South West London and St George's Mental Health NHS Trust

Bed Management Policy

23rd May 2019 / Version 2.3
This policy supersedes all previous policies for Bed Management

South West London and St George's Mental Health NHS Trust

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Target Audience	ACCC, all ward teams, all urgent care services (street triage, HTTs, liaison psychiatry, Lotus & S136), community services
Relevant External Requirements	Various rules of the CQC, CCGs/NHSE and local authorities

Contents

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2.1	27.3.19	72-hour follow-up target, change to Black status rules and removal of Hume seclusion option	Not ratified by QGG	QGG
2.2	23.4.19	Further amendments to the sections listed in 2.1 above following QGG	Ratified by QGG	QGG
2.3	23.5.19	S12.4 and Appx 11 amended to better manage delays in admission	Ratified by Chair	Vanessa Ford DoN

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1. Introduction

1.1. Admission to hospital may sometimes be necessary as part of a person's treatment and recovery to provide a safe environment for their care. Inpatient care is considered when an individual has a clinical mental health need which cannot be safely treated in a community environment. Admission to an inpatient ward can be a stressful experience for the person. As well as supporting service users to be admitted to an inpatient environment if it is clinically appropriate, there should be equal focus on supporting service users to be discharged to the least restrictive environment when it is clinically appropriate to do so.

1.2. The general principles of effective bed management are set out in this document for all patients requiring inpatient admission. The purpose of this policy is to provide a clear framework for arranging admission to any Trust or external ward, and for transfers between wards and sites. The policy sets out clear guidance for situations where local bed capacity is low and will describe the escalation procedures to follow in order to ensure swift communication and resolution of delays. Supplementary process maps and protocols are detailed in the appendices.

1.3. The underlying principle of this policy is that South West London & St George's Mental Health NHS Trust (SWLStG) will provide an inpatient bed for the residents of South West London (and in some cases, a wider area) that are assessed to have a clinical need that requires inpatient mental health care.

2. Aim, objectives and scope

2.1. The aim of this policy is to ensure that the right patient is in the right bed at the right time, and is managed safely pending admission. This policy governs the management of all Trust inpatient beds.

2.2. The objectives of this policy are to ensure:

- efficient and effective use of all beds in the service and to make sure that beds outside the Trust are used only in exceptional circumstances, other than for patient groups such as CAMHS and Forensic patients (through the South London Partnership, SLP; details in Appendix 6), and women requiring a psychiatric intensive care unit (PICU) bed for whom the Trust has no internal provision.
- all inpatient sites and the personnel involved in the management of beds have a clear understanding of the procedures involved and the resources and options available;
- for all patients, an appropriate team acts as 'gate keeper' by assessing the patient before admission, and beds are found as swiftly and efficiently as possible once the need for a bed has been verified by the gatekeeping team; (Table 2 in section 7.2 below explains which teams perform gatekeeping in different circumstances)
- all patients are nursed in the least restrictive environment possible in accordance with NICE guidelines[1];

[1] 'The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. (NICE, February 2005)

- patient and staff safety issues are taken into account and patients not moved between wards unless it is clinically indicated or they request a move;
- that clinical need and clinical risk are the primary drivers when considering inpatient mental health care.

2.3. The general principles of this policy apply to all Trust inpatient beds. Additional pathways and processes apply to rehabilitation, Forensic, Specialist and CAMHS inpatient beds, described in the sections and appendices below.

2.4. Figure 1 below shows the Trust and contract wards covered by this policy.

Figure 1: Trust and contract Wards

Location	Pathway	Ward	Male	Female	Flexi	Totals
Springfield University Hospital, SW17 7DJ	Acute	Ellis*	12	0	0	12
	Acute	Jupiter	11	10	2	23
	Acute	Ward 3	8	8	4	20
	Acute	Ward 2	7	7	4	18
	PICU	Ward 1	13	0	0	13
	Rehab	Phoenix	4	12	0	16
	Older adults	Crocus	8	11	0	19
	Forensic	Hume	16	0	0	16
	Forensic	Halswell	16	0	0	16
	Forensic	Turner	18	0	0	18
	Forensic	Ruby & flat	0	10	1	10+1
	Forensic	Burntwood Villas	6	8	1	15
	CAMHS	Aquarius	5	6	1	12
	CAMHS	Corner House	3	3	0	6
	CAMHS	Wisteria	0	12	0	12
	Specialist	Avalon	0	0	17	17
	Specialist	Bluebell	3	11	0	14
	Specialist	Seacole	6	7	1	14
Queen Mary's Hospital SW15 5PN	Acute	Lavender	10	10	3	23
	Acute	Rose		21		21
	Acute	Laurel	23			23
Tolworth Hospital KT6 7QU	Acute	Lilacs	8	7	3	18
	Older adults	Jasmines	6	8	2	16
Mile End Hospital E1 4DG	PICU	Rosebank (ELFT)	0	5	0	5
Total			***183***	***156***	***39***	***378***

*In October 2019, Ellis Ward will move to Tolworth Hospital and increase to 18 beds.

SECTION A: CLINICAL MODEL OF INPATIENT CARE

3. Clinical overview of inpatient care pathways

3.1. In-patient care should be seen as a last resort, when community care is not possible or safe for an individual patient. It should never be the default option, but instead a carefully-planned intervention (even in an emergency situation) should be offered, following a thoughtful 'gate-keeping' assessment.

3.2. The overarching principle above applies to all Trust inpatient services. The Admissions Decision Trees in Appendix 1 show graphically where inpatient acute beds fit within the pathways.

3.3. The central aim of all wards is to provide a safe and therapeutic environment for service users during a critical phase of their illness. The objective is always to return the service user to an agreed level of functioning and enable them to resume their life in the community as quickly as possible.

3.4. The detailed clinical model of each inpatient ward or group of wards, and the criteria for admission or transfer to or discharge from the ward, are described in the relevant ward operational policy. The criteria for PICU and single-sex acute wards are summarised in the respective ward operational policies.

4. Target Group

4.1. Admission to hospital only occurs where community alternatives have actively been considered and rejected by the gatekeeping team (e.g. Home Treatment Team), where it is not safe or appropriate to provide care in the home or other residential setting.

4.2. Residents within the catchment area served by South West London and St George's Mental Health NHS Trust (five boroughs[2]), or served by the catchment area served by the South London Partnership (12 boroughs[3]) for Forensic and CAMHS patients, when necessary may be admitted on an informal basis or may be subject to a section of the Mental Health Act[4].

[2] Kingston, Merton, Richmond, Sutton, Wandsworth, plus in emergencies "boundary associates".
[3] Bexley, Bromley, Croydon, Greenwich, Kingston, Lambeth, Lewisham, Merton, Richmond, Southwark,Sutton, Wandsworth
[4] SWLStG has been designated by the relevant CCGs for this purpose under S140 of the Mental Health Act.

SECTION B: OPERATIONAL MODEL OF INPATIENT CARE

5. Principles and Functions

5.1. SWLStG is committed to providing an inpatient bed for those that are assessed to have a clinical need that requires inpatient care.

5.2. The Trust's Care Pathways incorporate several stages of which inpatient care is one (see Appendix 2 for Acute Adult Beds, Appendix 6 for Forensic, Specialist and CAMHS admissions).

5.3. As well as supporting service users to be admitted to an inpatient environment if it is clinically appropriate, there should be equal focus on supporting service users to be managed in alternative ways and discharged to the least restrictive environment when it is clinically appropriate to do so.

5.4. These pathways are overseen by Bed Management Teams within each Service Line

5.4.1. Admission to an inpatient acute beds can occur 24 hours per day , 7 days per week

5.4.2. Discharge from an inpatient adult acute bed can occur 7 days per week between the hours of 0800 and 2200 (or outside those hours in exceptional circumstances if clinically safe to do so).

5.4.3. Specialist wards listed in Appendix 6 do not routinely allow admissions or discharges out of working hours (0900-1700, Monday-Friday).

5.4.4. A patient who would normally go to another ward cannot be admitted to a specialist ward listed in Appendix 6 except in exceptional circumstances where this has been approved in advance by the Director on call. (Older adults wards listed in appendix 6 do not count as specialist wards for this purpose.)

6. Gatekeeping teams

6.1. There are several teams providing a gate-keeping function to in-patient beds across the Trust, as set out in Table 1 overleaf:

Table 1: Gatekeeping teams assess patients for admission or home treatment

Patient group	Gate-keeping team(s)
Working-age adults (Acute and Urgent Care)	• Psychiatric Liaison, for patients presenting to A&E • Street Triage, for patients seen by police on the street • Home Treatment Teams for all other working age adults (including where the gatekeeping assessment is a Mental Health Act assessment or assessment for CTO recall)
Children & adolescents (CAMHS)	• Adolescent Outreach Team (AOT) • CAMHS Emergency Care Service for young people presenting to A&E • Crisis Response team / CAMHS bed management as developed through the SLP for admission to IN and out of SLP beds
Older adults (CMHA)	• Kingston and Richmond Single Point of Access • Wandsworth CMHT • Merton CHMT Sutton CHMT
Adults requiring specialist beds (Forensic, Specialist & National)	• Forensic Outreach Service, for community forensic patients • Forensic Referrals Panel, for other forensic referrals • Via individual named consultants for specialist/national services

6.2. These teams work with the key objectives:
- Right patient,
- Right place,
- Right time.

6.3. Gatekeeping teams are responsible for gatekeeping all inpatient beds. All those being considered for clinical treatment in an inpatient bed must be referred in the first instance to the relevant team from table 1 above.

6.4. Home Treatment Teams (HTTs) provide a 24 hour 7 days a week consultation and assessment service including gate keeping and operate in all localities; as part of the acute and urgent care pathway. They offer home treatment as an alternative to hospital admission when this is clinically appropriate. Other gatekeeping teams have different availability.

6.5. There may be occasions where it is not in the best interests of the service user for the gatekeeping team to carry out a face to face assessment (for example, where the patient is outside London and it would be clinically inappropriate to delay an urgent admission while the gatekeeping team staff travelled to the area to undertake an assessment). In such cases, the gatekeeping team must still screen

the referral and make an initial decision on admission based on the referral information, discussion with the referrer, and partial assessment (e.g. by telephone).

6.6. All practitioners wishing to admit a patient to hospital, including urgent and emergency admissions, must begin by contacting the relevant gatekeeping and bed management team. Where specific arrangements apply in emergency situations, these are set out below and (in the case of specialist services) in appendix 6.

7. Referrals & gatekeeping processes

7.1. For all admissions, the gatekeeping assessment must be recorded on the appropriate RiO/iAPTUS form, as set out in Table 2 below. This remains the case even if exceptional circumstances prevented the team from conducting a face to face assessment.

7.2. To avoid delay, a request for admission can be processed by the relevant bed management team and proposed receiving unit or ward on the basis of an oral handover from the gatekeeping team. In this case, the gatekeeping form below must still be completed within two hours of the oral handover, or by the time the patient is transferred to the receiving unit or ward, whichever comes first.

Table 2: Forms required to support admission processes

Patient group	Form(s) required
Working age adults (A&UC)	• Gatekeeping Form and • Barriers to Discharge Form http://imapps/documents/GatekeepingRedirect.pdf
Children and adolescents (CAMHS)	• NHS England Form 1 & 2
Older adults (CMHA)	• MHA Section papers • Mental Capacity Form on RiO
Adults requiring specialist placement (Forensic, Specialist & National)	• SWLSTG SLP Referral Form • South London Partnership Hub Consultancy Protocol (to be ratified)

7.3. **Informal Admissions:**

7.3.1. Within each Service Line the Trust has Home Treatment Teams or other teams offering alternatives to admission. These teams also gate-keep access to all inpatient beds.

7.3.2. Referrals to the Home Treatment Team are to be made by telephone only.

See Appendices 2 - 7 for other forms and details of how to make referrals to the relevant gatekeeping team.

7.3.3. Before a patient is admitted to hospital, a referral must to be made to the relevant team which **must** undertake a face-to-face assessment and record

the outcome in the patient progress notes (iAPTUS and/or RiO as appropriate).

7.3.4. For informal admission to be recommended, the gatekeeping assessment must confirm that the patient has capacity to consent to admission, does consent, and understands what admission will involve (e.g. the administration of medication, no smoking in the hospital etc.)

7.3.5. If all options to support treatment in the community have been exhausted and inpatient care is indicated then then the relevant referral for admission form must be completed, as listed in table 2 above.

7.4. **Formal Admissions:**

7.4.1. All referrals for a mental health act assessment (MHAA) must include a referral to the relevant gate keeping team (e.g. Home Treatment Team). This process ensures that home treatment, as an alternative to hospital admission has been considered

7.4.2. The Home Treatment Team or other gatekeeping team should either be involved in a discussion about home treatment prior to the MHAA being considered and arranged, or participate in the MHAA, whichever is considered more appropriate given the patient's presentation and the likelihood of home treatment being suitable.

7.4.3. Similarly, if a patient is being considered for recall under a Community Treatment Order (CTO), the gatekeeping team should be involved in the discussion or assessment during which a decision is made about whether to recall.

7.4.4. ACCC or other relevant bed management team should be informed of planned MHAAs and CTOs, and of the outcome. Neither MHAAs or recalls under CTO should be delayed because of any predicted difficulty in finding a bed if the patient is detained. In the event of a local bed being unavailable once the decision to detain is made, the bed management team will prioritise finding an alternative (including private) bed without delay under S12.15 below.

7.4.5. If a patient is detained urgently and the gatekeeping team was unavailable, a referral must still be made by telephone to the relevant team and clear reasons for urgent admission under detention documented.

7.4.6. In all of these scenarios, the gatekeeping team is responsible for ensuring the relevant gatekeeping form from table 2 above is completed, either by that team itself or by the staff conducting the MHAA or CTO recall. For the avoidance of doubt, the assessing AMHP is not expected to complete the gatekeeping form, only the member of the relevant gatekeeping team (e.g. HTT).

7.5. **Emergency Department (ED) referrals:**

7.5.1. SWLStG provides psychiatric liaison services at A&E Departments of three local acute hospitals: St George's Hospital, Kingston Hospital and St Helier Hospital. The Psychiatric Liaison Teams carry out gatekeeping assessments

to the same standard as other gatekeeping teams, and decide whether hospital or other intensive support is clinically indicated.

7.5.2. If hospital admission is clinically indicated then the Psychiatric Liaison team can refer directly to the relevant SWLStG Bed Management Team (e.g. ACCC) for a bed, without the Home Treatment Team carrying out a duplicate assessment. This decision would be in the best interest of the patient. On these occasions the Psychiatric Liaison Team must complete the relevant referral forms (see table 2 above).

7.6. **Referrals to Lotus Assessment Suite**

7.7. All referrals for further assessment on the Psychiatric Decision Unit (Lotus Assessment Suite) must comply with the Lotus Operational Policy. This includes having mental capacity and consenting to assessment on Lotus, and understanding the nature of the assessment environment (e.g. having couches rather than beds, and without full gender separation).

7.8. If the gatekeeping team assess the service user as requiring clinical care which can only be provided in an inpatient ward then they will notify the relevant bed management team (e.g. ACCC) by telephone that an inpatient bed is required.

7.9. The gatekeeping team will discuss with the bed management team the level of clinical need and risk for the patient so that an appropriate bed is allocated.

7.10. The gatekeeping decision recorded on the forms specified in table 2 must be accompanied by an up to date risk assessment. (See Appendix 5 for a screen shot of the Gatekeeping form.)

8. Psychiatric Intensive Care Unit (PICU)

8.1. Psychiatric intensive care is for patients who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control with a corresponding increase in risk which does not allow their safe, therapeutic management and treatment in a less acute or a less secure mental health ward.

8.2. The Trust aims to identify and where possible avoid the need for intensive care wherever possible, through its ‘PICU prevention’ initiative, led by the Advanced Clinical Practitioner for PICU. This includes supporting staff on other wards in the management (including pharmacological management) of acutely disturbed behaviour.

8.3. SWLStG provide a 13 bed male PICU at the Springfield University Hospital site, SW17.

8.4. In addition, the Trust commission contractual and additional ‘spot-purchased’ private female PICU beds at other private providers.

8.5. If the capacity of these resources is exhausted, the out-of-area bed processes described in section 11 below apply.

8.6. **Adult Male PICU**

8.6.1. Referral from another Acute ward to the Male PICU on Ward 1 is via a telephone referral to the Advanced Clinical Practitioner (ACP) or PICU Ward Manager.

8.6.2. Outside working hours, the referral can be taken over the telephone by Medical and nursing staff (Band 6 and above) on Ward 1.

8.6.3. Ward 1 staff complete a screening and decision form (PICU Alert Form) during the conversation (see Appendix 4) and will provide a decision to the referrer within 30 minutes.

8.6.4. The PICU team carry out an assessment within 2 hour of the referral and facilitate the subsequent admission to PICU.

8.6.5. If the referral is declined then the Ward manager needs to describe the rationale for this decision within 60 minutes. Out of hours, the most senior nurse on duty does this. This conversation should lead on to providing advice on management of the patient, and the support of the PICU ACP.

8.6.6. Out of hours, ACCC staff may carry out the screening & assessment and facilitate the transfer to Ward 1.

8.6.7. Referrals for Male PICU from the community, A&E or other non-inpatient location will be to the ACCC (once admission has been gatekept by the HTT or Liaison Teams). The ACCC, in conjunction with the Ward 1 PICU nurse in charge, screen the request for PICU using the same screening & decision form.

8.7. **Adult Female PICU**

8.7.1. Female PICU beds are provided externally. Referrals for female PICU can be made via a telephone referral to the ACP or in their absence the Matron for Urgent Care.

8.7.2. Outside working hours, referrals should be made by telephone to ACCC.

8.7.3. Referrals from community teams to Female PICU will be assessed and facilitated by the ACCC; with the support of the ACP in hours.

8.7.4. The process for Admission, Clinical Review and transfer back to an acute ward and to the community is coordinated by the ACP for PICU.

8.8. **Adolescent PICU**

8.8.1. These beds are provided through the South London Mental Health Partnership's arrangements, access to them is through the CAMHS Bed Management.

9. Mother and Baby process and agreement

9.1. When considering making a specialist mother and baby placement, the needs of the child and the mother are paramount to ensure that both are cared for in the most appropriate environment that best meets their needs.

9.2. As the Trust does not provide specialist mother and baby facilities, a preferred placement will need to be sought following a multi-disciplinary review, taking into account the views of the patient and children and families social services.

9.3. At all times, ACCC will coordinate all admissions to a Mother & Baby unit (MBU) following guidance set out by NHS England. During working hours, they will do this in consultation with the Perinatal Service.

9.4. The protocol at Appendix 7 sets out the process to be followed.

10. Bed Management teams

10.1. The Trust's primary bed management team is the Acute Care Co-ordination Centre. However, other teams or virtual teams manage or assist in managing certain specialist beds, as shown in table 3 below.

Table 3: Bed management teams

Patient group	Bed management team
Working age adults (A&UC)	Acute Care Co-ordination Centre (ACCC)
Children and adolescents (CAMHS)	SLP CAMHS bed management team, assisted by ACCC
Older adults (CMHA)	ACCC
Adults requiring specialist placement (Forensic, Specialist & National)	Forensic Referrals Co-ordinator and Panel Individual specialist wards' MDTs and consultants

10.2. In case of disagreement, the gatekeeping team has the final decision on whether or not a patient shall be admitted; the bed management team cannot refuse a request for admission for a patient who has had a gatekeeping assessment.

10.3. In case of disagreement, the bed management team has the final decision on *where* a patient shall be admitted, as they are the sole team with an overview of the whole system, and in a position to balance the competing needs of different patients. They must take into account the recommendation and reasons provided by the gatekeeping team and by the proposed receiving ward or unit, but the decision is theirs.

10.4. If the manager or nurse in charge of a proposed receiving ward or unit reports that the ward/unit cannot safely receive the patient (e.g. because of a serious incident or emergency), they should attempt to reach agreement with the bed management team on an appropriate course of action (e.g. delaying admission, or accepting a settled patient from another ward to enable the new admission to go to that other ward). If agreement cannot be reached, both the bed management team and the receiving ward must escalate the situation to the Manager on call who will make the final decision.

10.5. Patients can only be admitted to unoccupied beds. Beds cannot be 'created' in additional areas of a ward, or wards go above their maximum agreed bed number, except when the Trust is at Bed Capacity Status 'Black' (see below) and with the prior agreement of the Director of Nursing & Quality or (out of hours) the on call Director.

10.6. Patients can only be admitted to age-appropriate wards. Children & adolescents cannot be admitted to adult wards, or adults to CAMHS wards, without the prior agreement of the Director of Nursing & Quality or (out of hours) the on call Director.

10.7. Likewise, patients can only be admitted to gender-appropriate wards. Women cannot be admitted to male wards (or the male area of a mixed ward), or vice versa, without the prior agreement of the Director of Nursing & Quality or (out of hours) the on call Director.

11. Reporting of Bed Capacity

11.1. The ACCC holds responsibility for keeping an up to date account of all beds occupied by Trust patients, including external beds; and the reporting of Occupied Bed Days (OBDs) as part of the Trust's contracting and finance governance arrangements.

11.2. The Trust Bed Capacity is available on MyDashboard 24 hours per day http://imapps/reportserver/Pages/ReportViewer.aspx?/adhoc/InpatientManagement/InpatientMatrix&ReportCode=3&WardBorough=All&WardCategory=All

11.3. The Trust aims for a bed occupancy of 90% (except on certain specialist wards which may accept higher occupancy rates as set out in appendix 6).

11.4. The BRAG Bed Capacity Status rating will be reported along with the bed capacity at 0800hours and 1500hours daily by ACCC.

11.5. The Bed Capacity status can be raised from Green to Amber on the authority of ACCC. Raising the status to Red or to Black requires the authority of the relevant Head of Service Delivery or Clinical Director during working hours, or the on-call Director outside working hours. This is because of the additional measures that affect services across the Trust when status Red or Black is declared.

11.6. These additional measures include authority to place patients in private or out of area beds. If the current Bed Capacity Status does not provide such authority and the criteria for raising the status to a higher level are not met, patients can only be placed in private or out of area beds with the prior approval of the Director on call.

11.7. The Bed Capacity Status can be reduced from any level at any time on the authority of ACCC alone.

11.8. The involvement of other agencies and NHS bodies in support of the Trust when status Red or Black is declared will be co-ordinated by the relevant Head of Service Delivery or Clinical Director (when Red), or the Chief Operating Officer or Medical Director (when Black), as appropriate.

11.9. Bed capacity and escalation is supported by the Bed Management Escalation Criteria and Actions, a copy of which is in Appendix 14. This sets out which other local partners and agencies should be alerted at each stage.

11.10. The Business Continuity Plan is also relevant for how bed management will respond to serious incidents threatening business continuity.

12. Management of Pending Referrals for Inpatient beds

12.1. The Acute Care Coordination Centre (ACCC) have responsibility for the recording requests for inpatient beds; and the accurate recording of inpatient location (be that SWLStG, private PICU or other location).

12.2. The ACCC hold responsibility for recording and monitoring the details of those who have been referred for working age and older adult inpatient care. This is known as the “Pending Referral List”.

12.3. The ACCC will circulate the “Pending Referral List” to all Executive and on-call Directors and other key leads at 0800hours and 1800hours daily. (See Appendix 8). This projects demand for beds over the next six hours and beyond.

12.4. All patients will be allocated a bed within four hours of receiving the decision of the gatekeeping assessment, and efforts will be made to allocate a bed within the first two hours wherever possible. Any inability to allocate a bed within four hours must be reported by the referrer as an incident, whether the cause is internal to the Trust or relates to the police, ambulance service, local authority/AMHP service or other factors. (See also section 12.14 below. The reason for the two-hour time limit is that this is longest an ambulance crew can be required to wait with an AMHP and patient after a Mental Health Act assessment.)

12.5. Relevant assessment documentation and risk assessment must be completed and available to ACCC on RiO within an hour of the initial request for a bed. Any delay in providing this information should be reported as an incident.

12.6. The ACCC will proactively project where beds are likely to become available and ensure that all plans for leave/discharge are in place.

12.7. The responsibility for co-ordinating the support for the patient whilst a bed is being organised, lies with the referrer who has called the bed management team to request the bed, unless they have agreed that another team will co-ordinate this on their behalf (e.g. an AMHP may reach agreement with a CMHT that the CMHT will co-ordinate support until the bed becomes available). For the avoidance of doubt, this means that the referrer (or the team whom they have agreed will discharge the responsibility on their behalf) must coordinate the arranging of whatever support is required, not necessarily provide that support themselves. This must include a process for reviewing the patient’s condition at appropriate intervals while on the pending list, and updating the requirement for an inpatient service (e.g. from Lotus to direct admission, or from an acute ward to PICU or forensic, if the patient’s condition or risk of harm to others deteriorates). See the further guidance in appendix 8 on keeping patients safe while waiting for admission.

12.8. If a bed is no longer required, it is the responsibility of the referrer (or any person or team acting on the referrer’s behalf) to inform the bed management team that the bed is no longer required. The referrer must make an entry in RiO confirming that they have spoken to the team informing them of the reason why an inpatient bed is no longer required. Until such time the bed management team will continue to find an inpatient bed.

12.9. Every effort will be made to admit service users to the ward associated with their borough (their Home Ward). However, for reasons associated with supply & demand this may not always be achievable. See Appendix 11.

12.10. At times where the demand for a gender specific bed outstrips supply the “Flexible Bed” guidance should be followed (see Appendix 2).

12.11. At times of sustained increased demand for gender specific beds there may be a need to change the function of a ward to female only or male only. This requires the permission of the relevant Clinical Director during working hours or the on-call Director outside working hours, and if approved must be done according to agreed processes, respecting patient dignity and preferences.

12.12. **Prioritisation of pending referrals**

12.13. The ACCC will continue to review the 'pending referrals' list and ensure that all patients are found a bed within the agreed timescale.

12.14. ACCC will adjust priority for available beds according to:

- patients' current clinical need;
- the risk of harm to the patient or others (taking into account the environment in which the patient is currently located, and the ability to manage any risk of harm safely in that environment); and
- the likelihood of the need for readmission, in the case of patients on leave (see section 14 below).

12.15. If, two hours after receiving a decision to admit from a gatekeeping team, no bed has been identified and it appears likely that no bed will imminently be identified, the bed management team must inform the responsible Matron. This will trigger consideration of an out of area or private bed under section 11.6 above, following discussion with the Head of Service Delivery or (out of hours) the Director on call.

12.16. **Return/referral of patients from acute hospitals**

12.16.1. Where a patient is admitted to an acute medical ward for treatment, the bed will be held for a minimum of 12 hours (generally longer in specialist services) pending a decision by the transferring ward about the likely timeframe the patient would need to be medically cleared. This is consistent with the principles of returning patients to wards to continue treatment/assessment rather than patients going to a different ward.

12.16.2. During this time, the sending ward may send a staff escort with the patient if clinically necessary to manage them safely, or if they are detained under the Mental Health Act. This escort may be withdrawn either by agreement with the acute hospital, or (for informal patients) if the sending ward assesses that it is no longer necessary

12.16.3. This requires a pro-active approach from the transferring ward to establish likely timeframes with the medical ward, which should be clearly documented in the notes.

12.16.4. In the case of patients returning from a medical or surgical ward in an acute hospital, it is imperative that the patient is cleared as medically fit to return to a mental health ward. It is the responsibility of the Psychiatric Liaison Team to establish and confirm medical clearance, and report to the bed management team any special equipment (e.g. bariatric or pressure-relieving mattress) the patient will require.

12.17. **Patients from out of area**

12.17.1. If a patient from outside the relevant catchment area is referred for an inpatient bed, the ACCC will contact their counterpart in the person's "home" trust. They will negotiate admission directly to the appropriate hospital.

12.17.2. If there is a delay of more than four hours in admitting the person to their "home Trust" then the bed management team will escalate this to the relevant Head of Service Delivery (or the Director on call out of hours), for consideration of an interim admission to an SWLStG bed. ACCC and other bed management teams **cannot** accept an out-of-area patient into an SWLStG bed without such permission in advance. Permission is unlikely to be granted in the case of a patient from a nearby London area.

12.17.3. In the case of working age adult patients, the "home" Trust is determined by reference to the NHS England London Mental Health Compact, which states that the responsible Trust is that covering the area in which the patient is "usually resident". It is irrelevant which GP they may be registered with. (This is in contrast to the DH guidance on the commissioner responsible for funding the admission, which is based on GP registration. Thus SWLStG will accept patients usually resident in its area with out-of-area GPs, and charge their care to the CCG responsible for that GP. Conversely, SWLStG will decline to admit a patient registered with a local GP but usually resident outside the catchment area.)

12.17.4. Patients who have no fixed abode may still be admitted to an SWLStG bed if there is evidence that they are usually resident within the catchment area (e.g. they regularly use a shelter or friend's or family address within the catchment area).

12.17.5. Sometimes at the point of admission, a patient's catchment area may not be clear. If staff realise that an out of area patient has been admitted to a Trust bed every effort must be made to return the patient to their home trust as soon as possible and within 72 hours maximum.

12.18. Overseas Visitors

12.18.1. The Trust is not funded to care for patients whose status is identified as "Overseas Visitor". Therefore, all NHS trusts are obliged under Department of Health guidelines to identify all patients in treatment who are overseas visitors. For Trust staff this information must be recorded in the patient's RiO notes following the RiO Guidance Notes for Overseas Visitors and refer to the Overseas Visitors Team. (Overseas visitors process is currently being established in SWLStG by Head of Service Delivery, Acute and Urgent Care and the Finance Contract team.)

12.18.2. An overseas visitor is someone who is not ordinarily resident in the United Kingdom, or someone who has been living outside the UK for more than 3 months. If they do not live permanently in the UK they may be charged for their treatment. Being registered with a GP and having an NHS Number does not mean that the patient is automatically entitled to free hospital treatment. British passport holders who are not UK residents are not automatically entitled to free NHS treatment either.

12.18.3. How to Identify Overseas Visitors, and accounting for the health surcharge on visa applicants: *Guidance will be included in this section when available.*

13. Clinical and Non-Clinical Transfers

13.1. The Matron, Clinical Director, or Out of hours the Manager On Call should be consulted whenever advice is needed.

13.2. **Patients transferred between wards**

13.2.1. The over-riding principle is that, to the maximum extent possible, patients should not be moved between wards for bed management reasons. Where decisions are taken to transfer patients to another ward, for either clinical or non-clinical reasons, the following actions should be taken:

13.2.2. If a non-clinical transfers occurs:

(i) Between 9am to 5pm, ACCC cannot make a decision on their own to move patients between wards. A discussion must take place between respective ward managers, Matrons and preferably between respective Consultants.

(ii) Out of hours, the On Call Manager should be contacted and they will escalate to the On Call Director as appropriate.

(iii) There should be clear documentation in RiO justifying the need for the transfer. This needs to be under a heading 'Non clinical move'

13.2.3. If a move is intended to be temporary, this can only be for a maximum of 72 hours. In this case, the Responsible Clinician of the original ward will remain the same. The original ward team will provide a brief handover summary of the patient's care including care plan, medication, observation level and leave arrangements.

13.2.4. If the patient is expected to remain (or does remain) on the ward for more than 72 hours, then the care will be transferred to the receiving ward together with the relevant clinical information being updated in iAPTUS and/or RiO as appropriate, to ensure that transfers between treatment wards are safe by providing staff on wards receiving transfers with clinical information regarding the risks, treatment objectives and outstanding clinical requirements of patients referred/transferred.

13.2.5. Patients will not be moved after 9pm wherever possible. Any move will be discussed with the patient prior to the transfer taking place

13.2.6. There may be strong clinical grounds for not transferring a patient. In these circumstances this must be agreed between the respective consultants. The reasons must be documented on iAPTUS and/or RiO as appropriate.

13.3. **Transfer of patients detained under the Mental Health Act**

13.3.1. Note that in some cases (particularly patients detained under Part III of the MHA), there may be legal limits on where the patient can be transferred (e.g. to a unit specified on a warrant only), or the consent of the Ministry of Justice may be required.

13.3.2. The Trust has a duty to uphold patient rights of appeal against detention under the MHA and to ensure that patients have their appeals heard without undue delay. The relevant Mental Health Act Administrator must be informed when a patient who is detained under a section of the mental Health act is transferred to a different ward/site.

13.3.3. With this in mind, the following procedures have been agreed:

(i) either enable the patient to attend the hearing at the previous site as arranged;

(ii) to hold the arranged hearing at the new site on the date already agreed, with professionals who know the patient best (from the former site) in attendance;

(iii) In exceptional cases consideration may need to be given to deferring the arranged hearing but this should be fully discussed with everyone involved including the patient.

13.4. **Transfers of patients to and from acute hospitals, including in emergencies**

13.4.1. Before transferring a patient, staff in the originating ward must involve the relevant psychiatric liaison team; ensure the correct information accompanies the patient; and make appropriate arrangements for escorting and observing the patient.

13.4.2. Appendix 14 contains detailed guidance on this, along with a checklist to be used prior to transfer and a template for the accompanying referral letter.

14. Overnight leave from wards

14.1. A leave plan will be agreed with each service user and family/carer as appropriate prior to going on leave from an acute ward. This will include discussion of where the patient will come for review at the end of leave, and what would happen if they need to come back into hospital for any reason, including the possibility that their bed would not be in their previous bedroom or even on the same ward (though wherever possible it will be to the same ward). It will also include an estimate of their likelihood of needing to come back into hospital, and what priority they should have with ACCC for a bed on the same ward in that situation. This will be recorded clearly in RiO progress notes and in individual care plans.

14.2. For working age adults, referral to HTT will be considered by the ward team prior to leave commencing. Their support may be required to facilitate successful supportive leave from the ward. HTT will be asked (before the leave begins) to make a face to face contact visit with the service user in their home to support the leave plan.

14.3. In the event of leave breaking down completely and a bed being required for the patient, if their bed has been released to another patient (as will often happen with working age adults and older persons services, but rarely in specialist services), the service user will be prioritised for the next available bed, based on the priority grading agreed with ACCC when the leave was planned, amended as necessary to reflect any change in presentation whilst on leave. HTT will continue to support the service user until a bed has been identified.

14.4. The plan including the ward contact number should be printed and given to the service user and carer prior to commencing leave..

14.5. If the team feel that a referral to HTT is not required, the service user and family/carer will be asked to contact the ward directly by phone if there any problems or concerns during the leave period.

14.6. If the patient fails to return from leave as planned, the AWOL policy must be followed.

15. Discharge Planning

15.1. **Discharge Coordination**

15.2. Discharge planning, coordinated by the clinical team and care co-ordinator, supported by the ACP/ADP, commences on admission and an estimated date of discharge will be agreed by the Multi-Disciplinary Team (MDT) within 72 hours of admission and entered into either iAPTUS and/or RiO as appropriate.

15.3. The following general headings are some of the areas to consider:-

- Patient's expectations of the admission and plans for discharge
- Assessed risk and patient identified risk
- Individuals' goals and aspirations
- Need for continuing support and treatment
- Ability to function independently or with available supports of Carer or significant others
- Home situation
- Employment
- Other support systems and resources.

15.4. Discharge plans will in almost all circumstances include a CPA or discharge planning meeting prior to discharge, and the involvement of the care co-ordinator and (where appropriate) carers and family.

15.5. It is recognized that the EDD and Discharge Plan may need amending due to clinical needs and changes in the acuity of the patient's mental health. A discharge plan should highlight any issues pertaining to successfully discharging the patient.

15.5.1. As well as being recorded in iAPTUS and/or RiO as appropriate, for acute adult in-patients these issues will be logged as barriers to discharge.

15.5.2. ACPs/ADPs will monitor these issues and ensure that these tasks are completed in a timely way to reduce any unnecessary delay in discharge. Delays will be flagged at the daily discharge meetings and reported as DToCs (see section 17 below).

15.6. Where there is no existing Care Coordinator and when appropriate/indicated, one must be appointed within 48 hours of the need being identified (usually at the point of admission), and well before the patient is discharged.

15.7. The Care Coordinator should meet the patient and Named Nurse regularly throughout the patient's stay in hospital. The ACP/ADP and Care Coordinator have a joint responsibility for ensuring that discharge arrangements are complete before the patient leaves hospital.

15.8. The **Primary Nurse** on the acute inpatient ward is responsible for ensuring that the following tasks relating to a patients safe and timely discharge occur:-

- The client has been involved in formulating their health and social care plan and has a copy of it. This should include techniques to manage their own recovery and the ability to identify relapse indicators. This should be filed in RiO in the Crisis, Relapse and Contingency Plan Section "My Crisis Plan".

- The patient knows the arrangements for their aftercare and who to contact about these once they leave hospital.
- Where necessary, the Care Coordinator and other services involved in the client's care are made aware of the date of discharge particularly if the intended discharge date has been altered.
- The patient has a two week supply of medication (depending on whether the patient has a history of self-harm and risk presentation, in particular, a history during the previous three months), knows the arrangements for obtaining further supplies and understands why it has been prescribed, how to take it and possible side effects they can expect.
- The patient's property is checked for contraband items (i.e. items which are not permitted on the ward under its operational policy or other Trust policies) and all non-contraband items returned.
- The timing of the discharge takes into account availability of support and transport etc.
- The discharge care plan summary is completed (and legible) and faxed to the GP and a copy given to the patient on the day of discharge (or before).
- The Care Coordinator must make arrangements for all patients who are considered to be at risk of suicide to be seen within three days of discharge and for all other patients to be seen within seven days of discharge. Where telephone follow-up is required this will be undertaken by the ACCC.

15.9. The **Consultant and Advanced Clinical Practitioner (ACP)** are responsible for:-

- Verification of purpose of admission and expected length of stay
- Establishment of scope for discharge within 24 hours and work to expedite discharge: Invoking a rapid review by a Consultant (especially at weekends), arranging temporary accommodation from budget to permit early home treatment (not exhaustive).
- Support carer engagement triggering Carer's Assessments as required, and to work closely with carers and relatives in the interests of supporting timely discharges.
- Pre-empt and resolve arising barriers to discharge i.e. keys, other agency support to discharge.
- Promote 'conditions based discharge' so that discharge takes place once agreed conditions are met.
- Ensure early liaison with Community Teams of pending discharges to HTT or direct to community teams.
- For detained patients, short periods of section 17 leave or the use of Supervised Community Treatment for those detained for treatment may be considered where appropriate in line with legislation and least restrictive principles.
- To develop effective relationships with local authorities, housing providers, tenancy support teams and benefit agencies specific to Boroughs
- Pre-empt, accelerate homelessness unit input / liaison.
- On the acute inpatient wards

- Introduce HTT involvement at the right point to commence facilitated early discharge by HTT.
- Investigate cases that are about to pass / have passed projected milestone dates recorded for passing key stages in the acute care pathway i.e. discharge review, discharge plan in place, discharge.
- Organise reviews and S117 meetings where critical decisions are made in relation to cases assigned in order to facilitate timely discharges.
- Work to facilitate / broker positive risk taking over cases between Ward and HTTs and HTT and Recovery & Support Teams (RST) consultants and team managers, working as an intermediary and negotiating local 'transfer of contracts' and trial home treatment.

15.10. **Referrals to the Home Treatment Teams for Early Discharge from Acute Adult wards**

15.10.1. The Standards for contact by Home Treatment Team for early discharge support are set out in Appendix 10.

15.10.2. Home Treatment Teams assess patients being considered for acute hospital admission, offer intensive home treatment rather than hospital admission if feasible, and facilitate early discharge from hospital. Key features include 24-hour availability and intensive contact in the community.

15.10.3. For those services users that have already been admitted to hospital, referrals are accepted as part of the discharge preparation and planning. In that regard, referrals should be made as early as possible and ideally following the initial review in the early days of an admission.

15.10.4. It is expected that the service user will be involved in the decision to refer to HTT for early discharge/ Home treatment. The ward team need to record and share the patient's agreement / disagreement with this will be shared with HTT at the point of referral.

15.10.5. If a patient or their carers/ family is ambivalent about home treatment the this will not prevent the ward team from making a referral to HTT; nor will it prevent the HTT from attempting to engage the patient and their carers/ family in an assessment.

15.10.6. Wards must refer to HTT prior to discharge. Any referrals that are received after the patient has left the ward will be dealt with, but will be reported as an incident, as this is an unsafe practice.

15.10.7. Inpatient staff and Home Treatment staff will have weekly ward based face to face review meetings to identify service users for community Home Treatment.

15.10.8. Any one of the five HTT's can process an inpatient ward referral on behalf of another HTT and carry out the initial assessment to determine whether treatment can be continued at home rather than on the ward.

15.10.9. Patients referred to HTT as part of discharge planning should in all but the most exceptional circumstances also have been referred to a Recovery Support Team or equivalent.

15.10.10. Following assessment, if an inpatient is accepted for Home treatment by HTT then the HTT must be involved in any remaining discharge

planning during the short window between acceptance and discharge from the ward - whether face to face, or by telephone or Skype/videoconference.

15.10.11. Prior to discharge patients will be given a Home Treatment Team information booklet.

15.10.12. The HTT must carry out a face to face contact with the patient within 24 hours following discharge.

16. 48-hour, 72-hour and 7-day follow-up

16.1. The general rule is that patients discharged from inpatient care (from any type of ward in the Trust, including specialist wards), and also from the Psychiatric Decision Unit & S136 suite, should be followed up, face to face, within 48/72 hours of discharge, unless one of the exceptions in section 16.4 below applies. The paragraphs below make clear whether the 48- or 72-hour target applies; in all cases, the period begins at midnight on the day after discharge.

16.2. If the patient has been referred and accepted for Home Treatment after discharge, this first face to face follow-up will be conducted by the HTT concerned, and will be within **48** hours of discharge.

16.3. If they do not require Home Treatment, but will be followed up by any Trust community team (e.g. Recovery & Support Team, Early Intervention Team, Forensic Outreach Team, Complex Needs Team, Community Mental Health Team, Older Persons' CMHT, Adolescent Outreach Team, CAMHS Tier 3 team or other Trust CAMHS service, or a specialist deaf or eating disorder community service), that first face to face follow-up will be by the community team concerned, within **72** hours of discharge.

16.4. If they are not being followed up by any Trust team (i.e. they are being discharged to the care of their GP, or transferred to the care of another provider, whether as an inpatient or community patient), then the first follow-up will be conducted by the discharging ward team within **48** hours of discharge, and may be done by telephone. This includes patients discharged from Lotus PDU and the S136 suite. This means a telephone call to the patient if discharged to their GP, and to the provider in other cases. The contact, including telephone contact, should be recorded as an appointment in staff diaries/clinics. Details should also be recorded in the patient notes so that it is clear to whom the Trust has spoken (name, job role, name of provider team). Should a telephone contact feel insufficient, this should prompt the discharging team to reconsider whether the planned discharge arrangements are safe.

16.5. In order to facilitate this first face to face follow-up, it is important that the discharging team refer to the relevant community team for allocation of a care co-ordinator, and to the Home Treatment Team if appropriate, in good time (well before discharge, and often as part of an early review after admission, as set out in operational policies).

16.6. Where a Home Treatment Team is intended to follow up initially, that team must be involved in discharge planning, whether face to face, or by telephone or Skype/videoconference.

16.7. When the follow-up meeting or telephone call takes place, it should be conducted according to the Community Minimum Quality Standards.

16.8. Should the patient not be available at the agreed time for the first face to face follow-up, the Clinical Disengagement and Did Not Attend policy must be implemented without delay. (This requires, for example, an immediate attempt to make contact by phone, an MDT plan for liaison with others and further visits if they cannot be reached by phone, and the consideration of a police welfare check or Mental Health Act assessment.)

16.9. A face to face or (where the appropriate criteria are met) telephone contact within 48/72 hours will also meet the requirements of the national standard that patients should be seen within 7 days of discharge from a ward.

16.10. It is accepted that in a small number of very limited circumstances, the follow-up contacts described above may not be possible. According to guidance from the Department of Health (2010) and from the Trust's auditors, such circumstances include deportation or repatriation; readmission before follow-up; and dying before follow-up. If the patient is in another country and cannot be contacted, attempts should be made to contact a service available to care for them. Patients who go on holiday or who are imprisoned must still be followed up by telephone.

17. Delayed Transfers of Care (DToC)

17.1. Delayed Transfer of Care (DToC) is a formal term. A DToC occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when all of the conditions below are met:

a. A clinical decision has been made that patient is ready for transfer AND

b. A multi-disciplinary team decision has been made that patient is ready for transfer AND

c. The patient is safe to discharge/transfer.

17.2. Although a patient under section may not be safe to discharge, if it has been determined that the patient's care does not need to continue in an acute setting in accordance with criteria a, b and c above for reportable DTOCs (medically fit, MDT decision and safe to transfer) and there are delays in transferring the patient to an appropriate non-acute setting, these should be considered reportable[5].

17.3. The process for identifying, recording and reporting formal delayed Transfers of Care (DToC) is described in Appendix 10.

18. The use of bed and breakfast accommodation

18.1. Bed and breakfast accommodation may be used after a patient has been discharged (following a full clinical risk assessment and discharge plan) and when the only reason for their remaining in hospital is the patient's lack of accommodation in the community.

18.2. This will be for a time limited period whilst services are actively trying to find appropriate accommodation. In addition, patients should not routinely be sent on leave to B&B accommodation.

[5] based on guidance received to SWLStG from the DoH in December 2017.

18.3. Any additional support required by the service user whilst they are resident at the B&B accommodation should come from the local HTT, not by the patient returning to the ward.

18.4. If there are exceptional circumstances that mean that leave to B&B accommodation appears appropriate, these must be discussed in advanced with the relevant Matron.

The process for organising B&B accommodation will be done by the ACCC. The B & B closest to the Borough HTT should be used wherever possible.

19. Closing a ward or room to admission

19.1. **Planned and unplanned ward closures**

19.2. Where a ward closure is planned, prior agreement must be obtained from the relevant Clinical Director in consultation with the Chief Operating Officer and Director of Nursing.

19.3. In an emergency situation (e.g. infection outbreaks, or inadequate staffing to manage a ward safely), a decision to close a ward to admissions may be made by the most senior nurse, doctor or manager present, in consultation with the Director of Nursing (or out of hours the Director on call). Such unplanned closures must be reported as an incident.

19.4. The decision to close a ward to admissions will be reviewed on a daily basis.

19.5. **Availability of individual beds/ bedrooms**.

19.6. It is essential that action is taken swiftly to restrict the time a service user's bedroom is classified as "unavailable" following damage by bringing a room back into use as quickly as possible. Damage to other areas of a ward can also impact on the availability of rooms, due to the damage causing security risks/safety issues.

19.7. Effective communication and escalation of the problem is critical and ward managers are responsible for ensuring that across the 24 hour period, a nominated person takes responsibility for reporting significant damage that renders a room unusable (whether temporary or permanent).

19.8. Once the Estates technician has assessed the damage and before a bedroom is declared "out of use" the authority of the Head of Service Delivery / On Call Manager must be obtained.

19.9. Any prolonged unavailability of rooms must be reported to the Director of Nursing and Chief Operating Officer.

SECTION C: SUPPORTING INFORMATION FOR POLICY

20. Training and Development

20.1. In conjunction with the Managers, all staff in teams/units/services of the Acute Care Pathway will identify their particular training needs for example, Mental Health Act and other relevant legislation, Safeguarding, Benefits, Child Protection, Medication Management and Cultural Competency.

20.2. Regular team and continuous professional development meetings will be held to support the Knowledge and Skills Framework Development Review and profiles. Each member of the team will have an annual Development Review and this will identify the individual's training needs and feed into the Team's development and training needs.

20.3. Most teams within the Acute Care Pathway are identified as a suitable placement for student nurses and Occupational Therapists and actively participates in their training. Placements may also be available for students from other disciplines undertaking statutory training and for short placements for partners from other statutory and non-statutory agencies such as the London Ambulance Service, Police, Social Services, Probation Services, MIND, etc.

20.4. Training and development will reflect the needs of the Trust, Local Authority or other partner organisation and of the individual, as described in their Personal Development Plan.

20.5. South West London and St George's Mental Health NHS Trust recognises that continual professional development is a key element of ensuring delivery of the highest possible quality of service.

20.6. All new staff will attend an induction programme.

20.7. Staff will attend or undertake on line, statutory/mandatory training sessions including Fire, Health & Safety, Food Hygiene, Assessment & Management of Risk, Medicines Management f(for qualified nursing and medical staff) , Adult and Child Safeguarding, Cultural Awareness, Proactive Physical Interventions and Information Governance.

20.8. South West London & St George's Mental Health NHS Trust aims to provide pre and post registration training to the highest standards. Students from various disciplines are regularly attached to teams as part of their training. All such students will be advised of this Operational Policy and will have clearly understood supervision arrangements within the team. It should be noted that patients have the right to choose if students are present for their appointments.

21. Risk Assessment / Safety

21.1. **Personal safety**

21.2. It is mandatory for all nursing staff working within the acute setting to have up to date training in Breakaway and De-escalation Techniques, as well as Adult Basic Life Support. Each site operates an emergency response team system should a ward require further assistance in the event of an emergency. This team can be summoned by activating a bleep or phoning a designated emergency number depending on the site in question. Each ward has a localised lone working procedure.

21.3. **Environmental Risk Assessment**

21.4. The Trust has set a mandatory standard for all work areas to consider the following 14 risk assessments as a minimum: - Violence & Aggression, Fire, Manual Handling (loads & people), Display Screen Equipment, Slips, Trips & Falls, Control of Substances Hazardous to Health, Corporate Clothing (including Body Jewelry), Sharps, Lone Working, Work Equipment, Personal Protective Equipment, Stress, Ligature Points.

21.5. Risk assessment is only effective if the information and knowledge is incorporated into routine and individual practice.

21.6. Trust procedures on Critical Incident Reporting must be adhered to and one to one debrief and Team Critical Incident Analysis must be performed after a critical incident or near miss occurs. This includes ensuring follow up actions and recommendations are implemented post analysis/report.

21.7. **Audit and Evaluation**

21.8. The ACCC will routinely carry out audits to evaluate the effectiveness of the whole ACP systems for example on re-admission rates, emergency admissions, admissions to non trust beds, bed days occupancy etc.

21.9. The teams within the Acute Care Pathway will set aside regular time for audit projects to evaluate the service and targets set. The Teams cooperate with Trust wide audits, for example, the biannual CPA Audit, Prescribing Observatory in Mental Health - POMH (UK) audits and National Staff and Patient Surveys and Local Service User and Carer Experience Surveys.

21.10. Managers are responsible for working with their team members to ensure collection of the data necessary for these audits and ensuring that the learning from them is enacted throughout the service.

21.11. Borough Business Forums are expected to agree additional team audits that will be undertaken, and individual professions will determine uni-professional audits that will be undertaken. Service users and Carers, and partner agencies should have the opportunity to contribute to the development of the audit programme.

21.12. **Equality Impact Assessment**

21.13. An equalities impact assessment has been conducted and this policy was not found to affect one group of those listed in the Trust assessment tool less or more favorably than another.

21.14. **Complaints**

21.15. The Trust is committed to the early resolution of complaints either by an immediate informal response from front line staff, or by subsequent conciliation by the Patient Advice and Liaison Service and ultimately by investigation by staff empowered to deal with complaints.

21.16. All complaints and comments will be taken seriously and viewed as a positive means of gaining feedback from people who use our services.

21.17. The Trust Complaints Policy gives further details and should be read in conjunction with:-

1. Guidance to support implementation of the National Health Service (complaints) Regulations 2004. Department of Health 2004

2. Trust Complaints leaflet
3. Managing Complaints – a guide for the local resolution of service user and Carer complaints for Service Managers
4. Patient Advice and Liaison Service leaflet
5. Complaints - a guide for staff
6. Trust Incident Investigation Handbook
7. TWC10 Critical Incident Reporting and Inquiry Procedure
8. Administration of Clinical Negligence Liability and Property Expenses Claims
9. HR4 Disciplinary Procedure.

22. Responsible Commissioner Guidance

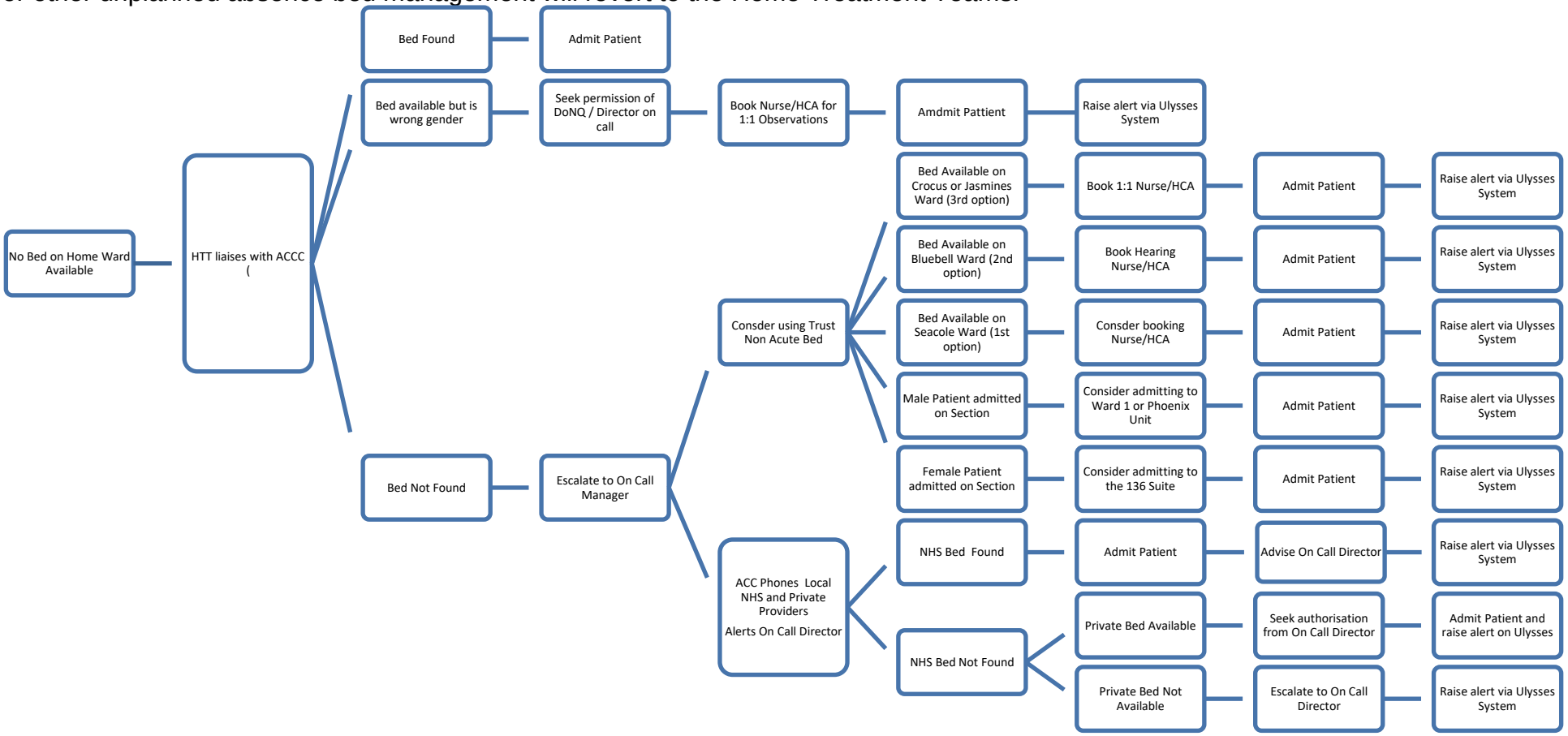
22.1. The 'Who Pays? Determining responsibility for payments to Providers' guidance determines which commissioners should pay for a patient's healthcare costs. The guidance is complex and runs to 40 pages. However for 95% of patients the rules are simple and straightforward. The Contracts Department can provide advice on issues in office hours (ext. 6543).

22.2. For on-call purposes the following should be used as a guide:

- Generally the Trust is commissioned to provide healthcare to people usually resident within the Trust's geographic boundaries (see also S12.17.3 above).
- GP registration determines which CCG should pay for the care of most patients. So for example if someone is registered with a Wandsworth GP then Wandsworth CCG will pay for their healthcare regardless of where they live. So they could live in Kingston, be seen by Kingston services and Wandsworth CCG will pay for this.
- The Trust has cross boundary contracting arrangements for patients living within the Trust's geographic area and registered with GPs in surrounding areas. So for example if someone lives in Sutton and is registered with a Croydon GP then Sutton services should treat them and Croydon CCG will pay.
- If someone is visiting the area (eg from Birmingham) and becomes unwell the Trust has a responsibility to provide them with urgent or emergency treatment. The costs will be covered by what is known as the Non Contract Activity processes. If they are admitted to inpatient services they should be repatriated to their local services as soon as clinically appropriate.
- If someone is placed by Trust services outside of the Trust's geographic area eg in a hostel it is usually the case that care is handed over to the local team and the person will be treated by services at that other Trust in a crisis (with the originating CCG here paying). If care has not yet been handed over to the local team then should a crisis arise the individual should be treated by this Trust's services.
- There are exceptions to this and rather than make this brief guide over-complicated and unwieldy for someone on-call it is best to address commissioning responsibility issues with the contracting team in office hours. To quote the guidance, "*no treatment should be refused or delayed due to uncertainty or ambiguity as to which CCGs responsible for funding an individual's healthcare provisions".*

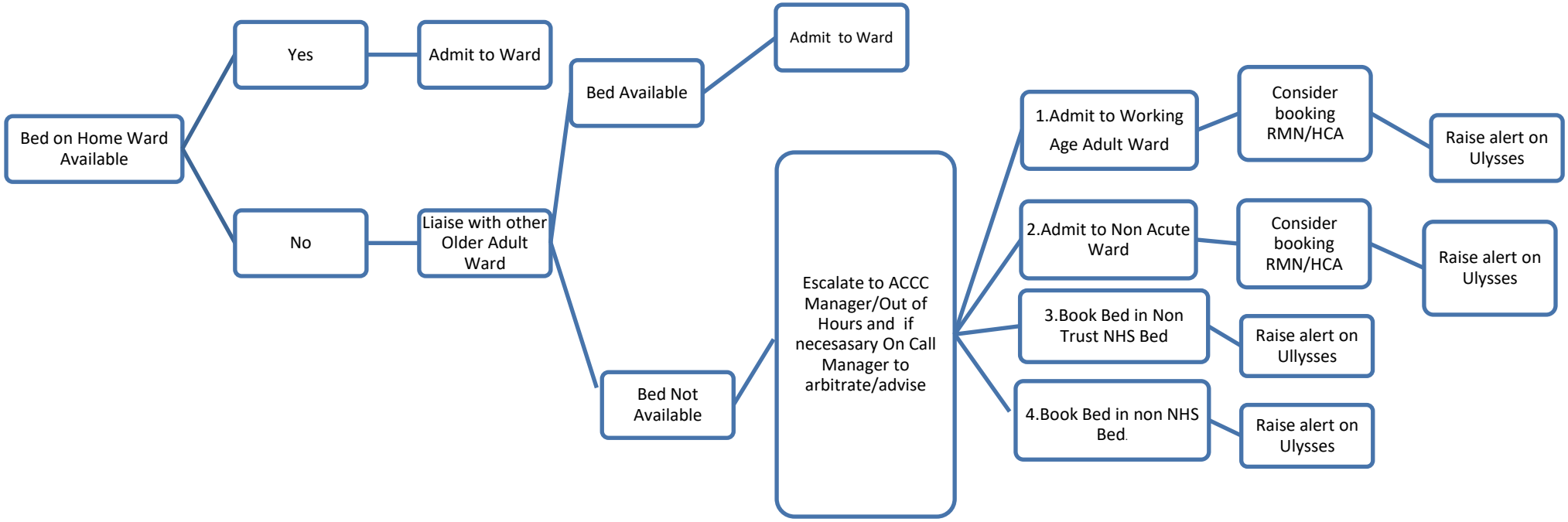
Appendix 1: Admissions Decision Trees

Adults of Working Age: All admissions will be managed by the Acute Care Coordination Centre – if this is not functioning due to illness or other unplanned absence bed management will revert to the Home Treatment Teams.

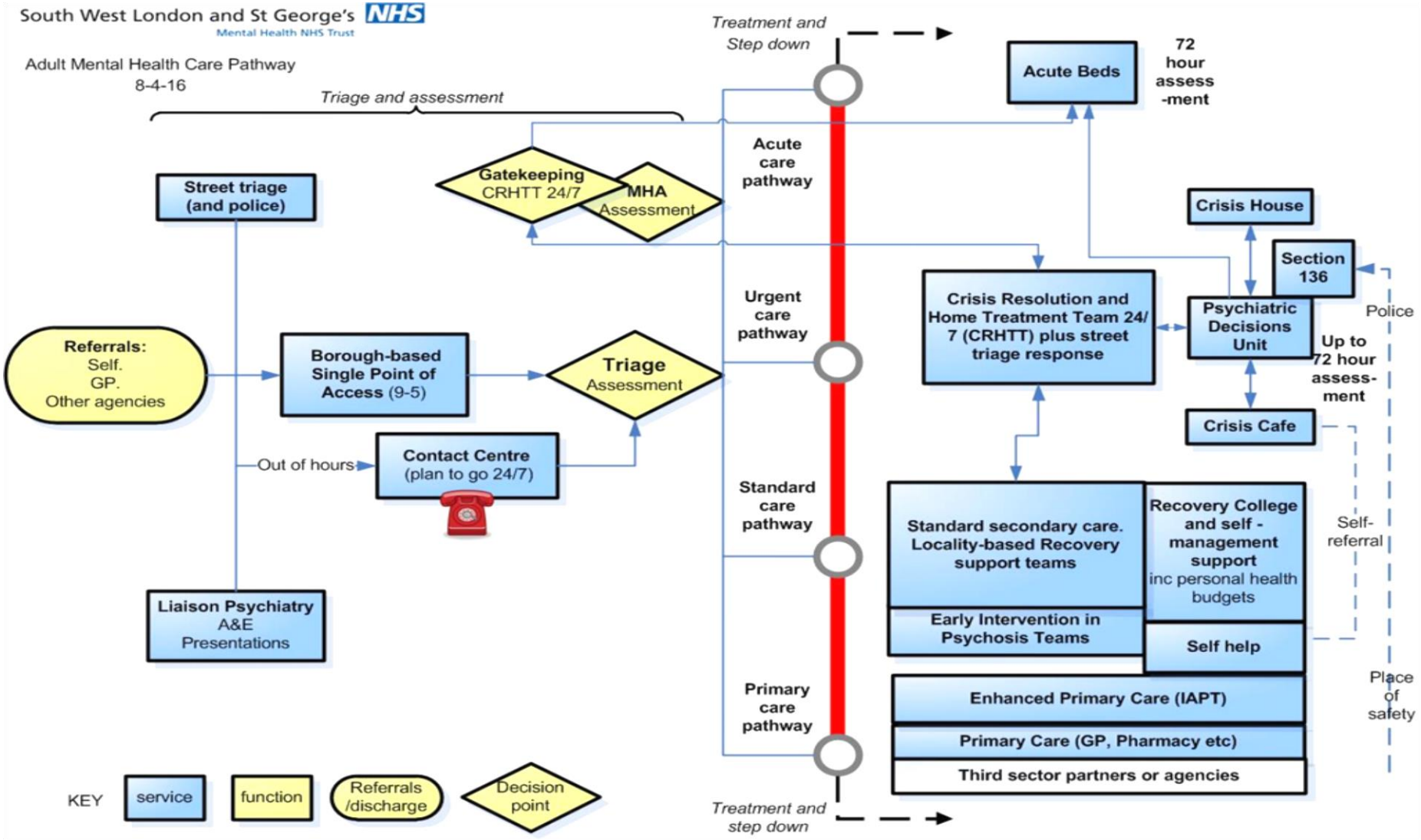


Before 9pm consider moving “settled” patient from Acute Admission Ward to create bed - admitting an acutely unwell patient to a non-acute ward should be the last resort. As an alternative to purchasing out of area beds patients should be admitted to Seacole/Bluebell beds. (updated June 2015). Female patients should not be admitted to the Crocus Ward flexi beds as these do not comply with single sex guidance.

Older Adults



Appendix 2: Acute and Urgent Care Pathway and Acute Care Co-ordination Centre (ACCC)



Acute Care Coordination Centre (ACCC)

The ACCC is responsible for coordinating the flow through the Acute Care Pathway 24 hours a day; and is responsible for coordinating admission to the Older person's wards at Crocus & Jasmine and for assisting in managing the Trust's tier 4 CAMHS beds, forensic beds and specialist beds, in some cases working within the South London Partnership.

The ACCC are responsible for negotiating and arranging all referrals and admissions (See Appendix 1 for Admission Decision Trees). The ACCC will:

- maintain an up to date bed state and ensure that all bed management activity is communicated effectively (see Appendices 3 and 9 for examples);
- work with the HTTs to ensure gate keeping of referrals
- check GP details, address of patients and their catchment area[6]
- identify an acute or older adult bed (or assist in identifying a CAMHS, forensic or specialist bed) for all patients who require admission
- follow procedures in relation to use of leave/AWOL beds;

All requests for inpatient beds are coordinated by the ACCC. They will use their clinical judgement to provide the most appropriate inpatient bed for that service user.

- The ACCC will coordinate all referrals for Male and female PICU
- The ACCC will coordinate all referrals to Private Adult and private PICU beds
- The ACCC has delegated responsibility for securing beds in a Mother and Baby Unit (MBU) in accordance with the Pan London Agreement. The Clinical Lead for Perinatal Mental Health Services must be informed of all admissions, preferably before the admission unless admission occurs out of hours or at weekends.
- The ACCC's function in relation to CAMHS, forensic and specialist beds is one of sharing and passing on information and providing assistance where necessary to the SLP or Trust staff arranging admission to those beds. Detailed arrangements for these processes are set out in Appendix 6.

The ACCC are responsible for keeping accurate accounts of the following at specific points in the day. This will be done via a bed situation report describing the information (See Appendix 3)

- Number of beds available
- Projected number of discharges
- Number of service users requiring a bed
- Projected number of beds available in the next 24 hours

The ACCC are responsible for describing the status of Trust's bed capacity and the first line of escalation is the Manager of the ACCC.

The ACCC clinicians, with the support of Advanced Clinical Practitioners, Ward Managers and Consultants across the Trust, will:

- take a pro-active role in identifying service users who can be discharged from an inpatient acute adult wards and will
- work with the MDT and the HTT's to support early discharge from these wards.

[6] Establishing the Responsible Commissioner "April 2006

Flexible Beds

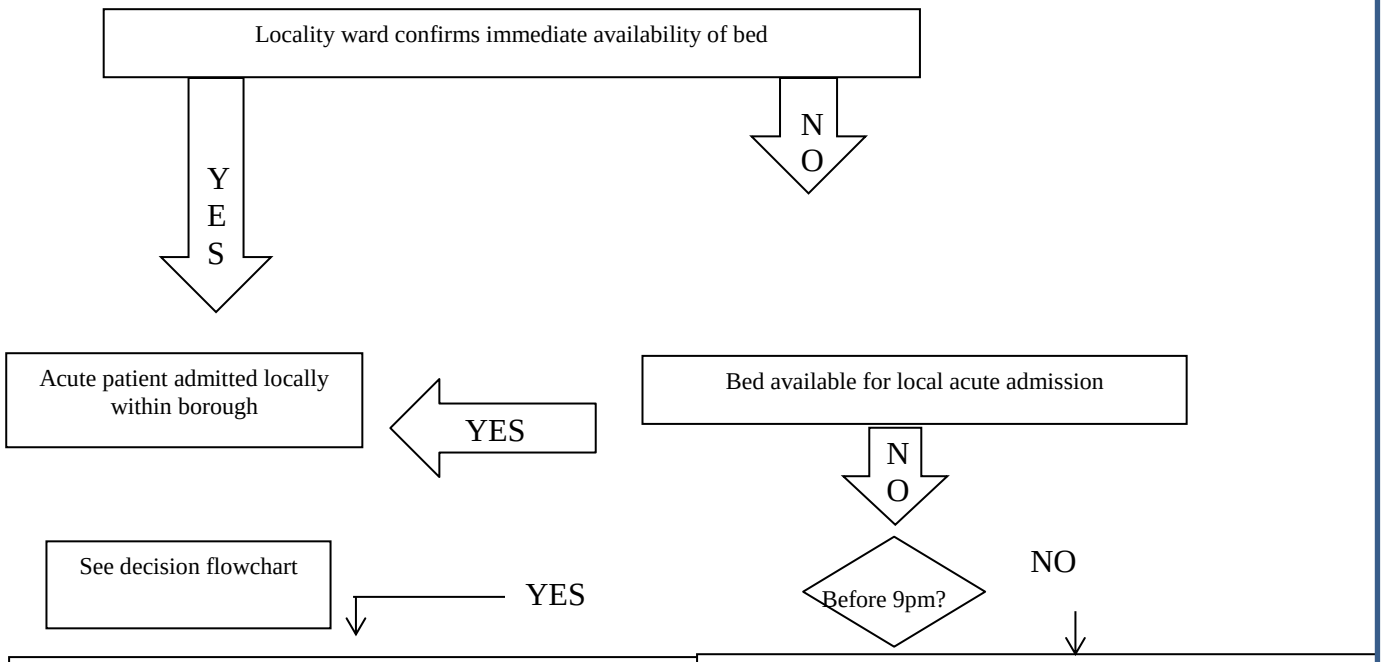
All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. Consideration should be given to the particular needs of transgender patients..

‘Flexible’ Beds are those on a mixed ward that can, in certain circumstances be switched from male to female beds and vice versa. These flexible areas in most wards can only accept one gender (i.e. if a male is admitted into the flexible gender area, the flexible area can only be occupied by other males in order to maintain compliance with these standards, and vice versa.) The design of some newer wards (e.g. Ward 2, Ward 3) does allow some flexibility through dividing floors within the flexible beds area, but this is not the case in older wards.

However flexible beds are configured, the patients in those beds must have access to toilets and bathrooms allocated to their sex without having to walk through an area occupied by the other sex.

The process of switching beds from male to female or vice versa must be done sensitively with the minimum of disruption to patients on the ward, and with appropriate changes to signage (e.g. to toilets) as necessary.

The Acute Care Co-Ordination Centre (ACCC) is the recognised gatekeeper of adult acute beds. They will be aware of local occupancy and vacancy and early discharge potential, and outliers on at least a daily basis. The ACC Manager (supported by the ACC team) updates and feeds information into wards and are utilised as a reference point for bed management issues and retain responsibility until patient is successfully discharged or otherwise.
Responsible managers and inpatient consultants facilitate bed management in conjunction with the ACC Team. The ACCC operates 24/7.



IDENTIFY and TRANSFER OUT existing green zone in-patient (see Decision Tree)

1. Ward staff facilitate green zone patient transferred to outlie in nearest locality bed.
2. If not possible green zone patient transferred to outlie in nearest bed in neighbouring borough
3. As preference to purchasing a bed out of area and as a last resort, an admission to Seacole or Bluebell ward should be made . As of 22.6.2015. The Executive Management Committee agreed that these wards will accept admissions as a last resort and this will not be restricted to green zoned patients. For an admission to Bluebell you will need to ensure that a hearing member of staff comes to the ward and stays (see decision flowchart p.29)

In all cases outlier to be reviewed next day with a view to returning to host ward or discharge.

Acute patient requires an admission as identified on the left. If no beds are available across the whole Trust See separate page at back of the booklet for details of bed providers (NHS and private) – adults, older adults, learning disabilities) See next page for CAMHS flowchart and referral form.

Ensure Sandie Belcher (Acute Care Pathway Manager is informed of any admissions to another provider including the private sector. Log as an incident on Ulysses in heading state Admission to External Bed. Add to register of Admissions Non-NHS Trust beds.. Ensure Out of Area Discharge Coordinator is aware of admission.

Mother & Baby Unit bed:
Contact needs to be made with Coomb Wood, NW10 7FL direct (the MBU in CNWL), see website for referral form
Tel: 020 8955 4495
Fax: 020 8955 4497
Unit email: **pmhs.cnwl@nhs.net**
Unit Website : **www.cnwl.nhs.uk/coombe-wood.**
Trust Website : www.cnwl.nhs.uk
The ACCC has other MBU providers if Combe Wood is full

Appendix 3: Sample Bed Situation Report

Bed Capacity Report

29/01/2018 08:00

Category	Ward	M	F	Flex	AWOL	Leave	Vacant Beds	Occupied Beds	Total Beds	Occupancy
In-patient Acute Adult	Lilacs	0	0	0	0	0	0	23	23	100%
	Jupiter Ward	0	0	0	0	0	0	23	23	100%
	Lavender	0	0	1	0	0	1	22	23	100%
	Ellis	0	0	0	0	0	0	12	12	100%
	Ward Three	0	0	0	0	0	0	20	20	100%
	Laurel	0	0	0	0	0	0	23	23	87%
	Rose	0	0	0	0	0	0	23	23	96%
	Ward Two	0	0	0	0	0	0	18	18	100%
	Subtotal:	**0**	**0**	**1**	**0**	**0**	**1**	**164**	**165**	**98%**
PICU	Ward One PICU	2	0	0	0	0	2	11	13	15%
	Huntercombe Female PICU	0	0	0	0	0	0	2	2	500%
	Other Private Male PICU	0	0	0	0	0	0	0	0	
	Other Private Female PICU	0	0	0	0	0	0	1	1	
	Subtotal:	**2**	**0**	**0**	**0**	**0**	**2**	**14**	**16**	**93%**
Older People	Jasmine Ward	1	1	1	0	0	3	13	16	81%
	Crocus	0	0	0	0	1	1	18	19	90%
	Subtotal:	**1**	**1**	**1**	**0**	**1**	**4**	**31**	**35**	**86%**
CAMHS	Aquarius	1	0	1	0	0	2	10	12	92%
	Subtotal:	**1**	**0**	**1**	**0**	**0**	**2**	**10**	**12**	**92%**
Deaf	Bluebell	0	1	0	0	0	1	13	14	79%
	Corner House	0	0	5	0	0	5	1	6	83%
	Subtotal:	**0**	**1**	**5**	**0**	**0**	**6**	**14**	**20**	**80%**
Forensic Services	Halswell	0	0	0	0	0	0	16	16	100%
	Hume	0	0	0	0	0	0	16	16	100%
	Ruby	0	0	0	0	0	0	10	10	100%
	Shaftesbury MSU Rehab Fla	0	0	0	0	0	0	1	1	100%
	Turner	0	0	0	0	0	0	18	18	100%
	Subtotal:	**0**	**0**	**0**	**0**	**0**	**0**	**61**	**61**	**100%**
Psychological Therapies	Avalon	0	5	0	0	4	9	15	24	75%
	Seacole (OCD/BDD)	3	1	0	0	0	4	10	14	86%
	Wisteria (ED Inpatient CAMH	0	2	0	0	0	2	10	12	83%
	Subtotal:	**3**	**8**	**0**	**0**	**4**	**15**	**35**	**50**	**80%**
Rehabilitation	Burntwood Villas	0	0	3	0	0	3	12	15	80%
	Phoenix	0	0	0	0	0	0	16	16	100%
	Westmoor House	0	0	1	0	0	1	12	13	92%
	Subtotal:	**0**	**0**	**4**	**0**	**0**	**4**	**40**	**44**	**91%**
Assessment Suite	Lotus Assessment Suite	0	0	0	0	0	0	5	5	100%
	Section 136 Suite (Lotus)	0	0	2	0	0	2	0	2	0%
	Subtotal:	**0**	**0**	**2**	**0**	**0**	**2**	**5**	**7**	**71%**
Total:								**379**	**410**	**92%**

Appendix 4: Screening and Decision Form (PICU Alert Form)

PICU ALERT FORM

DATE: **TIME:**

RiO Number	
NHS Number	
Date Of Birth	
Date of Admission to Acute Ward	
Mental Health Status including Consent for Treatment and Expiry Date	
Brief Description of Issues or behaviours of concern	**SITUATION & BACKGROUND:**
What action(s) has the team taken to manage the concerns/issues including 1:1 or 2:1, review of medication etc. (Please see attached advice sheet at the end of Alert Form)	**ASSESSMENT & RECOMMENDATION:**
Known Diagnoses	
Current treatment including medication	
Any known medical reasons?	
Any current safeguarding concerns?	
What help does the team require from the PICU? **e.g. Advice or Transfer to PICU**	

Completing this form will help the PICU team to in-reach effectively with your team and also help in advance planning for the Women's PICU.

If not known to the Trust and not on RiO, please attach progress Notes, Risk Assessment, Care Plans if client is not on RiO

ADVICE SHEET

At the point of completing the PICU Alert Form, it is safe to assume that Verbal De-escalation has been ineffective and PRN/Rapid Tranquilisation has been administered with no desired effect. It will also be assumed that Increase observation/Engagement has been implemented i.e level 1 or 2 with a clear care plan as to the purpose of this important intervention.

Whilst the Alert Form is to inform the PICU Team of someone who may require Intensive Care input, it is not a Referral Form on its own, although it may lead to a referral based on the information provide regarding risk management and intervention already implemented.

The philosophy of Psychiatric Intensive Care can be applied to Acute Services via a series of interventions, predominantly focusing on a combination of nursing AND medical model. The behaviour displayed will likely be attributed to symptoms of a severe mental disorder; which requires treatment. If behaviour displayed is not attributed to a disordered that is treatable on PICU

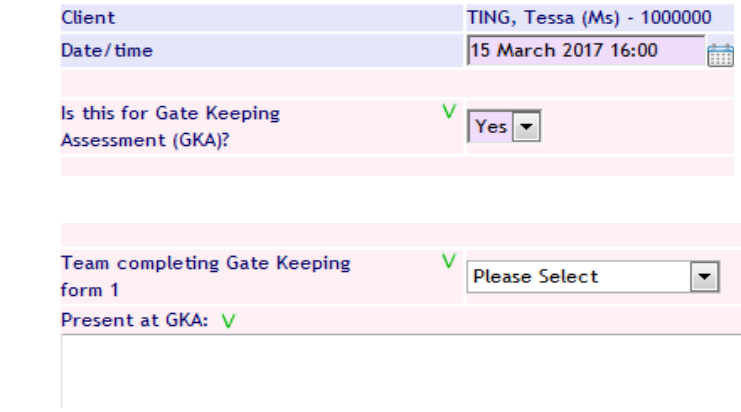
Questions to ask and things to consider:

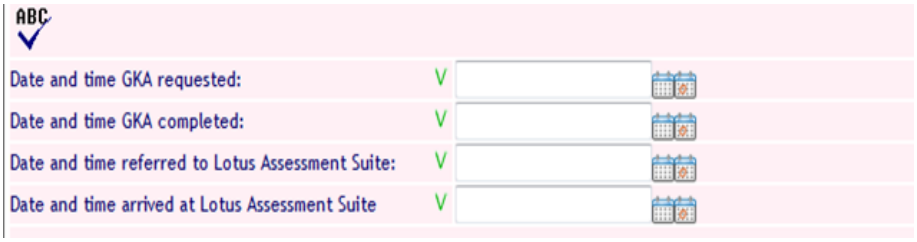
- Have reviewed treatment plan – Is client on max BNF dose of Antipsychotic and/or Mood Stabiliser [Have we optimised treatment]
- Have we included regular benzodiazepine as a short term management of agitation/aggression? If yes, has this been reviewed i.e. clonazepam increased to 4 times daily or do we need to switch to diazepam?
- Careful consideration to be taken when giving the above benzodiazepine as although we are hoping to reduce agitation, at the same time we have to ensure that the psychosis or other diagnosed disorder i.e. Bipolar Affective Disorder is being treated so regular reviews of medication need to be a focus.
- When using Rapid Tranquilisation in psychotic patients who are displaying regular episodes of violence, the advice is to use PRN antipsychotic oral/IM. The antipsychotic of choice will be Haloperidol as per Nice Guidelines (Trust Policy allows Aripiprazole IM if Haloperidol is deemed unsafe; however Aripiprazole is not under the Nice Guidelines for managing violence and aggression. Please consult with Ward Doctors and pharmacist regarding use of Haloperidol and try to have an ECG or identify most recent ECGs.
- Acuphase (Zuclopenthixol Acetate) can also be considered with consideration below:

Not recommended for RT due to long onset and duration of action, but may be considered as an option when:

- service user will be disturbed/violent over extended time period
- past history of good/timely response
- past history of repeated parenteral administration
- cited in an advance directive

Appendix 5: Screen Shot of Gate Keeping Form





For full details please refer to the Gatekeeping Standard Operating Procedure (SOP)

Appendix 6: Forensic, specialist, CAMHS & older adult admission processes

FORENSIC SERVICE: Halswell Ward, Turner Ward, Ruby Ward, Hume Ward

Admissions to secure beds (medium and low) in the forensic service are coordinated by the weekly referrals and bedstate meeting in collaboration with the South London Partnership (SLP) forensic workstream. The latter extends to all secure beds in the SLP i.e. South London & Maudsley NHS Foundation Trust, Oxleas Foundation Trust and South West London & St George's NHS Trust. Referrals for admission are submitted to the SLP Hub and thereafter directed to the relevant workstream pathway as follows:

SLP Women's pathway
SLP Acute and recovery (A2) pathway
SLP Assertive Rehabilitation pathway
SLP Specialist pathway

Each pathway holds regular referrals and bedstate meetings, chaired by a Clinical Lead. Urgent referrals are dealt with outside of the regular pathway meetings in consultation with the pathway clinical lead. Referrals are allocated to clinicians and gatekeeping assessments are conducted. If admission to a medium or low secure bed is supported, a bed is identified within the SLP secure estate. Once the admission ward is confirmed a nursing assessment is conducted. The timing of admission to a secure bed at SWLStG is ratified by the forensic weekly referrals and bedstate meeting. Urgent admissions to beds that arise between the weekly meetings are ratified by the Clinical Director/Head of Service/Matron/Head of Nursing; requests for urgent admission should be directed to the Referrals Co-ordinator and will be screened by the duty consultant.

In scenarios where no bed is available within the SLP, the case is referred to the SLP Hub Clinical Director for sign off to refer to the independent sector. In these circumstances the patient is followed up by the SLP Hub Out of Area team with a view to repatriation to the SLP as deemed appropriate.

EATING DISORDERS SERVICE: Avalon Ward

A weekly multidisciplinary referrals and bedstate meeting is held in the Eating Disorders service where referrals for admission are allocated to clinicians for gatekeeping assessment and patients

admissions are planned. Urgent admissions outside of this process are led by consultants in collaboration with Avalon ward inpatient unit ward manager and the Service Line Matron

DEAF SERVICE: Bluebell Ward

A weekly multidisciplinary referrals and bedstate meeting is held in the Deaf service where referrals for admission are allocated to clinicians for gatekeeping assessment and admissions are planned. Urgent admissions outside of this process are led by consultants in collaboration with Bluebell ward inpatient unit ward manager and the Service Line Matron. In the rare event that bed management of acute beds in the Trust necessitates the placement of a hearing patient on Bluebell ward, the protocol for management of this patient by acute services should be followed (see appendix 2).

OCD/BDD: Seacole Ward

A weekly multidisciplinary referrals and bedstate meeting is held in the OCD/BDD service where referrals for admission are allocated to clinicians for gatekeeping assessment and patients admissions are planned. Urgent admissions outside of this process are led by consultants in collaboration with Seacole ward inpatient unit ward manager and the Service Line Matron.

OLDER ADULTS: Jasmines Ward, Crocus Ward

Inpatient admissions may be planned through assessment by the CMHT where the patient's needs cannot be met in the community, or in a crisis or emergency situation. Admissions can be made through the following pathways:

- Older People Community Mental Health Team professionals
- Transfer from within hospital boundaries
- Through liaison psychiatry in acute hospitals and A&E Departments in the relevant boroughs

CAMHS: Aquarius Ward, Wisteria Ward, Corner House

CAMHS: Aquarius

Bed management for these wards is provided by ACCC; currently all hours. They also assist in accessing other beds, such as CAMHS PICU which can be required in an emergency situation

and LD/ASD/LSU/MSU which are usually planned. From May 2018 Bed Management will be provided in working hours by the South London Partnership Bed Management who oversee the use of all five wards within the partnership (Snowsfield Adolescent Unit, Bethlem Adolescent Unit and Bethlem Adolescent PICU, alongside Aquarius and Wisteria). The NHS England CAMHS Tier 4 referral form- currently known as form 1 &2 needs to be completed and submitted with a child psychiatrist's involvement in the assessment and referral; the bed managers assess the suitability for admission, and explore whether alternatives to admission have been appropriately considered and may link with the Adolescent outreach Team for their assistance in avoiding an admission. They will liaise with the General Adolescent Units / wards to manage where this patient can most appropriately be admitted and will assist with step-up and down between PICU and GAU. Out of working hours this function will continue to be provided by the ACCC

CAMHS: Wisteria

For young people requiring a bed for an Eating Disorder intervention the form should be sent directly to Wisteria ward; contact will be made directly with the referrer and the referral considered by the referrals panel. The ward works closely with the Community CAMHS Eating Disorders Team and will accept appropriate referrals in urgent situations through that route. The form also needs to be logged with the Bed management. Most young people referred to Wisteria will be invited for an assessment day when the admission will be planned, ensuring that goals for the admission are agreed between the family, young person and ward MDT.

CAMHS: non SLP beds- when a bed outside the partnership is required due to the need being for a more specialist bed, not available in the partnership or to SLP beds being full and the situation having a high level of urgency, the bed management works on the agreed protocol for obtaining authorisation from the SLP CAMHS Clinical Director for funding this out of area placement.

CAMHS: Corner house

This is a national ward for children and teenagers who are Deaf and who use BSL to communicate; it provides a deaf friendly environment, many of the staff are also Deaf and so it is not suitable admissions of hearing young people. The referral form should be sent directly to the ward; they manage their own referrals with a weekly MDT meeting and offered assessments which then lead to planned date for admission. The ward does not take emergency admissions.

Appendix 7: Protocol for Mother and Baby Unit (MBU)

Southside
105 Victoria Street
London SW1E 5RS
Tel: 0113-8070-437
E-mail:kevindowling@nhs.net
July 2014

Chief Executive
London Mental Health Trust

Dear

Pan London Mother and Baby Unit (MBU) Admission Procedure (24 hours per day)

I write to bring the Pan London Mother and Baby Unit (MBU) Admission Procedure to your attention. A copy is enclosed for your information.

I would be grateful if you would ensure that the document is circulated to all departments in your Trust that may be concerned with the admission of service users to inpatient settings, including Bed Managers, Home Treatment Teams, Psychiatric Liaison Teams, On-Call Psychiatrists and Female Acute Wards.

The attached protocol was developed by the London Perinatal Mental Health Network. It is the product of a collaboration between commissioners, and providers, including clinical representation from the three NHS psychiatric Mother and Baby Units that serve London. The protocol is designed to make it easier for referrers to understand the service, and to improve equality of access for those patients who need the specialist care that is provided by the units. **The sections highlighted in yellow should be adapted to your local Services.**

Funding for Mother and Baby Units is held centrally by Specialist Commissioning enabling direct admission to the Units 24 hours a day, 7 days a week. Assessing clinicians can therefore ring the Units directly to arrange admission.

Further details about the Units can be found via the following links:

- Coombe Wood http://www.cnwl.nhs.uk/coombe-wood/

- Homerton http://www.eastlondon.nhs.uk/Services/Other-Services/Mother-and-Baby-Unit/Mother-and-Baby-Unit.aspx

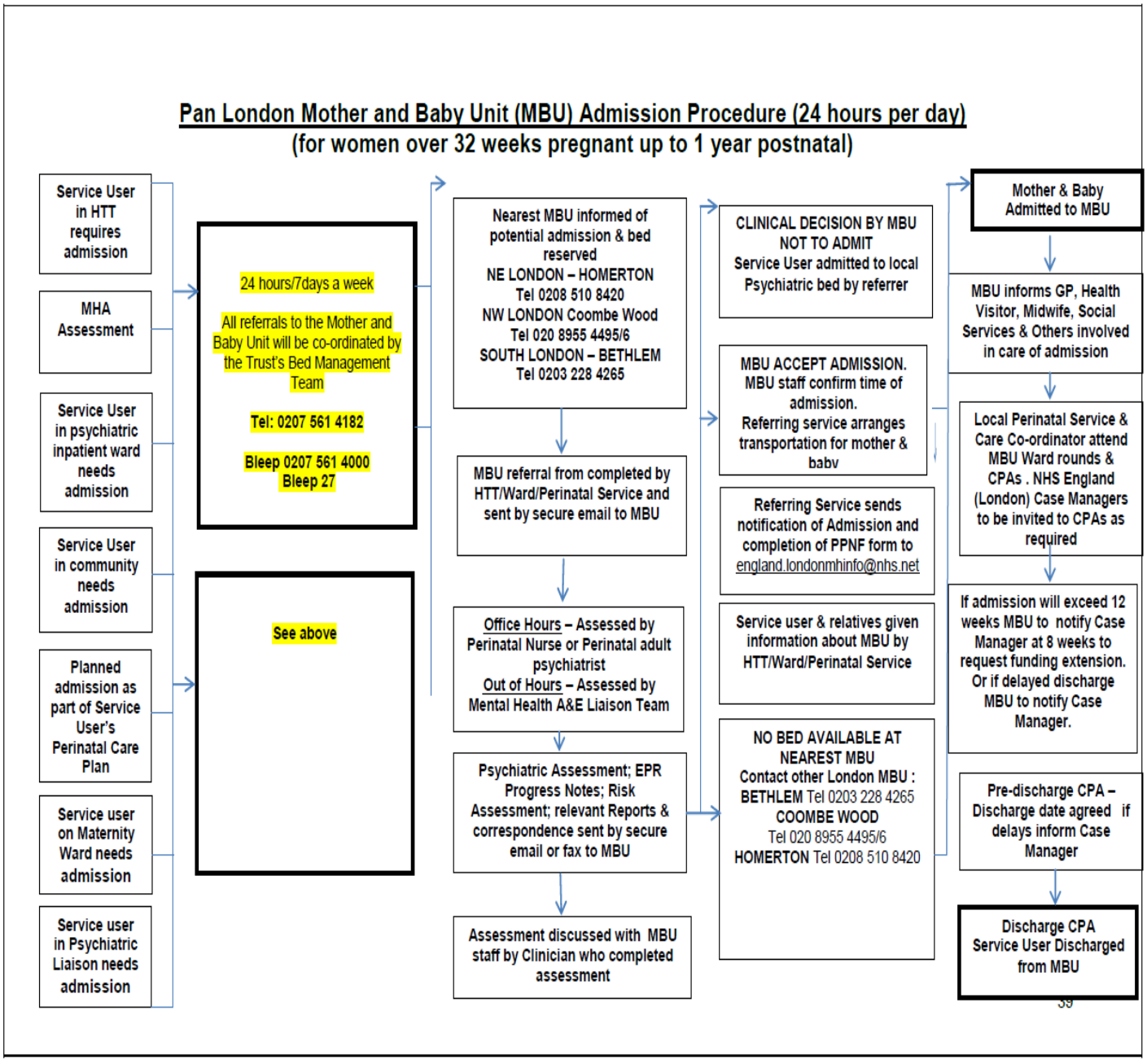
- Bethlem http://www.national.slam.nhs.uk/services/adult-services/perinatal/

I hope that you find the protocol useful. Should you have any queries arising from this correspondence, please do not hesitate to contact me.

Yours sincerely

Pan London Mother & Baby Unit Admission Procedure (24 hours per day)

For women over 32 weeks pregnant to 1 year



MBU Eligibility Criteria

Mother and Baby Units (MBUs) provide assessment and care for mothers with serious and or complex perinatal mental health disorders that cannot be effectively or safely managed in the community.

MBUs can manage acutely ill mothers and admit directly to the Unit in an emergency. However, in a mental health emergency the mother must have been assessed by a Senior Clinician and

accepted by a Senior Clinician from the Unit. There should be a Clinician at the MBU available on the telephone 24 hours/7 days a week to discuss referrals.

MBUs will accept referrals for pregnant women (from 32 weeks of pregnancy) and mothers with infants under the age of 12 months who fall into the following criteria:

- Women suffering from an active severe and enduring mental illness such as schizophrenia, schizoaffective disorder, bipolar affective disorder and recurrent depression experiencing a relapse during pregnancy or after delivery
- Postpartum psychosis
- Severe postnatal depression
- Identified high risk of relapse of postpartum psychosis or severe postnatal depression
- Women experiencing other psychiatric conditions with disabling symptoms in pregnancy or post-partum like severe Anxiety Disorders or Obsessive Compulsive Disorders
- Bonding or attachment difficulties secondary to maternal mental illness.
- Age 18 years or over (referrals for aged 16 years and over will be considered on a case by case basis)
- Prophylactic admission for women with an established diagnosis of severe and enduring mental illness such as schizophrenia, schizoaffective disorder, bipolar affective disorder and recurrent depression who are in remission but at a high risk of relapsing after giving birth (admission can take place during last trimester of pregnancy or postnatally)
- Women will not be admitted to a MBU under the following circumstances:
- For the sole purpose of a parenting assessment unless they are also suffering from, or there is a suspected/potential, serious or complex mental illness.
- Women with severe personality disorder, learning disability or substance misuse unless they are also suffering from, or there is suspected, serious mental illness.
- If there is evidence that the mother will not be capable of independent functioning in caring for her infant in the community without reasonable available support.
- If there is evidence of serious violence/aggressive behaviour that might pose a risk of harm or injury to her own or other babies on the In-Patient Mother and Baby Unit.
- Emergency admissions (in most cases recurrences of psychoses/severe depressive illness or postpartum psychosis) should wherever possible be admitted directly to a MBU and not placed first in an adult admission ward.

Appendix 8: Pending Referrals

An example of the Pending Referral list is shown below. Further guidance on the management of patients pending admission is provided on the next page.

02/02/2018 11:30

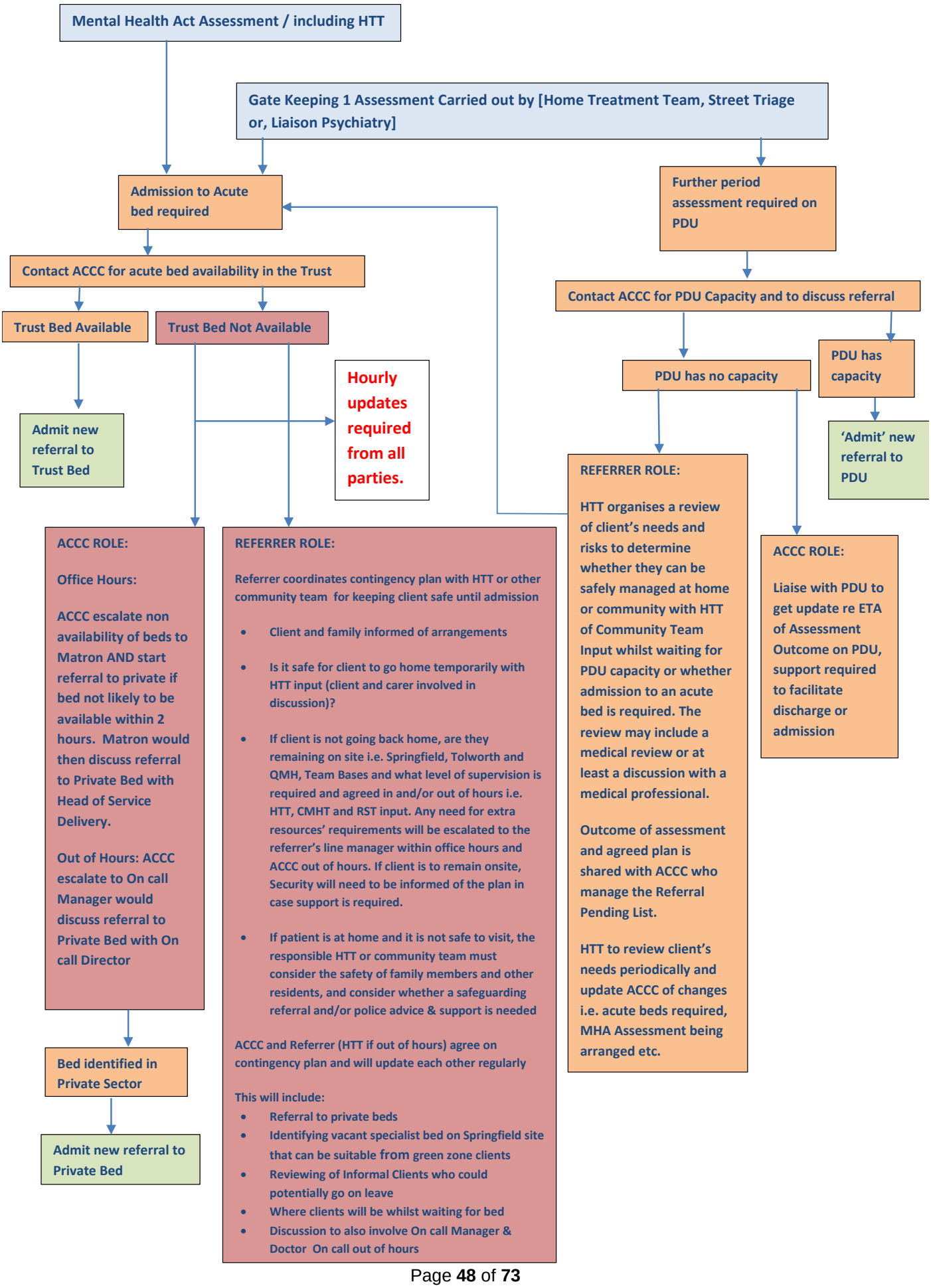
	Current	Total	%
Bed capacity	165	165	100%

Key	
Red	Urgent admission
Amber	Transfer or admission ASAP
Green	MHAA planned for future date

	Total	Male	Female
Beds available now	0	0	0
Beds required in the next 6 hours	8	0	0

RAG rating	Date of Referral	Time of Referral - use date and time format	Source of Referral	Initials	Gender	Age	RiO	NHS Number	Current Location	Nights in Inappropriate Bed	Plan/ Outcome	Comments
Amber	18-Jan	16:43	PICU Stepdown	MO	M	24	1302874	6401944188	Ward 1	PICU Stepdown		PICU Step down - Priority 1
Amber	25-Jan	11:15	PICU Stepdown	HA	M	22	1251832	6359671794	Ward 1	PICU Stepdown		PICU Step down - Patient cannot go to Laurel due to safeguarding 3 incidents and concerns for the other services user
Green	26-Jan	13:20	CTO Recall	RM	F	55	1084880	6251084529	Community			CTO recall for Tuesday 30th of Jan 2018 in the afternoon
Green	26-Jan	13:30	CMHT	MP	F	45	1107190	4409827251	Community			MHA, planned for Tuesday 30/01/18 at 10:30
Green	26-Jan	21:32	Wandsworth HTT	FC	M	49	1072195	4386755411	Community			Planned MHAA schedulled for Tuesday 30th by WHTT. 1st rec completed AMHP needs to apply for sec 135 warrant
Red	29-Jan	14:35	A& E	MH	M	22	1130374	4328224220	St Helier's A&E			Presented at St' Helier's A&E with his Dad. Patient is very suicidal. Psyh liasion feels that he is not acceptable for PICU or Lotus Suite. Requires an Actue Ward - Informal Admission- Referred to Lotus -(02082962682 - 07875722811). Declined by Lotus. St Helier agreed to keep overnight whilst male bed is sought.
Green	29-Jan	16:15	CTO Recall	RM	F	55	1084880	6251084529	Community			Sutton CMHT carrying out a CTO recall - on 30/01/2018
Green	29-Jan	16:15	MHA Assessment	FM	M	49	1072195	4386755411	Community			Planned 135 Warrant AMHP will bring him to Place of safety- 30/01/18

The flowchart below provides further guidance on keeping patients safe while waiting for admission.



Appendix 9: Standards for contact by HTTs for early discharge support

The Home Treatment Teams aim to facilitate early discharge, and treating clients at home is often the most therapeutic option. To do this:

1. The HTT and ward staff must work in partnership in this endeavour and have a mutual understanding and respect of each other's responsibilities and values.
2. Where possible clients will be identified from each ward round for referrals to the HTTs (so the client can be seen after the meeting and discharge plans made as promptly as possible).
3. For the HTTs this will necessitate the teams using RiO to see who is on the ward and checking if the client is well known to their service and proactively contacting the Multi-disciplinary team to suggest a referral.
4. When a client has previously been assessed by the HTTs but admitted to a ward the HTT will keep them on their client list for 72 hours to review options of home treatment with ward staff.
5. The ward staff should expect a client to be seen within a maximum of 24 hours from referral.
6. The HTTs should expect that:
    - The ward staff will ensure that there is an up to date risk assessment and mental state examination, medication regime and core assessment /or medical clerking so that the HTT can work safely with the client. The patient demographics including up to date telephone number also need to be checked.
    - Home circumstances also need to be known in case there are practical issues that stop the client returning home.
7. After the assessment there needs to be a clear action plan, detailing the team and staff member who is responsible for each action. The information will be recorded in the team's usual manner on RiO such as care plan, discharge notifications, etc.
8. Quarterly meetings will be held between Ward and HTT team managers to:
    - encourage a common sense of purpose
    - examine the referral process to make sure that it is as "lean" as possible
    - encourage ideas on improving the pathway between ward and HTTs and to ensure all staff in the referral pathway feel a sense of responsibility in making it as positive for the client as possible.

Appendix 10: Guidance concerning Identification & Recording of DToC for all service lines

Definition of DToC

Delayed Transfer of Care (DToC) is a formal term. A DToC occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when all of the conditions below are met:

a. A clinical decision has been made that patient is ready for transfer **AND**
b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
c. The patient is safe to discharge/transfer.

Although a patient under section may not be safe to discharge, if it has been determined that the patient's care does not need to continue in an acute setting in accordance with criteria a, b and c above for reportable DTOCs (medically fit, MDT decision and safe to transfer) and there are delays in transferring the patient to an appropriate non-acute setting, these should be considered reportable.

Why Record & Report DToC?

- The main aim of the DToC process is to help patients get the care they need in the right setting without delay
- The NHS is required to notify relevant local authorities of a patient's likely need for care and support and (where appropriate) carer's support, where the patient is unlikely to be safely discharged from hospital without arrangements for such support being put in place first (an assessment notice).
- If a local authority has not carried out an assessment or put in place care and support or (where applicable) carer's support, and that is the sole reason for the patient not being safely discharged, the NHS body has a discretion as to whether to seek **reimbursement from the relevant local authority** for each day an acute patient's discharge is delayed.

SWLStG DToC meetings

	Meeting	**Chair**	**Local Authority Representatives**	**CCG representatives**
Wandsworth	Tuesday 0830 Bld 3, Springfield site	Aisling Clifford	Ray Donegan Leon Gooding Lorna Smith	Mark Robertson Olatun Bankole
Richmond	Tuesday 0900 Bld 3 Springfield site	Aisling Clifford	Amy Shardlow Daniel Collins	Daniel Goldie
Merton	Wed 1100hours SLM office	Gina Morgan	Jennifer Lewis Anthony (social services)	Brian Siwela Merton CCG brian.siwela@nhs.net
Sutton	Tue 1130 Ward 3, Springfield	Deborah Stephenson	colin.grant@sutton.gov.uk	louise.fadina@nhs.net
Kingston	Thurs 3.30 Tollworth	Sharon Putt	Iain Richmond Rita Seewooru	Sylvie Ford
Crocus & Jasmine	Monday 1200 Springfield	Gill Moore	none	none

SWL&StG Steps for Identifying& Reporting DToC		
	Event	**Recording**
Step 1	The MDT considers if a person is a DToC if the answer to a, b & c is YES: **a. A clinical decision has been made that patient is ready for transfer AND** **b. A multi-disciplinary team decision has been made that patient is ready for transfer AND** **c. The patient is safe to discharge/transfer.**	The MDT clearly records the discussion concerning a, b & c in a RiO progress note under the heading "DToC" and sets the start date on a RiO delayed discharge form The MDT must describe the reasons for the delay in discharge. (this will inform the "*Delay Responsibility Code*")
Step 2	**Formal** Notice of Delay to LA or to Housing DTOC Notification Form.docx The NHS has to give at least 24 hours' notice of when it intends to discharge the patient (a **discharge notice**).	After the MDT decision the relevant agency will be contacted to notify them of a DToC by email using the DTOC Notification form – which is also uploaded to RiO. DToC can only formally begin when parties agree as to the reason and the **Delay Responsibility Code** The agency has **72hours** to agree the reason / responsibility. Where one party does not agree to the reason, this will be escalated to the weekly DToC meeting. **The DToC Occupied bed day count begins once agreement is achieved.**
Step 3	DToC is formally recorded on RiO the shared spreadsheet "**A" LIST** The spreadsheet is stored on SHAREPOINT & emailed to external colleagues weekly	ACP (or their delegate) for the relevant ward enters the DToC details in the DToC field on RiO. The ACP is responsible for updating the DToC spreadsheets
Step 4	Each borough has a weekly DToC meeting where stakeholders agree codes and discuss & record plans. 5 Borough meetings which cover Adult & Forensic wards A 6th meeting for Older Persons DToC	The meeting discussion stems from the Shared Spreadsheet. The Performance Analyst will also bring to the meeting the RiO report for cross checking with the spreadsheet. The chair of each meeting is responsible for ensuring that all details on the spreadsheet match the RiO generated report. ACP's will record corrections on RiO.
Step 5	Monthly Reporting of DtoC to the CCG on the 21st of each month **Any retrospective changes to information must be agreed and documented at the weekly DTOC meetings as the Trust would need to supply a clear rationale for any change. The DoH may not accept the resubmission of data if not provided**	Performance & Information Team submit the RiO Generated DToC report to the DOH via the Unify Portal on the 21st of each month Validation of DToC cases is completed by the Performance Analyst as follows: 1. Performance Analyst circulates the RiO DToC report on the 1th day of the month to Social Service rep, CCG rep & Chairs of the DToC meeting for COMMENT 2. 5 days are allocated to complete validation and sign-off by all parties all parties 3. Final sign-off will be based on the RiO summary report and will be completed by the HoS of each service line by the 15th of each month before being submitted to IM for uploading onto the Unify Portal on the 21st Any issues in relation to sign-off will be the responsibility of the HOS of each service line.

Appendix 11: Home wards protocol

Patient Treatment Responsibility in Home and Non-Home Wards

Preferred Option

The preferred option is for patients to be admitted to their home ward as this is the ward likely to be closer to their home and as such facilitates access for friends and carers. At the time of writing, home wards within A&UC are as follows:

- Kingston – Lilacs Ward
- Merton – Jupiter Ward
- Richmond – Lavender Ward
- Sutton – Ward 3
- Wandsworth – Ward 2, Laurel Ward, Rose Ward
- All boroughs – Ellis Ward, Ward 1 PICU, Phoenix Ward

The home ward is also likely to have good links with the appropriate Home Treatment Team for the borough.

The home ward is also likely to have knowledge of the patient from previous admissions in the case of patients who have had more than one admission. The guidance below addresses processes and responsibility where:

(i) No available bed on home ward.
(ii) Circumstances for transfer/admission to single sex ward

No available bed on home ward

If no bed is available on the home ward, the following steps should be taken:

1. Attempts will be made to identify a bed on the same site as a/the home ward if possible, e.g. a Merton patient would be admitted to Springfield rather than Tolworth.
2. Patients should be admitted into available beds. Settled patients should not be moved to make space for admissions unless the transfer is back to their home ward.
3. The patient will be the responsibility of the ward team where they are admitted for the length of their stay on that ward. This will include responsibility for any Mental Health Act related work.
4. If the duration of admission is likely to be short (7 days or less), the patient should remain on the ward to which they were admitted until they are discharged.
5. Patients should only be moved between wards once at most. Any further transfer should only be back to their home ward, and should wherever possible take place during the first 7 days after admission. Patients admitted to a non-home ward should automatically be considered for transfer to their home ward during the first 7 days.
6. Patients should not be transferred to another ward from their home ward to create a bed.
7. Patients who have Mental Health Act tribunals booked should not be moved close to the tribunal date without Consultant to Consultant discussion and clear agreement as to which

team will have responsibility for completing the tribunal paperwork and attending the hearing.

Admission/Transfer to Single Sex Wards

Patients may be considered for admission to Rose, Ellis or Laurel Wards if single sex accommodation is required for clinical reasons or patient preference. If it is not the patient's preference, there must be a specific clinical requirement for *single sex* accommodation: disruptive behaviour towards patients of another sex or gender identity is not a sufficient reason alone.

- All referrals should be discussed with the Ward Consultant or Manager where possible. Problems should be escalated by the ACCC to the Matron, Urgent Care during working hours and to the On Call Manager out of hours.
- Appropriate treatments options should be considered first which may manage the risk and therefore transfer is not required, such as optimal pharmacological treatment and increased observations levels.
- A detailed risk assessment should be carried out and documented prior to transfer which highlights a risk which cannot be managed with appropriate treatment options on a mixed ward.
- The need for PICU, assessment by forensic services or involvement of the criminal justice system should all have been considered prior to transfer.
- The acuity of the receiving ward must be taken into account in deciding whether, on balance, it is safer to move or not move the patient.
- Arrangements must be made for the patient's care co-ordinator and other community services to remain in touch with the patient following the move to what may be a non-home ward.

Admission to PICU

- There may be a case for direct admission to PICU in light of risk history, aggression and the section status of the patient.
- This should be reviewed on a case by case basis and discussed with the relevant Consultant.

Admission of working age adult patients to Older Adult Wards

- There should be a MAX of 25% of beds in each ward occupied by adult patients at any one time; so that is max of 4 in Jasmine and 5 max in Crocus. The 25/75 ratio of adult/op on the ward (at any time) is to ensure we try to maintain the ward for the purpose it is intended, that the consultants are not looking after too many adult patients and to maintain safety and quality.
- Agreement to admit or transfer an adult patient to an OP bed should be discussed and agreed with the Matron, Clinical Director, or Out of hours Manager On Call.
- There should be director level decision regarding admission of an adult to OP ward if that admission results in no male or female beds available on either OP ward.
- No adult under age of 65 should be admitted to a OP bed. Each adult patient over 65 should be discussed with the OP inpatient consultant in working hours to assess suitability for the ward (ie: will patient be safe on the ward with frailer elderly patients)
- Clinical /RC responsibility should be transferred from the Acute to OP ward consultant if the patient is likely to remain on the OP Ward for more than a few days. However the responsible adult community team should remain fully engaged in the patients discharge process.

- The preferred option is for patients to be admitted to their home ward as this is the ward likely to be closer to their home and as such facilitates access for friends and carers. At the time of writing, home wards within OP are: Crocus: Sutton, Merton, Wandsworth; Jasmine: Kingston and Richmond.
- An incident should be completed on Ulysses by the receiving ward and ACCC in all instances where an adult patient is admitted to an older adult bed, with a clear SBAR to highlight what steps were taken to prevent the admission, and detailing whether the risk posed to the patient in the community outweighed the inappropriate admission to an older person ward.

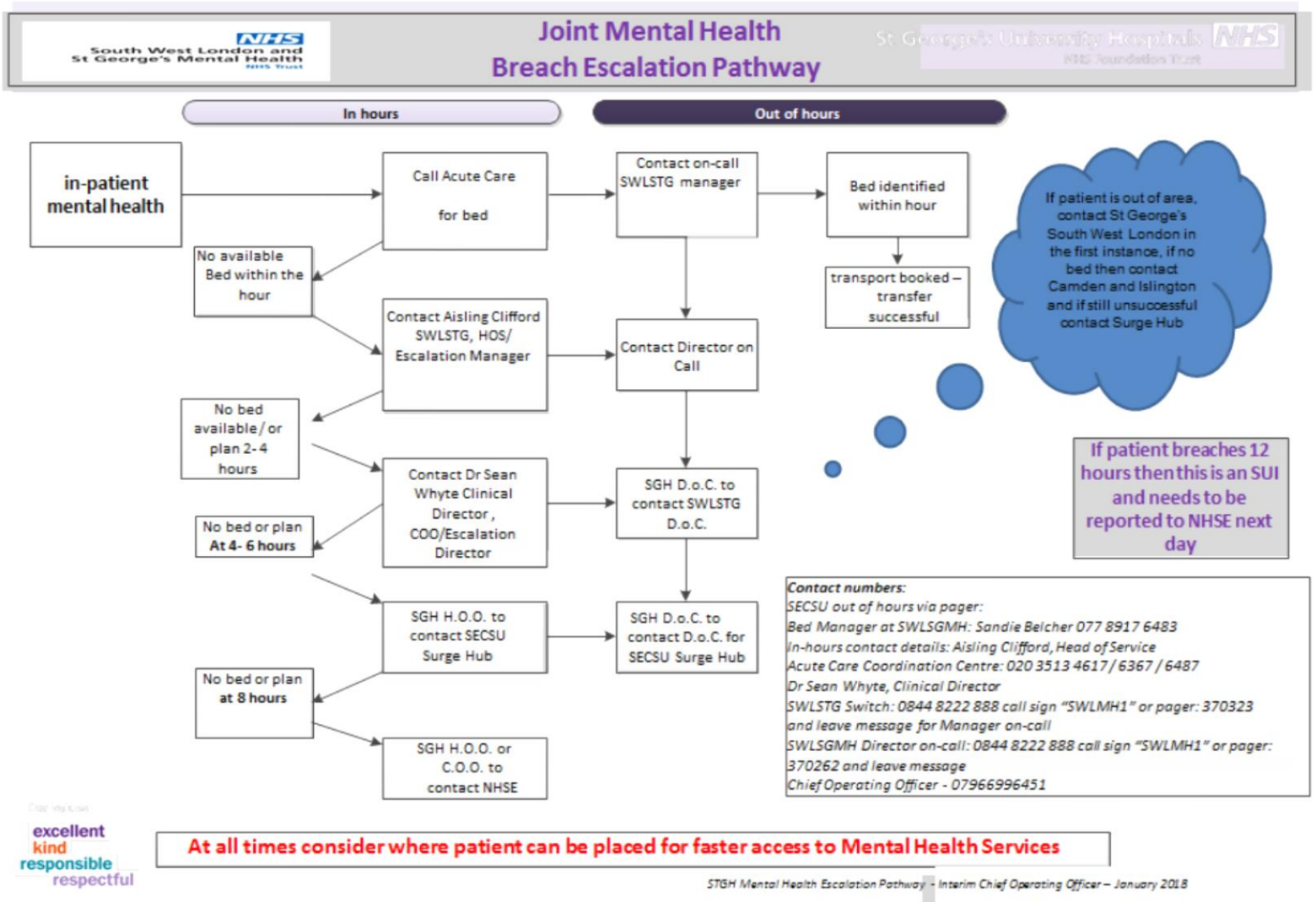
Admission of working age adult patients to Specialist Wards (Bluebell and Seacole)

- In view of the nature of these wards, careful consideration should be given to individual presentation, level of arousal and disturbance.
- Admission or transfer should only occur in exceptional circumstances, and should be for the minimum time possible (e.g. sleeping out overnight rather than a full transfer).
- Such admission or transfer can only go ahead if approved by the Director of Nursing & Quality (or the Director on call out of hours). It must also be reported as an incident.
- Admission should be analysed in the light of risk management and therefore may require transfer of a settled patient in the green zone, rather than admitting a new admission.
- Transfers to specialist wards should occur before 9pm to minimise disruption
- Any patients admitted to Bluebell Ward must be accompanied by a hearing nurse. In addition, if all the Bluebell staff on duty are D/deaf, the risk associated by this should be considered and noted in the incident report.
- The originating ward Consultant will remain responsible for this persons care unless negotiated with another Consultant who is available on the admitting ward site. Even in this case, the originating ward remains responsible for the elements of care listed below.

If a working age adult patient is on a specialist ward (or an older adults wards for a short period f time without a full transfer of RC responsibility) then it is the responsibility of the originating ward to support the older adult or specialist ward to manage the following aspects of the patient's care:

- Observation levels requiring additional staff
- Additional staff required to escort patients to appointments
- Taxi fares
- Additional expenses
- Discharge summary
- Blood tests
- ECG
- Physical health assessment
- Liaison with family and carers organisations
- Filling in medicine cards
- Changing observation levels
- Tribunal reports

Appendix 12: Bed management escalation criteria and actions



SWLStG TRUST WIDE BED MANAGEMENT ESCALATION CRITERIA and ACTIONS

GREEN Escalation Action Card

Criteria	Actions	Role Responsible
• Over 16 Acute beds available (165 Acute beds at 90% capacity) *Including all of the following* • At least 2 Male PICU beds available • At least 1 Contractual Female PICU bed available • At least 1 room available in the Health-Based Place of Safety • At least 2 spaces available on Lotus PDU	**Communication**	
	A&UC 9.30 Daily Discharge meeting	Head of Service / Clinical Director A&UC
	3pm Daily Report on bed state	ACCC nurse on Duty
	Rolling RAG Risk Rating for those on the Pending Admission List	ACCC nurse on Duty
	Business as usual	
	HTT visit the acute adult wards 3 times per week and consider early discharge for all Boroughs	Matron responsible for HTT
	Advanced Clinical Practitioner (ACP) coordinate all DToC actions	Matron responsible for ACP
	If Older Persons Wards are full this must be declared by the Clinical Director Overspill of Older Persons admission to Acute beds must be agreed on a case by case basis	Clinical Directors

AMBER Escalation Action Card
(In addition to Green Actions)

Criteria	Additional Actions	Role Responsible
Any of the following • Fewer than 16 Acute beds available (i.e. >90% occupancy) • Fewer than 2 Male PICU beds available • No Contractual Female PICU bed available • No S136 room available at Springfield Hospital within the next three hours • Fewer than 2 spaces available on Lotus	**Communication**	
	Alert Head of Service Delivery and Clinical Director	ACCC nurse on Duty
	Operational Change	
	ACP rostered on Weekends to ensure rolling support of discharge	Matron responsible for ACP
	ACP complete 3 weekly update on DToC & referrals to HTT	Matron responsible for ACP
	HTT representative to dial into Daily Discharge Meeting	Matron responsible for HTT
	Ward Teams provide 4pm daily discharge updates to ACCC	Matron Responsible for Acute Wards
	Overspill of Older Persons to be considered for temporary Private placement (rather than transfer to Adult bed)	Clinical Director

RED Escalation Action Card
(In addition to Amber Actions)

Criteria	Actions	Role Responsible
Any of the following: • Number of beds projected to be available are fewer than expected/pending admissions for that day • When anyone is waiting > 4 hours for a bed from decision to admit • Demand for PICU is anticipated and no Male PICU beds available (with no patients on transfer list) *or* No Female contractual or spot-purchased PICU bed available <u>RED</u> actions are relevant to <u>all</u> Trust inpatient beds	**Communication**	
	Alert Director of Nursing, COO & Medical Director	Head of Service Delivery / Clinical Director
	Alert Local SURGE Partners	COO
	Operational Change	
	These actions are authorised when status 3 (Red) is declared but not compulsory – each is at the discretion of the HoSD/CD in charge	
	Close S136 Suite to admissions	Clinical Director / Director on Call
	All requests for inpatient beds must be signed off by the consultant and team manager of the referring community/ HTT/liaison team	Clinical Director / Director on Call
	All informal patients to be assessed by the HTT/ Ward managers and HTT/ Ward Consultants with a view to continuing care under the HTT.	Clinical Director / Director on Call
	HTT to be allocated additional staff if that will assist with managing an increased level of home visits.	Head of Service Delivery / Manager on call
	*Utilise vacant Trust Adolescent, Older Persons, Deaf and Adult Beds (See process below)	Head of Service Delivery / Manager on call
	Consider Private Bed Referral if no Vacant Trust Beds available	Head of Service Delivery / Manager on call
	If Private bed is used the Matrons from ACC , RST & HTT will coordinate the review of these patients; including the early discharge and transfer back to SWL&StG bed	
	Report incident for reporting at Quality Matters	ACCC

***Guidance for temporary transfer of patients to vacant beds:**

- ACCC to identify vacant beds across the inpatient bed base
- Clinical Directors to oversee an assessment of risk and suitability before authorising transfer of patients to vacant beds
- Heads of Service to authorise additional staff where increased Observations are required to support the temporary placements
- ACCC to record the transfer as an incident on Ulysses if an adult is placed on an adolescent ward – and the “handler” will be the Clinical Director for the source ward

BLACK Escalation Action Card
(In addition to Red actions)

Criteria	Actions	Role Responsible
3 days or more of RED **(Or no bed in system)**	**Communication**	
	Alert CSU, CCG, LA and SURGE (to be cascaded to Local providers)	COO
	Operational Change	
	Daily Gold command meetings (can be merged with Daily Discharge Bed Management meetings) led by Director on call, *if* the decision has been made by the Director to step up to Gold Command (for example, if Black status actions are not leading to an improved position)	On Call Director
	On call Doctors work on site on weekend and bank holidays, if required	Medical Director
	Create additional Bed in Lounge areas	Clinical Director / On call Director
	Purchase NHS beds on a block for 1 month	COO & Director of Finance
	Utilise Private Beds for admissions	
	Follow the separate 'Approach to creating bed capacity' processes including board reviews, BRAG meetings and other actions (not yet incorporated into this policy as this is a protocol still subject to review and amendment)	Clinical Director / Head of Service Delivery

Appendix 13: Emergency seclusion protocols

Guidance for the emergency transfer of a working age adult patient for the purpose of seclusion

This guidance applies to situations in which a working age adult patient on an acute ward or Lotus requires immediate seclusion because they present an imminent risk of serious harm that cannot safely be managed in any other way.

Clinical Rationale:

- The patient requires an emergency transfer to a seclusion suite as they present an imminent risk of violence that cannot be safely managed by alternative interventions such as enhanced observations and medication, and in order to ensure the safety of patients and staff in a high risk situation.
  - ‘High risk’ chiefly includes acts of violence (or the imminent risk of violence) that cause harm to others and/or significant damage to property.
  - If a patient does not respond to de-escalation and requires restraint for a prolonged period (over 10 minutes) in order to prevent harm, this also amounts to a high risk situation.

Key Principles

- A patient requiring seclusion should be fully admitted to the unit in which that seclusion suite is situated.
- A patient should only be secluded in a suite appropriate to their gender. Seclusion in a non-gender-appropriate unit is only possible in exceptional circumstances and with the permission of the Director of Nursing & Quality, or out of hours the on-call Director (see also section 10.7 of the Bed Management Policy).
- Forensic seclusion facilities should only be used for those patients being treated in forensic services.
- Refer to the full Seclusion Policy for details not summarised in this appendix.

Process:

- Once a situation has been identified as high-risk, the nurse in charge of the ward, supported by either a senior doctor (i.e. Consultant or Higher Specialty Trainee, ST4-6/SpR) or an Advanced Clinical Practitioner (ACP), must assess the patient and the situation and reach a decision on whether immediate seclusion is necessary, or whether alternative interventions (such as rapid tranquilisation, de-escalation, time out or segregation) are more appropriate.
- ‘Supported by’ in the point above means that the doctor or ACP may either assess the patient jointly with the nurse in charge, or provide advice remotely, depending on their availability. In extreme situations the nurse in charge may need to make a initial decision alone and then discuss it with the relevant doctor or ACP at the earliest opportunity.
- This decision must be based on the criteria in section 13 of the Restrictive Interventions and Seclusion Policy.
- If the decision is that immediate seclusion is necessary, an urgent telephone referral to Ward 1 PICU (for men) or Rosebank Ward PICU in ELFT (for women) must be made – see section 8 of the Bed Management Policy for details of how to do this.
- The Matron or on-call Manager must be notified by this stage. They will support subsequent decision-making, liaise to ensure beds are made available where appropriate, and assist in planning a safe transfer to the identified bed.
- If the assessment of the PICU team is that the criteria for a forensic referral are met and seclusion within a secure (i.e. Forensic) ward is required, an urgent referral to the duty Forensic Consultant (or Consultant on call out of hours) must be made – see appendix 6 of the Bed Management Policy.
- If transfer to Ward 1 is considered appropriate, but there is no bed and the seclusion suite is already occupied, ACCC and either the ACP or nurse in charge of Ward 1 must consider stepping down or transferring the secluded patient, if possible.
- If a PICU bed cannot be made available immediately, ACCC will seek to identify a PICU bed in another hospital (NHS or private).

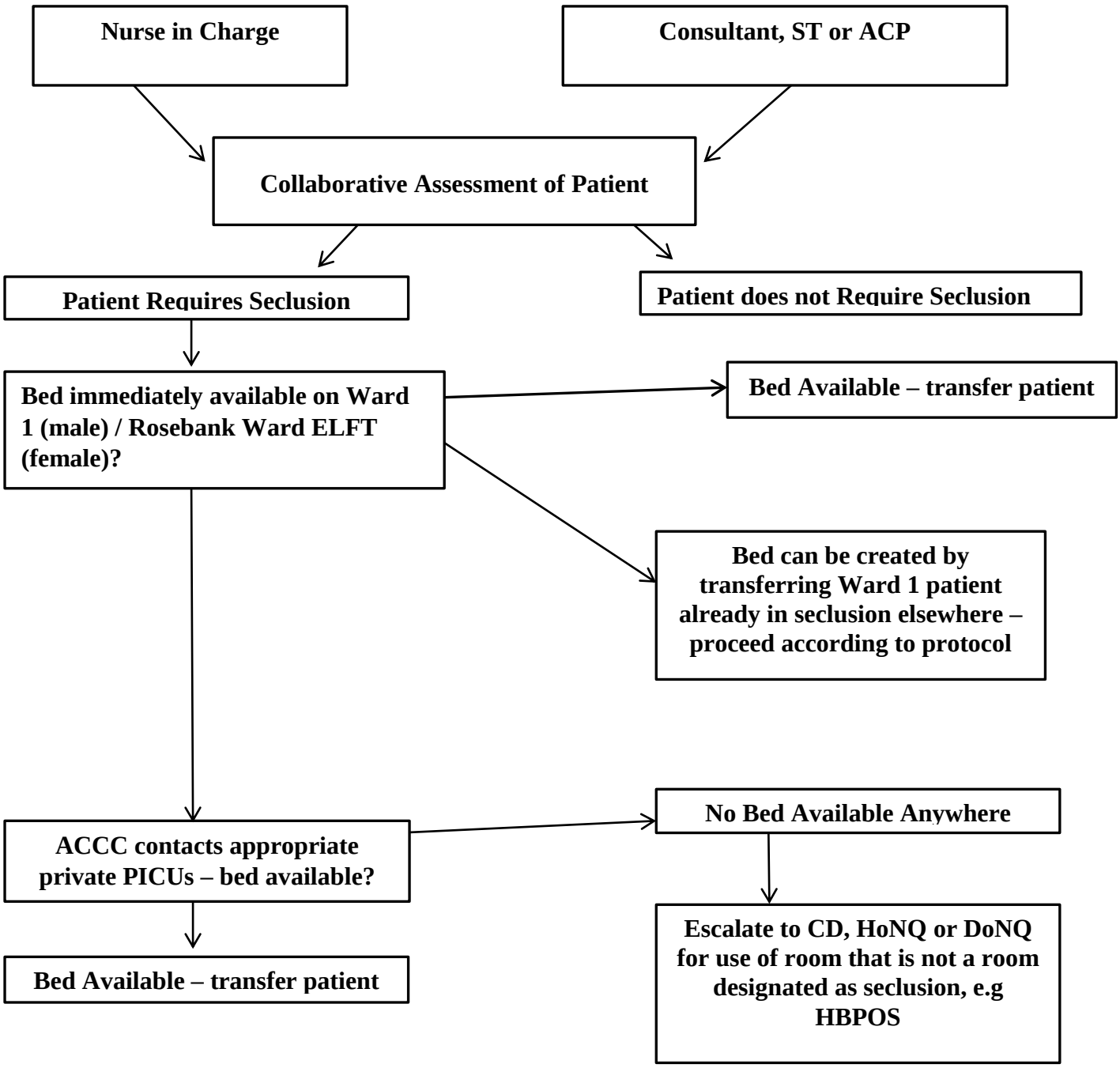
Emergency use of a room not designated as a seclusion room, pending transfer:

- If transfer to a seclusion suite following the process above cannot take place immediately, and the patient remains in restraint or imminent need of restraint on the acute ward, the nurse in charge, senior doctor, ACP or Matron should consider whether the safest option is the emergency short-term use of a room not designated as a seclusion suite (i.e. the Health-Based Place of Safety / S136 Suite).
- If a patient needs to be transported for seclusion, this must only be down using appropriate secure transportation.
- If they consider that this is necessary, they must seek the permission of the Clinical Director for A&UC or the Director of Nursing & Quality (or out of hours the on-call Director) before transferring the patient.
- While the patient is secluded within the HBPoS, the originating ward remain responsible for their overall clinical care, for obtaining additional staff, and (with ACCC and the ACP) for expediting transfer to an appropriate seclusion suite; the staff of the HBPoS (who are trained in seclusion protocols) are responsible for managing all entries into the room and all seclusion reviews.
- If the HBPoS is used, an update on the situation must be provided to the Director of Nursing & Quality (or out of hours the Director on call) every four hours.
- If all seclusion facilities are full this needs to be discussed and best clinical pathway agreed with the director and consultant on call.

Post incident management:

- The patient's risk assessment and care plan must be comprehensively and clearly documented to demonstrate the rationale for seclusion and the management plan during seclusion.
- Seclusion policy will be followed including regular reviews by MDT during and out of hours – duty docs, nurse in charge and consultant on call (where required).
- An incident report (or if appropriate, serious incident report) must be completed by the originating ward team.
- A Post Incident Review will be conducted by the originating ward's manager the next working day, with support from the relevant Matron.
- The responsible Matron will ensure support is provided for the staff members involved, any required actions are addressed and learning from the incident is communicated as required.

Emergency Transfer to Seclusion Pathway



Guidance for the emergency transfer of a secluded Forensic Service patient to another seclusion suite within the Forensic Service

The Springfield site has a total of five seclusion rooms, plus two S136 suites built to seclusion standards. In addition to the Ward 1 PICU seclusion, the forensic service has a total of four seclusion rooms. The seclusion on Hume low secure is male only. There are two mixed gender seclusion rooms in the main Shaftesbury Clinic and a female only seclusion on Ruby Ward in the Shaftesbury Clinic.

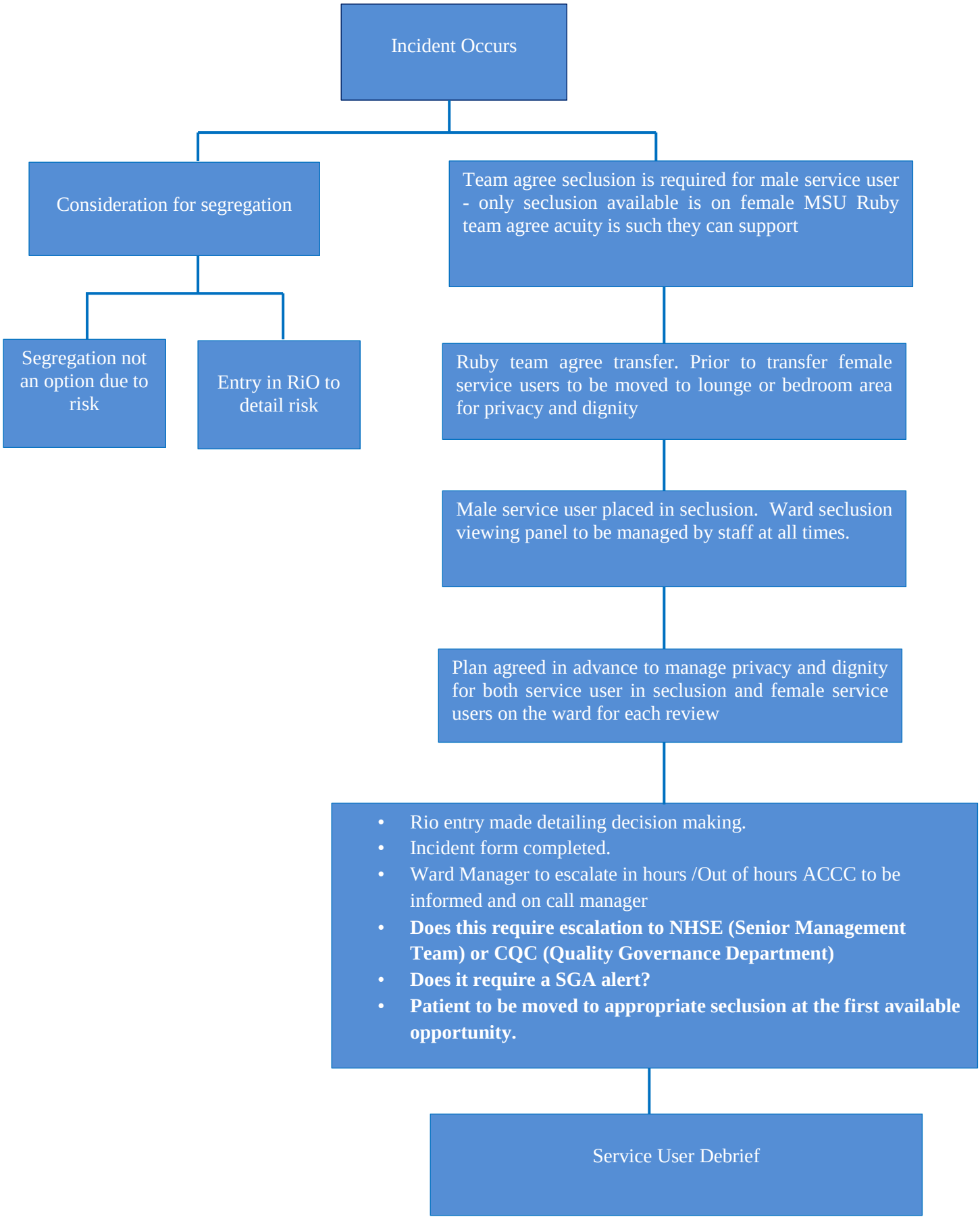
There have been occasions where the male or unisex seclusion rooms are in use or one is in use and one decommissioned due to damage. This poses a significant risk should seclusion then be required for another male service user.

This protocol has been devised as guidance for staff in the event a male Forensic Service user needs to be secluded on Ruby. This would be viewed as an extraordinary event and not the usual practice. This protocol should be read in conjunction with the Restrictive Intervention & Seclusion Policy.

Key areas for action when using this protocol:

- At all times consideration needs to be given to the privacy and dignity of service users on the ward and the service user being transferred to the ward.
- All transfers need to be done in a planned way and risks considered.
- The transfer to another area needs to be recorded in the seclusion care plan clearly stating the service user is moved as soon as possible.
- Escalation to Ward Manager/Matron in hours and on call team out of hours. With final approval by the Director on call/ DoNQ
- Incident form to be completed.
- Clear entry on Rio regarding decision making process
- As soon as the service can be moved safely they must be moved.
- The home ward is responsible for the transfer and additional staff. The host ward is responsible for managing all entries to the seclusion room, and all seclusion reviews.
- Consideration needs to be taken in ensuring, if possible, female service user is allocated to the female ward seclusion

Male MSU service user transferred to female MSU ward



Ward team to monitor seclusion use and move the service user at the first available opportunity.

Appendix 14: Transfers of patients to and from acute hospitals

Guidelines on the transfer of a psychiatry inpatient to an acute hospital ward

Liaison with the general hospital

- In situations where there is sufficient time, a psychiatry doctor should contact the relevant **on-call medical/surgical team** at the acute hospital to discuss the patient's management and potential transfer.
- Where a patient is transferred in an emergency without time for prior discussion, a psychiatry doctor should try to contact the relevant acute hospital team (Emergency Department or on-call medical/surgical team) to discuss the case.
- Staff from the psychiatry ward should contact the acute hospital **Liaison Psychiatry Service** to inform them of the patient's transfer and potential need for their involvement.

What information should accompany the patient?

- **Referral letter**, including details of the reason for transfer, the reason for psychiatric admission, the patient's current drug treatment including dose and form and details of any depot injections, a psychiatric management plan, a risk assessment and management plan (see below), and whether the patient is detained under the Mental Health Act (MHA).
- **Risk assessment and management plan**, noting relevant risk history, current assessment of risks of harm to self or others and risk of absconding, recommended actions in the event of an escalation of risk, the level of nursing observation required, and the role (RMN or HCA) of any 1:1 nurse recommended.
- **MHA papers**
    - In an emergency situation it is likely that a detained patient will be placed on Section 17 leave from the psychiatry ward, in which case the patient should be accompanied by **copies of the section papers and the Section 17 Leave Form.** Whether the section is then transferred to the acute hospital can then be discussed with the relevant Liaison Psychiatry Service.
    - If it is agreed in advance with the Liaison Psychiatry Service that the patient's detention will be transferred to the acute hospital, the **original MHA section papers** must accompany the patient. Part 1 of a **MHA H4 Transfer Form** must be completed and signed by a member of ward staff and the original form should go with the patient. (If this does not occur, RC responsibility remains with the psychiatric consultant.)
- **Medicines currently prescribed**
    - MAC and MAP, printed from JAC. Instructions on how to print can be found on Insite. This will inform the acute hospital ward team of all currently prescribed medicines and doses due (MAC), and all medicines administered in the last 7 days (MAP).
    - Teams still using paper charts (Burntwood Villas only) must send a photocopy of the current paper drug chart.
    - Medicines that have been dispensed for the individual patient and any medicines that the patient has brought in with them, including clozapine, should also be sent with them to avoid missed doses while waiting for the acute hospital Pharmacy to supply.

Nursing escort and observation

- The patient should be accompanied by a member of nursing staff who is suitably qualified and trained to undertake the necessary level of patient observation (as determined prior to transfer) and to be able to respond appropriately to changes in the patient's mental state and level of risk.
- The accompanying nurse should not leave the patient until it has been judged that 1:1 observation for mental health reasons is no longer required. This assessment should be made by Liaison Psychiatry staff. The escorting nurse should not leave unless there is suitably qualified member of staff is available to take over observation.
- The usual arrangement between local mental health and acute trusts is that if a patient is transferred from a psychiatry ward to an acute hospital ward and requires ongoing observation for mental health reasons, this will be arranged and funded by the mental health trust. This arrangement will continue until such time that it is agreed between the two organisations that the responsibility will be transferred to the acute trust.
- It should not be assumed that an RMN undertaking patient observation will have the expertise to manage a patient's physical healthcare. The responsibility for this rests with the acute hospital ward staff.

All patients will have an appropriate set of nursing observations recorded within an hour prior to transfer between Trusts or Hospitals.

Template for referral letter to the general hospital

[*INSERT DATE*]

Dear Sir/Madam,

Please see below referral details for [*INSERT PATIENT'S NAME*], who is being transferred from [WARD] at [HOSPITAL] Hospital to [*INSERT NAME OF GENERAL HOSPITAL*]. The originating ward can be contacted on [SWSLtG WARD PHONE NUMBER].

Patient's name:
NHS Number:
Reason for transfer to general hospital:

Summary of mental health needs and reason for referral to the psychiatric ward:

Status under the mental health act:
[Is the patient currently informal; detained under the capacity act; detained under MHA?]

Current medication:

Psychiatric management plan:
[Current care pathway and summary of care plans]

Risk assessment and risk management plan:
[Current assessment of risk of harm to self and to others and risk of absconding; relevant risk history level of observation required until review by Liaison Psychiatry; role of 1:1 nursing staff; recommended actions to be taken if level of risk changes or escalates; recommended actions to be taken if patient tries to leave the general hospital]

Yours sincerely,
[*INSERT YOUR NAME AND JOB ROLE*]

Checklist for the transfer of patients to a general hospital

This checklist must be used when transferring a patient to an acute/ general hospital for assessment or treatment of their physical health. This should then be uploaded on RiO and the original copy ncluded in patient transfer notes.

ACTION	COMPLETED? (sign and date)
Prior to transfer	
In the case of a routine transfer, the duty dr should **contact the relevant on-call medical team** at the acute hospital to discuss the patient's management and potential transfer.	
Where a patient is transferred in an emergency without time for prior discussion with the on-call medical team, the duty dr should try to **contact the relevant acute hospital's emergency department** to discuss the case.	
Nursing staff should **contact the acute hospital's Liaison Psychiatry Service** to inform them of the patient's transfer and potential need for their involvement. *St George's: 0208 725 3795* *St Helier: 0208 296 2751* *Kingston: 0208 934 3509*	
Accompanying the patient	
Referral letter including: • Summary of the reason for transfer to acute hospital • Summary of the background/reason for admission to SWLStG • Status under the mental health act (informal, MHA, DoLS, MCA, common law) • The patient's current drug treatment • A psychiatric management plan • A risk assessment and management plan • All contemporary physical health obs. (e.g. NEWS score) ***Template available on the shared drive***	
Risk assessment and management plan, noting relevant risk history, current assessment of risks of harm to self or others and risk of absconding, the level of nursing observation required until review by Liaison Psychiatry, the role of the 1:1 staff, recommended actions in the event of an escalation of risk, recommended actions in the event that the patient tries to leave the general hospital.	
List of medicines currently prescribed, print MAC and MAP from JAC, instructions on how to do so can be found on Insite.	

Medicines that have been dispensed for the individual patient and any medicines that the patient has brought in with them, including clozapine, **should be sent with them** to avoid missed doses while waiting for the acute hospital Pharmacy to supply.	
Nursing escort for transfer	
Discussion and allocation of appropriate staff to carry out escort, the patient should be accompanied by a member of nursing staff who is suitably qualified and trained to undertake the necessary level of patient observation and to be able to respond appropriately to changes in the patient's mental state and level of risk.	
Level of observation	
The **Psychiatric Liaison Team** will be responsible for clinically assessing the patient **to determine the level of observations** required and increase or decrease as clinically indicated and risk management dictates. Where there is a need for the patient to remain in the general hospital, the **escorting nurse should not leave the patient** until there is **confirmation** that a suitably qualified member of staff is available to take over observation or it has been judged that 1:1 observation for mental health reasons is no longer required.	

Name of staff completing checklist:

Designation:

Signature:

Guidelines on the transfer of an acute hospital inpatient to a psychiatry ward

When is a patient physically well enough to be transferred?

- A psychiatry ward is designed and staffed to manage patients with mental illness, but has a limited capacity to manage acute physical health problems. Physically frail patients and those with limited mobility may be at increased risk of inadvertent harm by other agitated patients. Generally a patient should be physically well enough and sufficiently mobile to be discharged home (with a package of care if necessary), in order for them to be transferred.
- Ideally a patient's **National Early Warning Score (NEWS) should be 0**. If the score is above 0 (e.g. due to a chronic but stable condition), the reason(s) for this should be discussed with the Liaison Psychiatry Service and/or the Acute Care Coordination Centre (ACCC) at Springfield Hospital, to ensure that the patient's needs can be safely managed on a psychiatry ward.
- A psychiatry ward will generally not be able to manage such things as:
    - IV lines and administration of IV drugs or fluids
    - Nasogastric (NG) tubes
    - Patients requiring oxygen therapy
    - Postoperative care

How is transfer organised?

- The Liaison Psychiatry Service will liaise with the bed management service for the appropriate mental health trust. For patients from SW London, this is the Acute Care Coordination Centre at Springfield Hospital (020 3513 6487).
- If a patient has significant mobility problems or if there are aspects of physical healthcare that will require additional resources or equipment, these should be discussed in advance to ensure that such care can be provided on a psychiatry ward and to ensure that any additional equipment is available and in place before transfer (e.g. dressings, hoist, specific hospital bed, bariatric or pressure-relieving mattress).
- If the patient has a hospital acquired infection (e.g. clostridium difficile, MRSA) or has been in recent contact with other patients with diarrhoea and vomiting, this should also be discussed to ensure that transfer is appropriate and that necessary precautions can be taken.
- Transport for most patients is organised by acute hospital staff. The Liaison Psychiatry Service can advise on whether an additional escort (e.g. RMN) is required.

What information should accompany the patient?

- **Discharge summary**
- **Specific guidance** on the ongoing management of physical health problems, outstanding investigations and plans for follow-up should be included in the discharge summary or should be provided separately. Please do not assume that staff on the psychiatry ward will know how to manage certain conditions (e.g. diabetes mellitus).
- A copy of the in-patient **prescription chart** (hard copy or printed form an electronic system) must be sent with the patient.

- **Medicines** that have been dispensed for the individual patient, and any medicines that the patient has brought in with them, should also be sent with them to avoid missed doses while waiting for the psychiatric hospital pharmacy to supply.
- For complex cases, please transfer with a full **copy of the medical records** for the admission.
- For patients detained under the Mental Health Act (MHA) to the acute hospital, the **original section papers** must accompany the patient. Part 1 of a **MHA H4 Transfer Form** (available from Liaison Psychiatry or online) must be completed and signed by a member of ward staff and the original form should go with the patient.

Transfer of patients from the Emergency Department

- Generally much of the guidance above will apply.
- Patients should be accompanied by an ED **discharge letter**, a copy of their current **ED record**, a **list of current medications** (either contained within the previous documents or on a separate list), **original MHA section papers** if the patients is being detained (H4 transfer form not required unless the patient has been detained to a St Helier Hospital bed under the care of the ED).

Appendix 15: Follow up of acute & PICU patients placed in beds outside the Trust

This Standard Operating Procedure (SOP) applies to all working age adult patients **admitted to an acute or Psychiatric Intensive Care Unit (PICU) bed outside the Trust**, whether private or NHS out of area. (This excludes women placed in contractual PICU beds, but includes those placed in external spot-purchased PICU beds.) The purpose of this SOP is to outline the role and function of Trusts community teams in supporting these clients.

The ACCC keeps a record of all clients placed out of area and in private sector on the Bed Management Spreadsheets (Pending List), and will ensure community teams and their team managers are informed on each occasion that they become responsible for a patient placed in an out of area bed. ACCC will also ensure that a Barriers to Discharge Form is emailed to the receiving Clinical Team to complete. On receipt of the completed form, they will forward it to the care co-ordinator for review and entry on RiO.