CLINICAL POLICY
Mental Health and Learning Disability Bed Management Policy

Policy Number	CLP142
Version:	V4
Purpose:	This policy is to support the process and procedures required to effectively manage GHC's Mental Health and Learning Disability
Consultation:	All Mental Health Operational Directorates Patient Flow Team Criminal Justice Liaison Service Integrated Commissioning Board LGBTQI+ Network Nursing, Therapies and Quality
Approved by:	Improving Care Group / Clinical Policy Group
Date approved:	19/06/2023
Author:	Holly Smith – Integrated Patient Flow Clinical Lead / Alison Teed – Former Integrated Discharge Hub Clinical Lead
Date issued:	12/10/2023
Review date:	**01/10/2024** - This policy will be reviewed and updated on a yearly basis to ensure information remains current.
Audience:	All Mental Health operational directorates Integrated Commissioning Board Nursing, Therapies and Quality Emergency Planning Response and Resilience Mental Health On-Call Clinical Managers.
Dissemination:	Policy will be available on the Intranet and its update will be published on the Clinical Policy Update Bulletin
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date Issued	Reason for Change
V1	Nov 2013	Policy Written by Leon Meek
V2	Nov 2015	Policy Review by Leon Meek
V3	Oct 2018	Policy Review by Leon Meek and James Lewis-Watkins
V4	12/10/2023	Policy Reviewed and changes made

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ABBREVIATIONS

Abbreviation	*Full Description*
GHC	Gloucestershire Health and Care NHS Foundation Trust
ABH	Actual Bodily Harm
AMHP	Approved Mental Health Professional
AWOL	Absent Without Leave
AOT	Assertive Outreach Team
CAMHS	Child and Adolescent Mental Health Service
CCG	Care Commissioning Group

CQC	Care Quality Commission
CRHTT	Crisis Resolution and Home Treatment Team
CTO	Community Treatment Order
DToC	Delayed Transfer of Care
ED	Emergency Department
GHC	Gloucestershire Health and Care NHS Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GRIP	Gloucestershire Recovery In Psychosis
Informal	Admission on a voluntary basis
MHA	Mental Health Act
MHICMS	Mental Health Individual Care Management Service
MST	Microsoft Teams
OAA	Older Age Adult
PICU	Psychiatric Intensive Care Unit
RC	Responsible Clinician
RiO	Electronic Patient Record System
SitRep	Situation Report
WAA	Working Age Adult

1. INTRODUCTION

Gloucestershire Health and Care NHS Foundation Trust provides integrated physical health, mental health and learning disability services across the county of Gloucestershire. As a trust we are committed to providing the highest possible level of care to those accessing our services, and recognise that the provision of timely, quality care, delivered close to home, and a seamless transition between services are crucial in a person's healthcare recovery journey.

Within the Mental Health and Learning Disability teams, we aim to deliver care in the least restrictive environment at all times, in line with the principles of the Mental Health Act (1983/2007) and Mental Capacity Act (2005), and the best interests of the individuals accessing our services. It is however acknowledged that on occasion, treatment in an inpatient environment is unavoidable.

Bed Management involves constantly monitoring and co-ordinating admissions to inpatient environments, as well as flow through the hospitals through to discharge, in order to maintain bed availability across the mental health and learning disability hospitals countywide.

2. PURPOSE

This policy sets out to identify procedures and arrangements in relation to Mental Health and Learning Disability Bed Management to ensure the appropriate provision of inpatient beds, across the Psychiatric Intensive Care Unit, Working Age Adult and Older Age Adult acute hospitals, and the Recovery and rehabilitation Units.

It will aim to provide all staff within the trust who are involved in the co-ordination and allocation of inpatient beds with a framework to safely and effectively manage mental health and learning disability bed capacity across the county.

3. SCOPE

All staff involved in admission to, and discharge from Mental Health and Learning Disability

inpatient beds.

4. DUTIES

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to up to date evidence based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Managers and Heads of Service will ensure that:

- All staff are aware of and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policy
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on MCA Compliance below.

Roles, Responsibilities and Accountability Specific to this Policy:

Bed State Reporting	Bed Managers
'Gatekeeping' Beds	Crisis Resolution and Home Treatment Team
Allocation of Beds	Bed Managers in hours On Call Clinical Manager
Admission to Mental Health and Learning Disability Beds	Crisis Resolution and Home Treatment Team AMHP Hub
Monitoring Patient Flow through Mental Health and Learning Disability Hospitals	Bed Managers Integrated Discharge Hub Leads Inpatient Modern Matrons
Delayed Transfer of Care	Integrated Discharge Hub Clinical Lead Bed Managers Ward Managers
Discharge Reporting	Inpatient Ward Managers Bed Managers
Escalation if Bed Demand is Greater than Capacity	Bed Manager Integrated Discharge Hub Leads Patient Flow Clinical Lead Inpatient Modern Matrons Inpatient Ward Managers Inpatient Consultants Crisis Resolution and Home Treatment Team

	Managers Crisis Service Manager AMHP Hub Lead Deputy Director for Urgent Care and Speciality Services

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

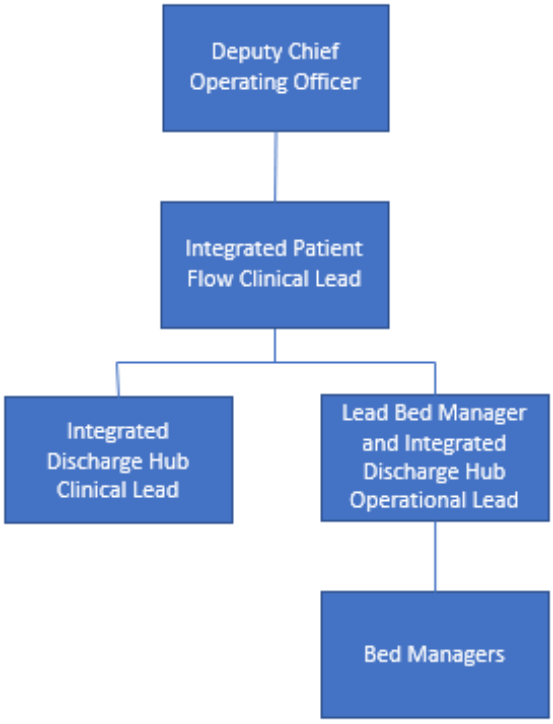
- Establish if the person able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk).
- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the persons best interests by other people. To be legally binding the person must have been over 18 when it was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.
- Where the decision relates to a child or young person under the age of 16, the MCA does not apply. In these cases, the competence of the child or young person must be considered under Gillick competence. If the child or young person is deemed not to have the competence to make the decision then those who hold Parental Responsibility will make the decision, assuming it falls within the Zone of Parental control. Where the decision relates to treatment which is life sustaining or which will prevent significant long-term damage to a child or young person under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

6. POLICY DETAIL

6.1 The Bed Management Team and Function

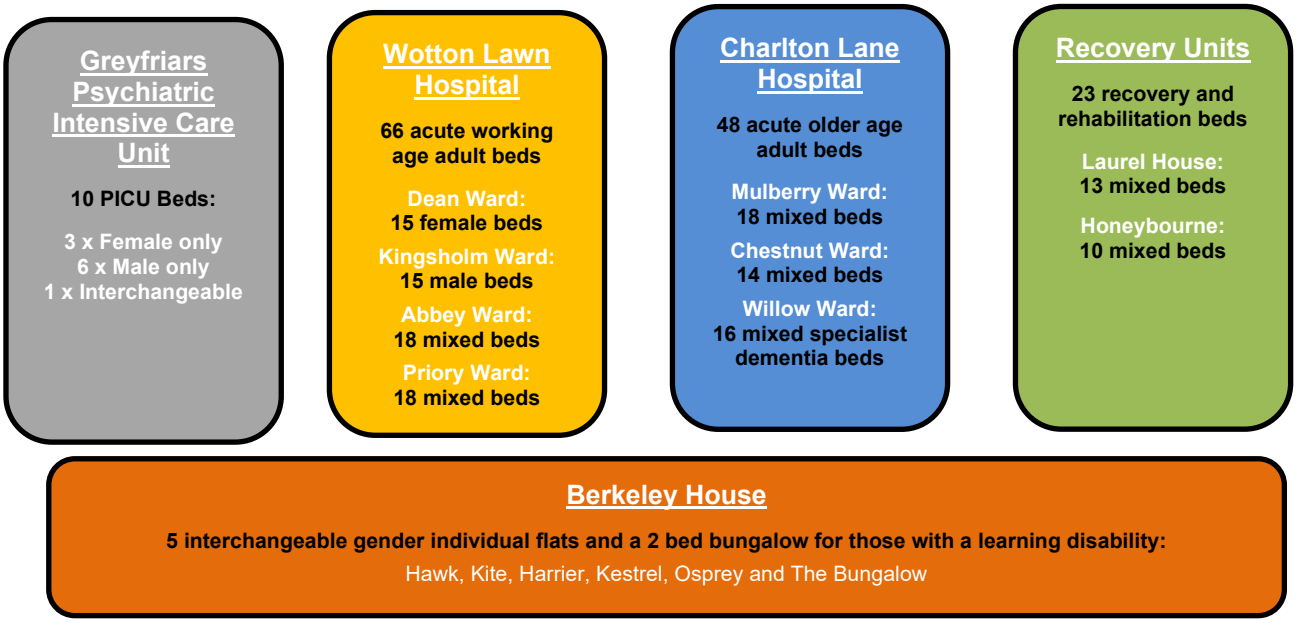
The bed management team, based within the integrated discharge hub at Wotton Lawn Hospital, cover the core working hours of 9-5, 7 days per week, 365 days per year. They accept referrals for inpatient beds from the Crisis Resolution and Home Treatment Teams (CRHTT), who are the gatekeepers of all acute inpatient beds, with the exception of specialist

beds allocated for the treatment of those with a diagnosis of dementia, or those assessed to need the enhanced care provided by the psychiatric intensive care unit (PICU). Referrals are reviewed by the bed management team, and then allocated to appropriate inpatient beds, where possible.



6.1.1 The Bed Census

The bed managers are responsible for the allocation of beds across the following units:



6.1.2 Bed Definitions

Vacant Bed
A bed which is not occupied by any individual and is free to accept an admission.

Informal Leave Bed
A bed which is not currently occupied, however there is a plan for an informal individual to return to that bed after a period of leave from the ward.

Section 17 Leave Bed
A bed which is not currently occupied, however there is a plan for an individual detained under the MHA to return there after a period of leave.

GHFT Leave Bed
A bed which is not currently occupied, however was occupied by an individual who has required transfer to GHFT for treatment for their physical health.

AWOL Bed
A bed which is not currently occupied, however should be occupied by an individual who has left the ward without the necessary leave allocation, or who has failed to return on time from leave.

Closed Bed
A bed which is vacant, but cannot be used for an admission, often due to maintenance and/or safety requirements.

6.2 Bed State Reporting

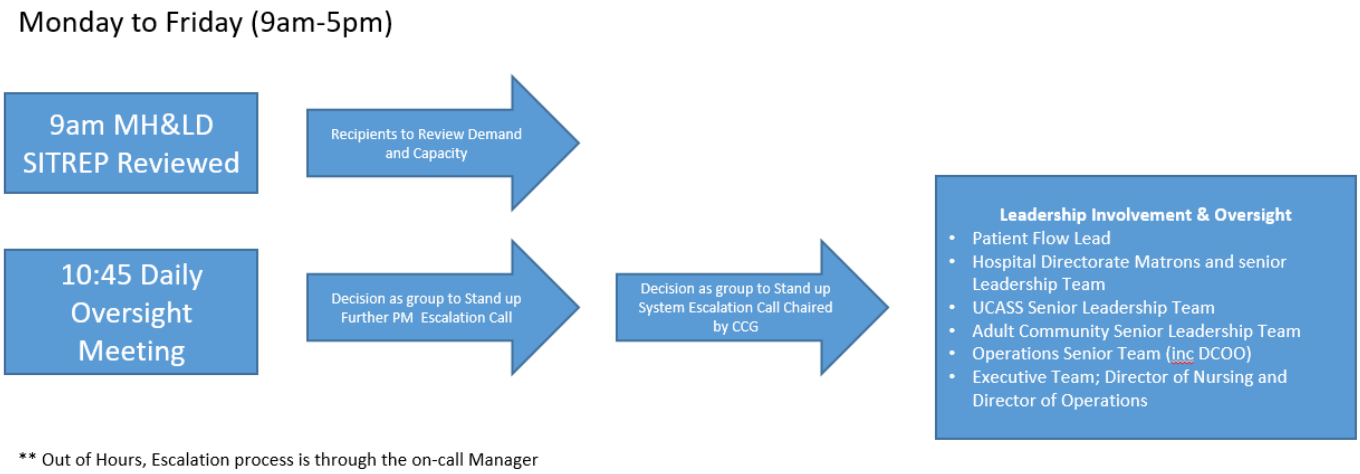
The bed state will be collated by the bed management team 3 times per day and recorded on the SitRep once for the daily operational oversight and flow oversight sitrep meeting accessible via teams.

- The Bed waiting list is accessible via RiO and is reviewed at the 10:45 – daily bed waiting overview call.
- At 5pm – an end of day proforma is sent via email - Reported to Hospitals, Urgent Care, Community Services, the Incident Room and relevant On Call Managers.

The Bed Manager should confirm with the Nurse in Charge of each ward that the RiO bed state accurately reflects the individuals in physical beds. The Ward Manager is responsible for ensuring their team are aware of the importance of accurate bed state reporting, and the potential consequences of an incorrect bed state being reported to the Bed Manager.

Leave beds and whether or not they can be used in an emergency should be reported by the Ward Manager at the daily bed overviewcall and recorded on the SitRep to be sent with the 5pm clinical report sent to the Clinical on Call Manager.

6.3 Escalation



** Out of Hours, Escalation process is through the on-call Manager

6.4 Admissions

6.4.1 Gatekeeping

No admission can be made to an acute inpatient bed, including PICU, without discussion and agreement with the CRHTT and the completion of a gatekeeping assessment, the only exceptions being a CTO recall, another area offering the admission, or for a specialist dementia bed. Whether the admission is on an informal basis or under the mental health act, the CRHTT must be involved in a face to face assessment wherever possible, or at minimum, in agreement that admission is the only option. Part of the gatekeeping assessment should be the formulation of goals for admission and a risk assessment, which will inform the treatment plan as well as discharge planning.

If an individual is subject to a Section of the Mental Health Act involving the Ministry of Justice (MoJ) and is either recalled to hospital or ordered to transfer to hospital from a prison setting, the MoJ may specify the type of bed to be allocated and whether this should be an acute ward, PICU or requiring a higher level of security. These restrictions are not negotiable at a local level and will need to be accommodated.

If the gatekeeping assessment identifies a need for admission, the CRHTT clinician or AMHP if appropriate should then contact the bed management team, who may offer suggestions to ensure that all avenues of home treatment have been explored, before completing the bed referral form with the CRHTT clinician or AMHP if appropriate. Please refer to the Crisis Resolution and Home Treatment Teams (CRHTT) Policy for further details.

In the case of a bed request for a CTO recall, an individual with a diagnosis of dementia, or if another area have offered the admission, the bed manager can be contacted directly to request the admission. For a CTO recall, a bed must be allocated and kept once the CTO recall papers have been issued. The recalling team should always discuss the recall with the bed manager before issuing the recall papers to ensure bed availability.

6.4.2 Bed Referrals

The Bed Management Team can be contacted on 0300 421 7990 between the hours of 9-5,

7 days a week. Out of hours, all admissions should be agreed by the On Call Clinical Manager for Mental Health. They can be reached via Wotton Lawn Reception on 01452 894500 who will arrange a call back.

Once a gatekeeping assessment has been completed and a need for admission confirmed, the bed manager will take the details of the individual and add them to the bed waiting list.

PICU's operate with their own admission criteria and acute admissions to PICU should be avoided where possible and only should be used in extremis. PICU should not admit informal patients directly to the ward due to the increased restrictions within the operational structure and environment of PICU.

Acute psychiatric beds require some safeguard threshold as there may be times when acute admissions are too high a risk to manage safely within an environment of the open acute wards due to this being the least restrictive inpatient environment. It is expected that any individuals that have current criminal charges and or current criminal allegations of ABH or above should be considered for specialist assessment.

6.4.3 Criteria for Admission

Once the bed manager has completed the referral form, they will then triage the referral and allocate the most appropriate bed. Priority for admission will be decided based on the criteria outlined fully in Appendix 1, and will be split into the following categories:

During the week, the above ratings can be clarified at the daily bed overviewcall if there is any challenge to the RAG ratings, out of hours, the clinical on call manager should be contacted if necessary. The referral will be added to the Bed Management Waiting List on RiO, where priority is categorised numerically.

1 = **RED** Referral
2 = **AMBER** Referral
3 = **GREEN** Referral
4 = Individual requiring repatriation from an out of county placement, not RAG Rated.

6.4.4 Specialist Beds

The bed manager is not able to access specialist beds for those under the age of 18, those requiring specialist treatment for an eating disorder or secure beds within the Forensic

Network. For “special urgency” admissions please refer to: section 140 of the Mental Health Act 1983/2007: Notification of Hospitals having Arrangements for Reception of Urgent Cases Policy. In line with the section 140 policy; escalation process and appropriate accommodation should be considered.

Eating Disorders:
Specialist Eating Disorder Beds are sourced by the Eating Disorders Team. If the eating disorder is not the predominant issue, there is a comorbid mental health need requiring inpatient admission and there is no imminent risk to the individual’s physical health as a result of their eating disorder, an eating disorder would not exclude someone from an admission to a generic mental health bed in Gloucestershire.

Further information on sourcing a specialist eating disorders bed can be found in the: Eating Disorders Specialist Service Operational Policy.

CAMHS:
No-one under the age of 18 should be admitted to any working age or older age adult bed except in exceptional circumstances. If this is absolutely unavoidable for any reason, please refer to section 140 of the Mental Health Act 1983/2007: Notification of Hospitals having Arrangements for Reception of Urgent Cases Policy – which outlines the process for “special Urgency” admissions. The CQC and the Integrated Care Board (ICB) will need to be made aware of the admission – process for this will be outlined in the Young People Receiving Care and Treatment in Adult Inpatient Services Policy (CLP262).

Within working hours, specialist CAMHS beds are sourced by the relevant CAMHS Team. CAMHS are part of the Thames Valley Tier 4 new care model, within which all referrals for beds are sent to the single point of access who will aim to allocate a bed to admit the young person as close to home as possible. This is a consultant led pathway, and all referrals should be made on ‘form 1’ and sent to the single point of access at Marlborough House in Swindon. If a need for a CAMHS bed is identified out of hours, the Clinical on Call Manager should be contacted in the first instance. In the absence of a CAMHS consultant, the Consultant on Call is able to complete the ‘form 1’ and send to Marlborough House for consideration.

Further information on sourcing a specialist CAMHS bed can be found in the: Children and Young People’s Service CAHMS Operational Handbook / Policy.

Perinatal Mental Health:
The Perinatal Mental Health Team support new and expectant mother’s experiencing mental ill health. Ideally, care is delivered at home and in the community however there are times when increased risk to Mother and/or baby does not allow this. If an admission is deemed necessary, the first choice would always be for a Mother and Baby Unit to be sought, so the mother and baby can receive the necessary support and treatment together. If a need is identified by the Perinatal Team, they will source the Mother and Baby Unit bed and arrange for admission.

There are occasions when the mental health of the mother may pose a risk to the baby that is unmanageable in a Mother and Baby Unit. In this instance it may be necessary for the mother to be admitted to an acute mental health bed for a short period of time while someone else cares for the child. Once the mother’s mental health has stabilised to a level deemed to be manageable either by a Mother and Baby Unit or by the Perinatal Team in the community.

In an out of hour's emergency, it may also be necessary for a new mother to be admitted to an acute bed until the Perinatal Team can be notified in working hours.

Further information about the Perinatal Mental Health Team can be found in the: Perinatal Community Team Operational Policy.

Secure Services and Forensic Mental Health:
Beds within Secure Services can only be accessed via the South West Regional Secure Network. In a small number of cases, the risk to an individual, others or the public may be so great due to the severity of a person's mental disturbance, that a PICU would be unable to safely admit the individual. Within hours, the Criminal Justice Liaison Service will take responsibility for sourcing the bed. Out of hours, secondary mental health services, usually 2 doctors and an AMHP, should make an initial assessment and refer to secure services if necessary. If admission to secure services is deemed to be the appropriate pathway, remand to prison as an intermediate place of safety is not acceptable.

Forensic beds should be sourced via the South West Secure Collaborative. Whilst finding the bed is not within the remit of the bed manager, they can support the On Call Clinical Manager or Consultant to make the referral out of hours – The Criminal Justice Liaison Service should be the main point of contact.

6.4.5 Bed Allocation

Locating the Most Appropriate Bed
Once a need for a bed is confirmed and the working list for bed demand has been prioritised as outlined in section 6.4.3 of this policy, the bed manager will allocate the most appropriate available bed.

The most appropriate bed should be decided initially, based on the risk and nature of the individual's presentation at that time. For example, if the referring team feel an admission to a PICU may be warranted, Greyfriars Unit should be invited to attend the assessment, which if considering an admission to PICU, would most likely be an MHA assessment.

Once the most appropriate environment has been sought, the individual will then be allocated a bed based on their age, home locality, needs and gender or in the case of an individual with a dementia, their diagnosis.

Greyfriars Unit have their own admission criteria, which is detailed in their Greyfriars Operational Policy and Handbook

- The bed manager cannot make the decision that an individual meets the criteria for a PICU admission but should facilitate Greyfriars' involvement in the assessment where necessary.
- Greyfriars Unit has 3 female beds, 6 male beds and 1 interchangeable bed.
- Greyfriars does not operate using a locality model and can accept people of any age, gender or diagnosis, providing they meet the criteria for PICU admission.
- In times of extremis, Greyfriars can be used for acute admissions, but all cases should be considered on an individual basis.

Working age adults, between the ages of 18-65 should be admitted to Wotton Lawn Hospital.

- Kingsholm Ward has 15 male only beds and covers the Gloucester and Forest of Dean locality.
- Dean Ward has 15 female only beds, and covers the Gloucester and Forest of Dean locality.
- Abbey Ward has 7 male beds, 9 female beds and 2 interchangeable beds, it covers the Stroud and Cirencester locality.
- Priory Ward has 7 female beds, 9 male beds and 2 interchangeable beds, and covers the Cheltenham, Tewkesbury, and North Cotswolds locality.

All beds at Wotton Lawn Hospital are en-suite, so in exceptional circumstances, a person can be admitted to a bed not allocated for their gender on either Abbey or Priory Ward. Additional staffing can be accessed, if necessary, in order to manage any risk this may present. Dean and Kingsholm Wards should be kept as single gender only in order to accommodate when a single sex environment is clinically indicated.

Older age adults, over the age of 65 should be admitted to Charlton Lane Hospital.

- Charlton Lane does not operate using a locality model.
- Any older age adult with a functional mental illness may be admitted to Mulberry or Chestnut wards, both of which provide a mixed environment.

Those with a diagnosis of dementia, regardless of age, should be admitted to Willow Ward at Charlton Lane Hospital, though can be referred to PICU if clinically indicated.

The Recovery Units have their own admission criteria, which is detailed in the Honeybourne and Laurel House operational policy.

- The bed manager cannot make the decision that an individual meets the criteria for a Recovery Unit Admission but will be involved in their referrals meeting to contribute towards a collective decision.
- Honeybourne has 5 male beds, 4 female beds and one interchangeable.
- Laurel House has 6 male beds, 5 female beds and 2 interchangeable beds.
- Individuals tend to be of working age, but there is some flexibility here based on need.
- In times of extremis The Recovery Units may need to accommodate acute patients, but they should be involved in all decisions regarding transfer and only lower risk individuals should be considered.

Referrals for Individuals with Impaired Mobility or who may Require Specialist Equipment

When the Bed Manager receives a referral for a WAA who is flagged as having impaired mobility or requiring specialist equipment, the Occupational Therapy Department and Physiotherapy Department should be notified at the earliest opportunity. The provision of accessible bedrooms and shower rooms at Wotton Lawn Hospital (WLH) is limited. As such, multiple transfers may be necessary in order to accommodate the individual and their required equipment in an appropriate room. In some cases, additional equipment will need to be ordered, particularly if the individual is bariatric, so the department will need time to arrange for this so the individual can be supported safely.

The Bed Manager should also inform the ward of any complexities at the earliest opportunity as they may need to arrange for additional staffing to provide support for the individual.

Referrals or Transfers for Individuals from Gloucestershire Hospitals NHS Foundation Trust

If an individual has been on leave to GHFT and has been identified for admission as an inpatient there or directly from the Emergency Dept, the relevant processes should be followed with particular attention given to identifying any physical health needs or changes the inpatient team are not aware of. As above, the Occupational Therapy department and Physiotherapists should be contacted at the earliest possible opportunity, to identify the need

for any in-hospital transfers that may be necessary and for provision of equipment. In addition to this, a medic-to-medic handover should be arranged by the Bed Manager or On Call Clinical Manager, to ensure the medical team at Wotton Lawn are in agreement that the individuals physical health needs can be met at Wotton Lawn. This should then be documented in the individuals RiO record before transfer is agreed.

Additional Considerations for those who Identify as a Different Gender to that which they were Assigned at Birth

Gloucestershire Health and Care NHS Foundation Trust's core values include being respectful and kind, and within this, to value each other's individuality. Transgender mental health is influenced by multiple socio-political factors and minority status. Transgender individuals experience an excess health burden and have difficulties that are poorly understood by many health practitioners. This is partly the result of both informational and institutional bias. It is important that as a trust we send a positive, welcoming message to the transgender individuals accessing our services, and in particular provide a safe inpatient environment where they can access high quality care.

Gender reassignment is when a person takes steps to alter the outward expression of their gender so that it better aligns with their sense of who they are. It is not necessary for a person to have undergone any medical process to change the physiological attributes of their gender in order to have the protected characteristic of gender reassignment and be protected by The Equality Act (2010). The Equality Act states that a person should not be discriminated against because of gender reassignment.

A transgender individual should be assigned a bed based on the gender with which they identify at the point of admission. This decision should be made in collaboration with the transgender individual, in order to ensure they are allocated a bed in an environment in which they would feel comfortable. For example, a non-binary individual may prefer an interchangeable bed on a mixed ward, all efforts should be made to accommodate this.

Transgender individuals also have the right to access single sex wards in accordance with the gender they identify with. They will be involved, as much as is possible, in the admission process with a view to help staff understand what they can do to support the transgender person on the identified ward. On the ward, transgender patients will be able to use any spaces, facilities and engage in activities appropriate to their gender identity.

In the presence of any risk related to the admission of a transgender service user to the ward where they feel more comfortable, additional measures will be taken, as much as practicable, to address and contain the risk. Equally, some other individuals on the ward might pose a risk to the transgender person as a result of their mental state. In these cases, risk will be assessed, and priority will be given to the transgender person remaining on their preferred ward, with additional measures put in place to contain the risk, however each case should be considered individually.

6.4.6 Bed Allocation in Extremis

During times of increased demand for beds, it may not always be possible to assign an individual to a bed for their gender on their locality ward, and clinical need should take priority in the provision of a single-sex environment. Risk should always be considered, and appropriate steps taken to mitigate if an individual is admitted to a corridor assigned to the opposite gender. Whilst every effort should be made to admit individuals to their locality ward,

continuity of care should remain the priority, so unless there is a clinical need, individuals need not be transferred back to their locality ward when a bed is available.

All cases will be assessed on an individual basis with support of the wider multidisciplinary team (MDT). Individual risk factors should always be considered, and where appropriate, mitigated before admission is agreed:

Admission to a bed in Gloucestershire should always be the preferred option, even if the available bed is not the most appropriate in terms of age, locality, or gender. All potential moves within hospitals in Gloucestershire should be exhausted before considering a referral to an out of county bed, though each case should be considered on an individual basis.

6.4.7 No Local Bed Availability

Admitting a patient to a bed in another county comes with its own associated risks for the patient, so should always be considered carefully. If all options to create a local bed have been exhausted, and it is not feasible to manage the associated level of risk with increased community support, admission to an out of county bed should be explored.

Placement within the NHS in a neighbouring county is always the preferred option, however increasing demand nationwide has meant in recent years that this is no longer an option.

The private sector offers a range of beds including male, female and mixed acute wards, and male, female and mixed PICU's. Any beds outside of these categories cannot be authorised by the bed managers and will need to be accessed via specialist services.

Out of County Provision
Checks need to be carried out to ensure that there are no local provisions available:

- Contact wards to see if there are any leave beds available to use.
- Check for bed availability in other locations across the trust IE, Recovery units, Wotton Lawn or Charlton Lane – if there are patients that would be managed in these areas consider transfer of patient care to facilitate admission. Transfers should only be used in extremis due to the impact on continuity and patient care.
- Consider early discharge options with support of CRHTT.
- Consider the use of hotel discharge or temp supported accommodation.
- Discuss options with senior management.

Referring to an Out of Area Bed
Once available beds have been identified, the following points should be considered:

- **The opinion of the patient and their family/carers** – for example someone agreeing to informal admission may feel differently if they were having to travel hundreds of miles for that admission.
- **CQC rating of the receiving hospital** – where possible, we should aim to only use hospitals with a 'Good' rating or above. If there are no such units available, further scrutiny of the CQC report is needed. Contact can then be made with the unit if necessary to ask what changes they have brought in to address the concerns raised in the report. This information should always be shared with an individual agreeing to informal admission to ensure they are fully informed with regard to what they are agreeing to. Likewise, if a

person is unable to consent, their views and that of their family/carers or nearest relative should still be considered.

- **Geographical location –** The nearer to home we can keep the individual the better.

In the event that a bed with a 'good' or above CQC rating cannot be found, a discussion should be had with the referring team, considering the patient and their family/carer's opinion, about whether the risk of staying in the community would be greater than the risk of sending the person to a 'requires improvement' or 'inadequate' out of area bed. If necessary, these discussions should involve the Associate Director for Quality and Clinical Compliance and the decision will be documented along with the rationale.

Once the most appropriate bed has been identified, the referral form required by the provider should be completed in full. This should be returned securely along with all supporting documentation and uploaded to the individual's RiO record.

Monitoring of Patients Admitted to Acute Out of Area Placements
It is the responsibility of the Bed Management Team and Integrated Discharge Hub Leads to maintain regular contact with out of area placements throughout the admission of any individual under the care of GHC. An update on progress should be sought twice per week – once over the weekend, and once prior to the weekly DToC meeting to allow for plans for repatriation to be discussed if necessary. This update should be documented in the individual's progress notes on RiO, and any actions communicated to the relevant person.

Individuals in out of area placements will be discussed at the daily bed overviewcall, and considered for repatriation as appropriate to do so or as local capacity allows.

It is also expected that the Care Co-ordinator will maintain contact with the individual and out of area placement throughout the admission. This includes attendance at MDT meetings, via MS Teams if necessary. The Bed Manager should ensure the Care Co-ordinator is aware of the admission as well as any transfers.

Monitoring of Patients Admitted to PICU Out of Area Placements
Greyfriars PICU hold the responsibility of maintaining regular contact with out of area PICU's where any GHC patient is placed. An update on progress should be sought at least once per week. This update should be documented in the individual's progress notes on RiO, and any actions communicated to the relevant person.

Once the individual is either deemed fit for transfer to an acute ward, or Greyfriars are in a position to repatriate directly to their Unit, they will make the bed manager aware. If the transfer is back to Greyfriars, Greyfriars should arrange the transfer. If the transfer is back to an acute ward, the Bed Manager should arrange the transfer.

It is also expected that the Care Co-ordinator will maintain contact with the patient and out of area placement throughout the admission. This includes attendance at MDT meetings, via MST if necessary. Greyfriars should ensure the Care Co-ordinator is aware of the admission as well as any transfers.

Allocation of Care Co-ordinator for Patients Admitted to Out of Area Placements
When an individual either new to services or who is not under secondary mental health services at the time of admission is admitted to an out of area placement, allocation of a Care

Co-ordinator at the earliest opportunity is essential to ensure continuity of care once we are able to repatriate the individual to Gloucestershire.

Repatriation of Patients to a Local Bed within GHC
When a local bed is available to repatriate an individual placed out of area to, the bed manager will liaise with the out of area placement to advise them that it is our intention to bring the person back to a local bed. The Out of Area Repatriation Form (see Appendix 2) should be sent to the placement for completion to ensure we have adequate information about the individual's progress and admission to ensure a safe transfer, and to maintain continuity.

Once the Out of Area Repatriation Form has been returned with supporting documents, transport can be booked to bring the patient back to Gloucestershire. The least restrictive form of transport should always be used in line with the transport policy. The bed manager can then provide both wards with estimated time of arrival (ETA's) for transport and arrange for verbal handovers from ward to ward, including medic to medic handovers if necessary.

Out of Area Placement Reporting
The Bed Manager will complete the Out of Area Placement Data Collection Spreadsheet for reporting to NHS digital. This should be completed on a monthly basis and sent to colleagues in Business Intelligence, Finance and Deputy Directors for Hospitals.

6.4.8 Inpatient Bed Management and Flow

The Bed Management Team should be aware of the bed situation within hospitals at all times, as well as the demand for beds in the community. This includes planned discharges, transfers, as well as plans for periods of leave.

Home Leave from Hospital

As part of an individual's treatment plan, often a period of home leave will be trialled in which the individual spends time readjusting to life outside hospital, whilst recognising that their mental state remains fragile and there may be a need for them to return to the bed if things do not go as planned. This leave may be for a few hours, one night, several nights or even a week or two.
The ward are responsible for recording on RiO the time the individual leaves the ward to go home, as well as the date and time they are due back.

Leave to Another Hospital (e.g. GHFT)

On occasion, an inpatient will need transfer to GHFT or other trust for assessment, treatment, or both for a physical health concern. Whilst we would ideally like to keep the individual's bed open for them to return to, we do not have the capacity for one individual to occupy two NHS beds at once. Once the individual is deemed to be medically optimised for transfer back to GHC, every effort should be made for them to return back to the ward they were on before transfer. The ward and Bed Manager should seek regular updates from GHFT.

Absent Without Leave: Informal

Whilst an individual in hospital on an informal basis would not be considered formally AWOL if they left the ward without agreement with nursing staff or failed to return from agreed leave without notifying the ward of their plans, they could still be considered AWOL in that there is no informal leave agreement in place to cover their absence from the ward. Every effort should be made to ensure an informal AWOL patient is able to return to the ward they are absent from, but each case should be assessed on an individual basis.

Absent without Leave: Subject to Mental Health Act

Individuals detained under the Mental Health Act must have Section 17 leave, allocated by their RC, and agreed by the nurse in charge of the shift at the point they leave the ward. If the individual leaves the ward without leave or fails to return from agreed leave without contacting the ward to explain why they are late, then they would be considered as AWOL, and dependent on individual risk factors, liable to be returned to the ward by police.
Every effort should be made to ensure an AWOL patient is able to return to the ward they are absent from.

Admitting to a Leave Bed

Where possible, leave beds should not be used, as it can be highly disruptive to an individual's care to be unable to return to their ward should their leave not go to plan.

There are however instances where it is more appropriate to use a leave bed than others:

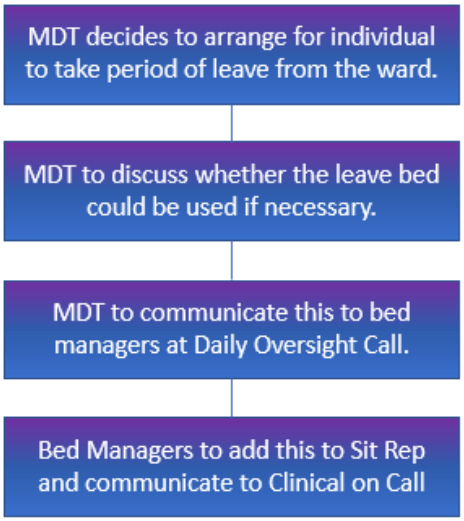
If an individual is on leave to another hospital, they could be deemed to occupy 2 NHS beds. They are safe in the other hospital, so the bed could be used dependent on individual risk and clinical factors.

If an individual is near to discharge, it may be decided that a 1–2-week period of leave would be beneficial with the continued protection of The Mental Health Act before discharge, in many cases, this bed could be used

Short term leave beds and AWOL beds are often a greater concern if not kept available, but it is important that the risk of each individual case are balanced, and where possible, discussed with the individual's MDT.

All above instances should be considered on an individual basis and every effort should be made to discuss with the individual's MDT before allocating a leave bed to another individual.

The MDT can communicate their views regarding the use of leave beds via the following pathway:



Transfers between Wards

Transfers between acute wards should be kept to an absolute minimum as a change of MDT can be highly disruptive to an individual's recovery. Wherever possible, the Bed Manager should consult the MDT of the individual requiring transfer prior to any move taking place. A transfer should only be agreed outside working hours if there is an imminent and unmanageable risk to the patient or others, but all moves should be considered on an individual basis.

If a transfer is unavoidable, or agreed with the individual's MDT, the transition should be as seamless as possible. The Bed Manager or On Call Clinical Manager out of hours, should ensure full handovers take place between nursing staff, therapies staff and medical staff where possible. In hours, the Bed Manager should be notified of all pending transfers, to avoid any uncertainty regarding bed availability.

Acuity should not routinely be a reason for a ward to decline an admission, particularly if a transfer is required to accommodate this. An individual deemed to be of lower acuity should not be transferred in order for an individual with higher acuity to be admitted elsewhere. If ward acuity is an issue, this should be escalated to the Modern Matron of the Hospital who will consider the most appropriate route to take.

Emergency Transfers Based on a Change of Acuity

Acute or Recovery Units to PICU – If an individual's mental state has deteriorated to the point that their risk is not felt to be manageable in an acute or recovery environment, and a PICU is felt to be necessary, it is up to the acute ward or recovery unit to refer to Greyfriars PICU, who will conduct their own assessment to decide whether a PICU admission is warranted. They will arrange this transfer with the referring ward if necessary and keep the Bed Manager informed.

Recovery Units to Acute Inpatient Bed – If there is an individual at the Recovery Units whose mental state deteriorates to the point that they can no longer be managed in a non-acute environment, the nurse in charge of the unit on which the individual is resident at the time, should contact the bed manager and explain the situation and need for a return to an acute hospital. The bed manager should consider this as a referral, and it should be treated

with the same degree of urgency as with any referral from the community.

Monitoring Patient Flow
The Bed Manager should maintain an overview of the patient's journey through the service and attempt to identify and address any barriers to discharge at the earliest opportunity to support a seamless transition to the next stage of the individual's care with no unnecessary delay.

Patient Flow and Bed Manager's Meetings
Wotton Lawn Hospital hold daily board rounds with the wards, where all acute individuals, their progress and barriers to discharge are discussed and actions are allocated to professionals. This is chaired by the ward management team with others senior professionals present. The Bed Manager should prioritise attendance for this meeting. CRHTT also aim to attend this meeting. Possible escalations and flow issues should be explored in this meeting daily.

If these meetings highlight issues relating to flow, the bed manager in extremis should escalate to patient Flow leads to consider additional escalation meetings whereby inpatient and community leads can come together to consider prioritisation and discharge options from the wards.

The Daily Bed Waiting Overview Meeting
The Daily Bed Waiting Overview Meeting is held Monday-Friday at 10:45 via Microsoft Teams and is chaired by the Crisis Lead with support of the Bed Manager. It should also be attended by the following:

Integrated Patient Flow Clinical Lead
Integrated Discharge Hub Leads
Crisis Services Manager
Crisis Team Manager
AMHP Hub Lead
MHLT

The Bed Manager will present the current SitRep detailing demand that day. The Crisis Team Managers and AMHP hub lead will run through the demand and the triage 'RAG' rating can be applied to assign priority need.

In the event of demand outstripping capacity, the need for a further call that afternoon can be agreed to allow the Ward Managers to work with the MDT, including Ward Consultants and CRHTT in order to identify any further discharges to increase capacity.

6.4.9 Clinically Ready for Discharge

A Clinically Ready for Discharge (CRD) status occurs when an individual is medically fit for discharge, but unable to move on to the next phase of their care, whether that be a further inpatient stay, or discharge. Delays of this nature are detrimental to the individual, as often the longer spent in an inpatient environment unnecessarily they run the risk of not returning to their optimum level of functioning, and it can have an increasingly negative impact on their

mental health.

Individuals deemed to be CRD are reported by ward management teams via RiO reporting and the validated at the Clinically Ready for Discharge weekly meeting chaired by the Hospital Service Director or nominated vice chair.

The Clinically Ready for Discharge Meeting (is held every Wednesday afternoon via MST), all CRD patients are added to this meeting for discussion. Recovery units are also included in this meeting if they are deemed CRD. A link is sent to all invitees. If unable to attend, a representative is to be nominated for each member.

6.4.10 Discharge Planning and Discharge

Discharge Planning should start at the point of the CRHTT Gatekeeping Assessment. The admitting clinician must consider goals of admission, which should specifically identify what needs to happen for the individual to be able to be discharged with CRHTT support for home treatment.

Once admitted, these goals should be discussed at the individual's first MDT, which should include wherever possible, their Care Co-ordinator, and amended if necessary. All barriers to discharge should be discussed at this stage, and an Estimated Date of Discharge (EDD) considered and set. This should be fed back to the Bed Management Team via the Board rounds or Bed Management Meetings. If these barriers are felt likely to lead to DToC status, they should be added to the Complex Discharge Planning Database + Discharge Pathway review so the barriers can be addressed at the earliest opportunity.

6.4.11 The Integrated Discharge Hub

The Integrated Discharge Hub is a multidisciplinary team consisting of the Bed Managers, Inpatient Social Workers and the Supporting Discharge Team, including VCS Providers. Completed referral forms to any team within the integrated discharge hub should be sent to dischargehubinbox@ghc.nhs.uk. Referral form can be found in Appendix 3.

If an individual has had no previous contact with a social worker at the point of admission, and has identified care needs, they can be referred to the Integrated Discharge Hub for allocation of an inpatient Social Worker. The Social Worker will complete an Individual Narrative Assessment (INA) with the individual to ascertain the individual's needs from their perspective. They are then able, in consultation with other professionals, to draw up a support plan to access the necessary care for that individual in the community.

If an individual could benefit from additional support to that provided by their community team on Discharge in order to reduce the risk of readmission, they can also be referred to the Integrated Discharge Hub to be considered for support from the Supporting Discharge Team, or one of the following VCS providers:

Young Gloucestershire
Offer a range of support for individuals between the age of 16-25

The Independence Trust
Offer a range of support for individuals of all ages to support independence.

Change Grow Live
Offer services to support those with substance misuse

POhWER
Offer support to those who have had multiple admissions

Elim Housing
Support homeless individuals to ensure nobody is discharged to the street

The Supporting Discharge Team can support with a variety of activities of daily living, and will set individualised, person centred goals with patients for a fixed period of time, with a view to reducing the risk of readmission, disengagement with services as well as their overall risk profile.

6.4.12 Infection Control

Infection Prevention and Control produce a daily flow chart which should be referred to prior to each admission to ensure the potential for exposing individuals to infection is kept to a minimum. Up to date processes can be found in the: Infection Control Policy (CLP243).

7. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
Reports can be accessed via the MH IP Dashboard on Tableau	Daily	These reports are discussed at Team Governance meetings

8. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm incidents, Regulation 20 Duty of Candour requirements must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources.

Appendix 1 - Triage Rating Criteria

Red Referral (1)

These referrals may indicate following types of risk:

- Imminent risk of self-harm unable to guarantee safety.
- Experiencing a psychotic episode and cannot be treated safely in the community.
- Recent suicide attempt, indicated by degree of lethal intent, impulsivity, and an inability to reliably safety plan.
- Current suicidal ideation with intent, plan & available means.
- Recent self-harm that is severe and risk of serious harm is high.
- Recent verbalisation or behaviour indicating high risk of severe injury.
- Imminent risk of harm to others manifested by one or more of the following:
  - Active plan, means and intent to seriously injure others
  - Recent episode of assault or physical harm to others
  - Recent and physically destructive acts that indicate a high risk for recurrence and serious injury to others.
- Imminent risk for acute and serious medical status deteriorating due to presence and/or treatment of active psychiatric symptom(s).
- Acute and serious deterioration from the patient's usual ability to fulfil usual activities of daily living to the extent that behaviour is so disordered, disorganised, or bizarre that it would be unsafe to leave the patient in a lesser level of care.
- Clinical history indicates serious risk if intervention is not timely.
- Non-engagement with intensive home treatment.
- Lack of carer / family support.

Amber Referral (2)

These referrals may indicate the following:

- Presence of an active psychiatric disorder that can either be more efficiently treated or treated more rapidly in an inpatient environment resulting in a decrease in patient suffering.
- A need for acute psychiatric interventions e.g. medication, ECT with a high probability of serious and acute deterioration of mental health if not admitted to hospital.
- Lack of carer / family support.

Green Referral (3)

All other referrals that do not fit into the above criteria will be classed as green.

This triage system should be used to *support* clinical judgement

Appendix 2 - Repatriation of Patient from Out of Area – Please click here to download an editable version of this form

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Repatriation of GHC Patient

Completing Organisation

Name of patient:	
NHS Number:	
Section status and expiry date:	
COVID 19 Swab results?	
Ward address /Number where patient is returning:	
Has a nursing and medical handover been given?	
Name and position of Nurse who took the handover:	
Name and position of medic who took the handover:	
Medication and Prescription chart included?	
Have all relevant documents been included?	
Any Physical Health conditions, NEWS Score.	
Any specialist/OT equipment needed?	
Is the patient Bariatric?	
Any mobility or transfer issues?	

Remaining Goals of Admission

Risk Assessment

(Please attach in separate document if necessary)

working together | always improving | respectful and kind | making a difference

working together | always improving | respectful and kind | making a difference

Summary of progress and Current treatment plan including physical health conditions or needs.

(Please attach in separate document if necessary)

Transport of patient will be organised once this form is complete and sent via email to the nurse in charge of the receiving ward and the bed management team.

Kind regards
Bed Management Team
Wotton Lawn Hospital
Horton Road
Gloucester
GL1 3WL

Bed Management Referrals and Enquiries: 0300 421 7990

Appendix 3 - Integrated Discharge Hub Referral Form – Please click here to download an editable version of this form

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Integrated Discharge Hub Referral Form

Patient Information	Name:	
	Date of Birth:	
	RiO Number:	
	Referring Ward:	
Community Support	Care Co-ordinator:	
	Mental Health Team:	

Homelessness	
If the individual is currently homeless, has no ongoing care needs and will have no accommodation on discharge, please check the box and complete Section 1 for a referral to Elim Housing	☐
If the individual has accommodation that is unsuitable, they can be discussed with Ellen from CCP on 07936 955421	

Social Care	
If the individual does not have a community Social Worker and has the appearance of care and support needs	☐
If the individual requires assistance with benefits, they can be discussed with Mandy from P3 by calling	
If the individual has complex financial difficulties, please refer to the Citizen's Advice Bureau by calling	

Supporting Discharge Team	
If the individual would benefit from additional support on discharge to prevent readmission or disengagement from mental health services, please check the box and complete Section 3 for a referral to the Supporting Discharge Team	☐

Voluntary Care Services (VCS)	
If the individual would benefit from a referral to any of the other Supporting Discharge Voluntary Care Services (Young Gloucestershire, Independence Trust, CGL or POhWER), please check the box and complete Section 4 for a VCS referral	☐

Integrated Discharge Hub Referral Form: Social Care

Patient Information	Name:	
	Date of Birth:	
	RiO Number:	
	Referring Ward:	
Community Support	Care Co-ordinator:	
	Mental Health Team:	

Social Care

Referral for an Inpatient Social Worker

If the individual has a community team and has previously been allocated a social worker, please contact them to refer for a social worker

Has the individual consented to this referral?	Yes ☐	No ☐
If no, please explain why:		

Please select identified care need from the table below and give a brief description of why you feel an assessment in this area is required			
Presenting Need	**Does this need apply to this individual?**		**Background information**
Making use of home safely	Yes ☐	No ☐	
Maintain a habitable environment	Yes ☐	No ☐	
Caring responsibilities	Yes ☐	No ☐	
Activities of Daily Living Nutrition Personal hygiene Toileting needs Appropriately clothed	Yes ☐	No ☐	

Relationships Develop or maintain family or other relationships	Yes ☐	No ☐	
Other Engaging in work, training, education Making use of community facilities	Yes ☐	No ☐	

What support did the individual have in the community prior to admission? **Is the individual a resident of Gloucestershire?**

Has the individual been involved with any other professionals during this admission or in the community?	Occupational Therapy ☐ Physiotherapy ☐ Psychology ☐

Referrer Information	**Name:**	
	Job Title:	
	Contact Number:	
	Location:	

Homelessness

Referral to Elim Housing

Has the individual consented to this referral?	Yes ☐	No ☐
If no, please explain why:		

Where was the individual living prior to admission?

Why are they unable to return to their previous accommodation?

Has the individual registered on Homeseekers?

Is the individual in receipt of Universal Credit or other benefits?	Yes ☐	No ☐	Don't Know ☐

Referrer Information	**Name:**	
	Job Title:	
	Contact Number:	
	Location:	

Supporting Discharge Team

Referral for transitional support on discharge

Is the individual willing to engage with the Supporting Discharge Team?	Yes ☐	No ☐
Has the individual consented to this referral?	Yes ☐	No ☐
If no, please explain why:		

Does the individual consent to share their details with other VCS Providers?	Yes ☐	No ☐	If you would also like to request a VCS referral at this stage, please go to Section 4		
Is the individual known to the hospital therapy team?	Yes ☐	No ☐	**Have the therapy team completed all necessary baseline assessments?**	Yes ☐	No ☐

Reason for referral
Anticipated goals of intervention

Referrer Information	**Name:**	
	Job Title:	
	Contact Number:	
	Location:	

Voluntary Care Services

Request for referrals to VCS

Young Gloucestershire			Independence Trust		
Additional support for people between the ages of 16 and 25			Additional support for anyone to maintain their independence after admission		
What support would the individual benefit from?			**What support would the individual benefit from?**		
Has the individual consented to this referral?	Yes ☐	No ☐	**Has the individual consented to this referral?**	Yes ☐	No ☐
If no, please explain why:			If no, please explain why:		
Change Grow Live (CGL)			**POhWER**		
Support for people with problems around substance misuse			Support individuals to identify & communicate their needs around discharge and beyond		
What support would the individual benefit from?			**What support would the individual benefit from?**		
Has the individual consented to this referral?	Yes ☐	No ☐	**Has the individual consented to this referral?**	Yes ☐	No ☐
If no, please explain why:			If no, please explain why:		

Referrer Information	**Name:**	
	Job Title:	
	Contact Number:	
	Location:	