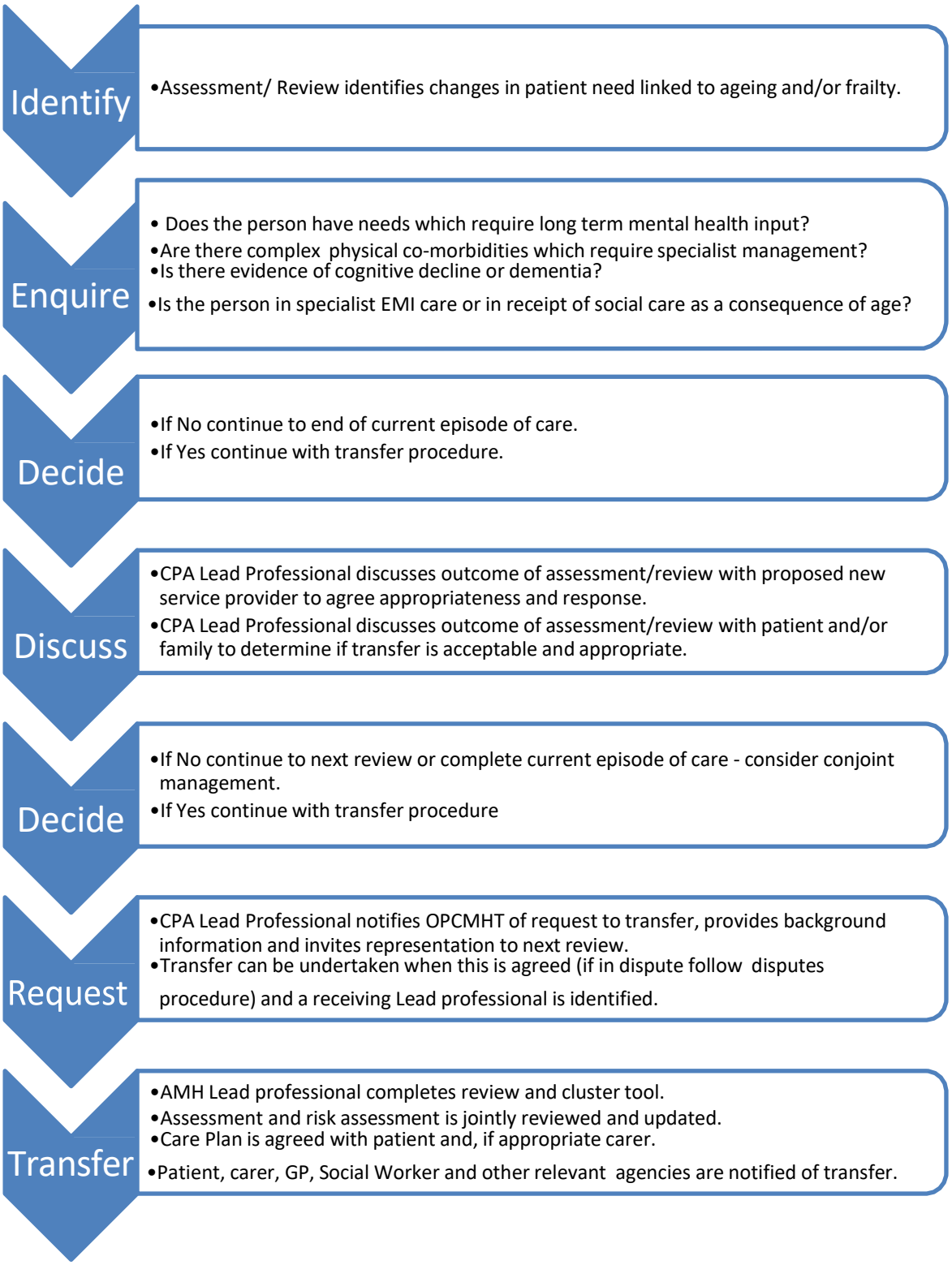
Admission to an Older Adult Inpatient Unit or an Adult Inpatient Unit should not result in a change or transition between services unless there is an assessed change in need that can no longer be met by the current service.

A service User who is admitted to Older Adult inpatient units due to possible vulnerability with Adult Patient unit but do not meet the criteria for transition should remain with Adult Community Mental Health and Crisis Services for support during and following discharge.

Should there be an assessed change in need then the protocol set out for transition should be followed. However consideration should be given to any changes being made during a period of inpatient/ crisis care due to the possible additional impact this may have on the service user. An extended period of joint working should be considered at these times of transition up to 6 months depending on the needs of the Service User.

Where a service user has complex needs or has had a significant period of care from AMH services, consideration should be given to a period of joint working between AMH & OPMH for up to 6 months in order ensure a smooth transition for service users.

## 5.3 Transfer Procedure



### 5.4 Continuity of Care

In general the principles and practices outlined in this policy supports the planning of care on the basis of retaining clinical and service continuity based on need rather than age and on this basis those receiving care in the Adult Mental Health Service will not be considered appropriate for transfer to an Older people's Mental Health Service in the following conditions:

- Those with a long-standing mental illness, with an existing adult mental health service and established relationship in the absence of significant indicators of dementia and/or frailty.
- Those who do not agree to a transfer of care – in these circumstances consider the need for specialist advice and support or conjoint management.

For those who have benefitted from treatment of long-standing mental ill health in adult mental health services and have been discharged from secondary mental health care at or after the age of 65 years re-referral to services will usually be made to the Older People's Mental Health Team. However if re-referral occurs within 3 months of discharge from specialist mental health services the discharging team will respond to the request for services to provide for consistency and continuity of care.

However should there have been a significant length of contact but re-referral is after the 3 month period for patient over 65 and there is no change in care need and the transition criteria is not met then a joint discussion should be held between AMH & OPMH. This should determine if the service user should remain with AMH services or if a period of joint working is required for up to 6 months based on service user's needs. These discussions should not delay service user accessing service.

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### 5.5 Dispute Resolution

In the event that there is a disagreement between the services which cannot be resolved at a team or service level, the matter is to be referred to the Lead Consultants/Clinical Care Directors who will review available information, determine if further assessment or information is required and liaise with the relevant team / service managers and Consultant Psychiatrists prior to making a final decision as to which service can best meet the needs of the patient.

## 6. EQUALITY & DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust approved EIA.

## 7. MENTAL CAPACITY

The Trust supports the following principles, as set out in the Mental Capacity Act and has applied them in the development of this policy:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act completed, or decision made, under this Act for or on behalf of a person

who lacks capacity must be done, or made, in his best interests.

- Before the act is completed, or the decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

## 8. IMPLEMENTATION

This policy will be disseminated by the method described in the Policy for the Development and Management of Procedural Documents.

## 9. MONITORING & AUDIT

Care groups should determine frequency and number of audits to be completed to provide assurance of compliance with best practice requirements as described within the policy to give assurance around patient experience and safe and effective care.

## 10. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Fit for Frailty; Consensus Best Practice Guidance for the care of older people living with frailty in community and outpatient settings. British Geriatrics Society (2014).

National Service Framework for Older People (DH 2001)

Criteria for old age psychiatry services in the UK: Royal College of Psychiatrist Faculty of the Psychiatry of Old Age (2015)

Department of Health (2008) Refocusing the Care Programme Approach – Policy and positive practice guidance.

## 11. RELEVANT HFT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

CARE PROGRAMME APPROACH GUIDANCE JOINT POLICY FOR THE TRANSFER OF CARE MENTAL HEALTH ACT POLICY
MENTAL CAPACITY ACT AND BEST INTEREST DECISION MAKING POLICY

## Appendix A – Fit for Frailty

# Fit for Frailty

**Consensus Best Practice Guidance for the care of older people living with frailty in community and outpatient settings**

**Published by the British Geriatrics Society**

***in association with the Royal College of General Practitioners and Age UK***

**Part 1: Recognition and management of frailty in individuals in community and outpatient settings**

### How to use this guide

This summary guide is for anyone who may be called on to provide support to older people living with frailty, including GPs, district nurses, social workers, care staff, paramedics and informal carers. It explains how to recognise frailty and offers guidance on how best to manage the condition.

A fuller and more detailed edition of the guide including case examples is available as a free download on our website (http://www.bgs.org.uk/campaigns/fff/fff_full.pdf).

Part 2 of the guide entitled, "Designing, Managing and Commissioning services for Older People with Frailty" will be published in December 2014.

### What is frailty?

Frailty is a clinically recognised state of increased vulnerability. It results from ageing associated with a decline in the body's physical and psychological reserves.

Frailty varies in its severity and individuals should not be labelled as being *frail* or *not frail* but simply that they have frailty. The degree of frailty of an individual is not static; it naturally varies over time and can be made better and worse.

Frailty is not an inevitable part of ageing; it is a long-term condition like diabetes or Alzheimer's disease.

### Why is frailty important?

Older people living with frailty are at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event which challenges their health (e.g. infection, new medication, fall, constipation or urine retention).

Frailty might not be apparent unless actively sought.

Many people with multiple long-term conditions will also have frailty which may be overlooked if the focus is on disease-based long-term conditions such as diabetes or heart failure.

Other people whose only long term condition is frailty, may not be known to primary care or the local authority until they become immobile, bed bound, or delirious as a result of an apparently minor illness.

There is evidence that in individuals with frailty, a person-centred, goal-orientated comprehensive approach reduces poor outcomes and may reduce hospital admission.

### When and how should frailty be recognised?

Any interaction between an older person and a health or social care professional should include an assessment which helps to identify if the individual has frailty.

The type of assessment will differ depending on circumstances. But planning any intervention, such as new medication, emergency admission or elective joint surgery, in an individual who has frailty without recognising it, risks significant harm to the patient as the presence of frailty may change the balance of benefit and risk.

### *Frailty syndromes*

The presence of one or more of these 5 syndromes should raise suspicions that the individual has frailty and that the apparently simple presentation may mask more serious underlying disease:

- Falls (e.g. 'collapse', 'legs gave way', 'found lying on floor)'
- Immobility (e.g. sudden change in mobility, 'gone off legs' 'stuck on toilet')
- Delirium (e.g. acute confusion, worsening of pre-existing confusion/short term memory loss)
- Incontinence (e.g. new onset or worsening of urinary or faecal incontinence)
- Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants).

### *Simple assessments for identifying frailty*

A range of simple tests for identifying frailty is available:

- Gait speed: taking more than 5 seconds to cover 4 metres
- 'Timed up-and-go test' (TUGT): a cut off score of 10 seconds to get up from a chair, walk 3 meters, turn round and sit down.

A brief clinical assessment would help exclude some false positives (e.g. fit older people with isolated knee arthritis causing slow gait speed).

• ***PRISMA 7 Questionnaire*** which is an alternative for self-completion, including use as a postal questionnaire. A cut off score of 3 or more suggests the need for further clinical review. (*see Box 1)*.

There is currently no evidence that routine population screening for frailty improves health outcomes.

***Box 1***

**Prisma 7 Questions**

1] Are you more than 85 years?
2] Male?
3] In general do you have any health problems that require you to limit your activities?
4] Do you need someone to help you on a regular basis?
5] In general do you have any health problems that require you to stay at home?
6] In case of need can you count on someone close to you?
7] Do you regularly use a stick, walker or wheelchair to get about?

## How Should Frailty Be Managed?

The gold standard for the management of frailty in older people is the process of care known as Comprehensive Geriatric Assessment (CGA). CGA involves a holistic, interdisciplinary assessment of an individual and has been demonstrated to improve outcomes. It can be time consuming so it is not feasible for everyone with frailty in community settings to undergo a full multidisciplinary review with geriatrician/old age psychiatry involvement.

However **all** patients with frailty should have a holistic medical review by their GP based on the principles of CGA. This must include a review of current symptoms and signs and consideration of underlying medical conditions. Some people will need referral to a geriatrician or old age psychiatrist for support with diagnosis, intervention or care planning, and others will need to be referred to other specialists in the community such as therapists, specialist nurses, dieticians and podiatrists (*figure 1*).

The result of this holistic review (CGA) should be a personalised Care and Support Plan (CSP) (http://tinyurl.com/qezrllt) focusing on the individual's needs and goals. The CSP documents a plan to optimise and maintain health and function, an escalation plan advising when the patient/carer might need to seek further advice, an urgent care plan and, when appropriate, an end of life care plan.

In an emergency situation, the presentation of an older person with frailty is not always straightforward. Frailty syndromes such as falls, delirium and reduced mobility, can mask serious underlying illness.

Prior knowledge that the patient has frailty and that they have a CSP in place will help decision making.

1. Assess clinical condition - measure vital signs and consider if any 'red flags' are present which suggest the patient needs acute hospital care - such as hypoxia, significant tachycardia or hypotension (if possible compare readings with what is usual for that patient as recorded in their CSP).

2. Assess current function - can they get out of bed, can they walk, are they able to use the toilet?

3. Are they confused? - is this usual (may need input from carers to determine this) or worse than usual? Patients with dementia are at higher risk of delirium. Is there evidence of head injury?

If the patient is stable, i.e. demonstrates usual level of function, but has a temperature or evidence of delirium, they will need timely medical review, but not necessarily immediate conveyance to hospital.

If a patient is not severely unwell but is unable to maintain their usual *status quo* in the community due to a change in their care needs, it is good practice to transfer care to a responsive community service rather than arranging admission to hospital, as long as a diagnosis has been made.

## Summary of BGS Recommendations

▶ Older people should be assessed for the presence of frailty during all encounters with health and social care professionals. Gait speed, the timed-up-and-go test and the PRISMA questionnaire are recommended assessments.

▶ Provide training in frailty recognition to all health and social care staff.

▶ Do not offer routine population screening for frailty.

▶ Look for a cause if an older person with frailty shows decline in their function.

▶ Carry out a comprehensive review of medical, functional, psychological and social needs based on the principles of comprehensive geriatric assessment.

▶ Ensure that reversible medical conditions are considered and addressed.

▶ Consider referral to geriatric medicine where frailty is associated with significant complexity, diagnostic uncertainty or challenging symptom control.

▶ Consider referral to old age psychiatry for those people with frailty and complex co-existing psychiatric problems, including challenging behaviour in dementia.

▶ Conduct evidence-based medication reviews for older people with frailty (e.g. STOPP START criteria).

▶ Use clinical judgment and personalised goals when deciding how to apply disease-based clinical guidelines to the management of older people with frailty.

▶ Generate a personalised shared care and support plan (CSP) outlining treatment goals, management plans and plans for urgent care. In some cases it may be appropriate to include an end of life care plan.

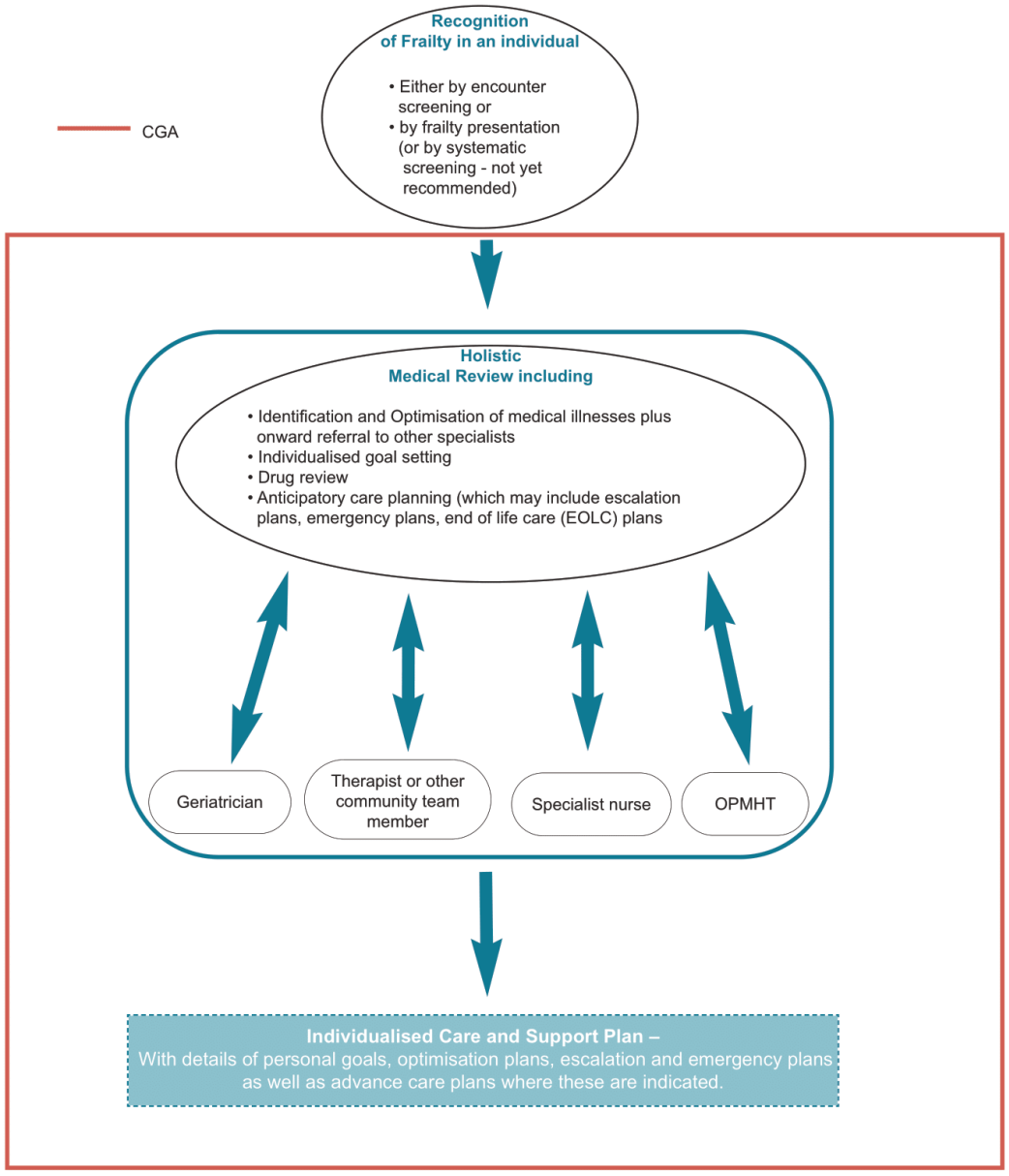
▶ Where an older person has been identified as having frailty, establish systems to share health record information (including the CSP) between primary care, emergency services, secondary care and social services.

▶ Develop local protocols and pathways of care for older people with frailty, taking into account the common acute presentations of falls, delirium and sudden immobility. Wherever the patient is managed, there must be adequate diagnostic facilities to determine the cause of the change in function. Ensure that the pathways build in a timely response to urgent need.

▶ Recognise that many older people with frailty in crisis will manage better in the home environment but only with appropriate support systems.

BGS **Consensus Best Practice Guidance for the Care of Older People Living with Frailty in Community and Outpatient settings**

*Fig. 1*





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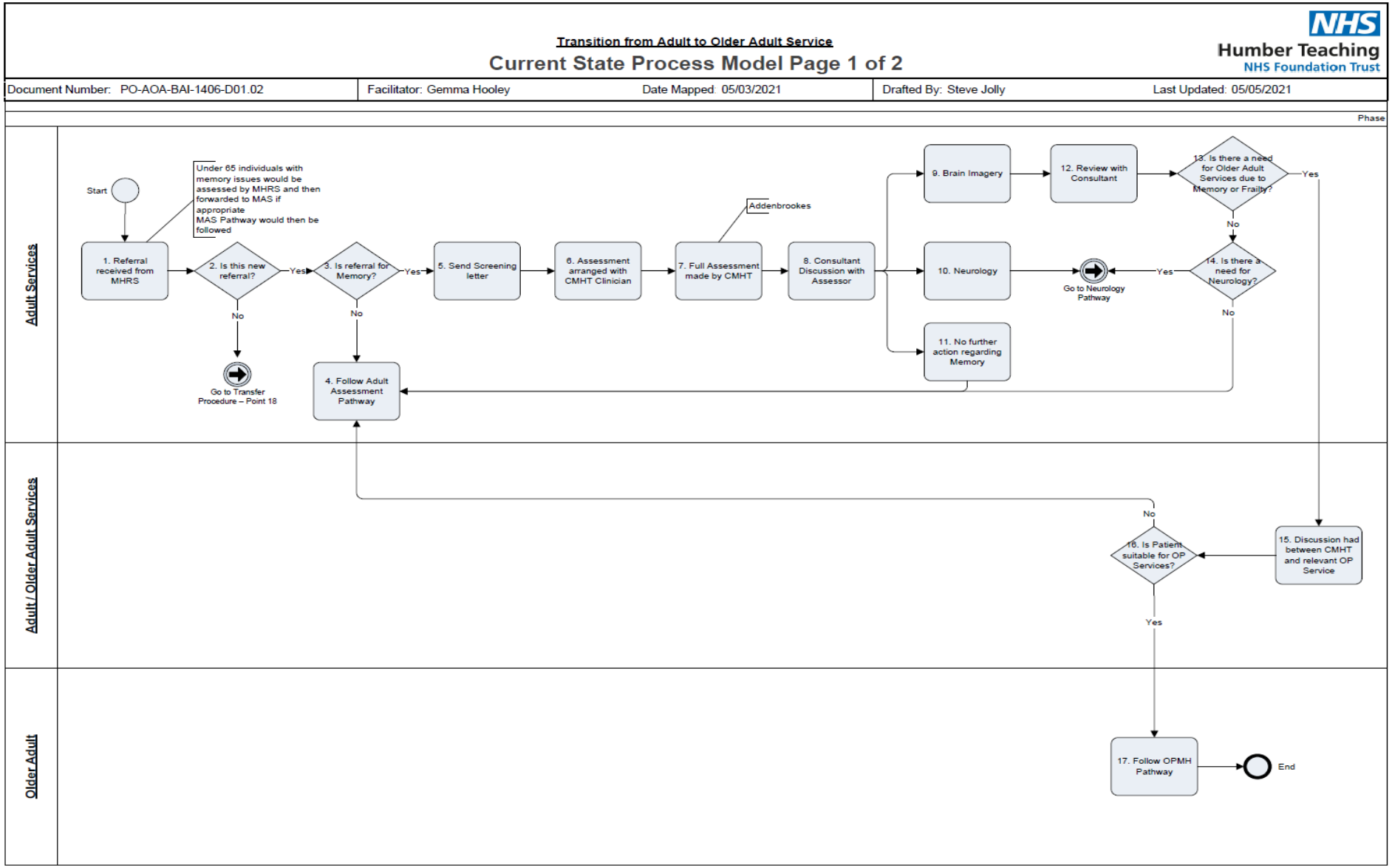
A BGS Campaign working in association with Age UK and the Royal College of General Practitioners
www.bgs.org.uk [Select Resources/Campaigns/Fit for Frailty]

Project Lead: Dr Gill Turner, Vice President for Clinical Quality

## Appendix B – Annotated Pathway



Transition from Adult to Older Adult Service

## Current State Process Model Page 2 of 2

Humber Teaching NHS Foundation Trust

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