Health and Social Care

REGIONAL BED MANAGEMENT PROTOCOL FOR ACUTE PSYCHIATRIC BEDS

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Review date	This policy will be reviewed every three years or at times considered necessary as a result of operational or legislative changes

1.0 INTRODUCTION

1.1 Following assessment, all patients requiring admission to an acute psychiatric bed must be admitted to an appropriate facility to meet their individual needs in a timely and efficient manner. This requires service providers to have effective bed management arrangements in place, including escalation policies to deal with bed pressures. Communication with the patient, their family and carers is an integral part of the bed management protocol, especially when alternative arrangements need to be put in place.

1.2 This bed management protocol has been reviewed by the Regional Bed Capacity Network Coordinators representing each of the five Trusts. The views of senior clinicians and managers have been sought in the review of the protocol within each Trust. The review was directed by the Regional Bed Management Network (RBMN) group and aims to facilitate and improve patient flow, reduce delays in discharge from hospital, reduce the length of patient stay, provide better outcomes for patients and to improve access to Adult Acute Mental Health in-patient services.

1.3 The terms of reference for the working group were to review theexisting protocol and bring it up to date.

1.4 The original Bed Management Regional Group (2008) considered best practice within Northern Ireland and elsewhere. It considered lessons to be learnt from effective bed management initiatives in acutemedicine and surgery and has made recommendations taking into account:

- the human rights framework;
- the document *“Who’s Been Sleeping in My Bed? The incidence and impact of bed over occupancy in the mental health acute sector”* Mental Health Act Commission (England) December 2006and;
- recommendations made by professional bodies in these matters.

1.5 The current challenge facing mental health providers is to ensure that acute beds are available in a timely, accessible manner to peoplewho require them. The Royal College of Psychiatrists (2011) recommends that acute bed occupancy should average 85%.

1.6 In 2015, the National Confidential Inquiry reported that suicides following discharge from a non-local ward had increased and advised that the clinical messageis that **acute admissions out of [Trust] areas should end – they are likely to add to suicide risk at the time of discharge**. Currently it is reported that 10% of all deaths by suicide within 3 months of discharge from a mental health inpatient setting in England, had been discharged from an out of Trust ward (National Confidential Inquiry, 2021). Nice (2016) advice regarding obvious risks on discharge related to potential communication difficulties. However, with ever-increasing demand upon beds regionally, it is recognised that out of Trust admissions are difficult to avoid.

1.7 The Bamford Review has given indicative numbers for acute beds. However, it also emphasised the need for a whole-systems approach tothe management of mental illness, in which no one part of the service can be considered in isolation. Against this background, and with ongoing investment in community based mental health services, HSC Trusts, in collaboration with commissioners are reviewing their future acute bed capacity requirements.

2.0 MANAGEMENT FRAMEWORK

2.1 It is clear that effective bed management requires managers andclinicians to work together to ensure that the use of inpatient beds is efficient and appropriate.

2.2 A system of bed management is likely to be less efficient where there are many points of access to admission. Evidence from the National Audit of Crisis Response and Home Treatment Teams in England suggests that where there is a single ‘gate-keeping’ function within Crisis Response and Home Treatment (CRHT), then beds are better managed.

2.3 In each of the Trusts in Northern Ireland the CRHT servicesundertake this gatekeeping function with the Patient Flow Co-ordinator administrating the process.

2.4 Each Trust now has an appointed Bed Capacity Network Coordinator who works closely with Clinical Leads, MDTs, Community Colleagues and Acute/Crisis Services to ensure a regional, managed approach to patient flow for adult acute mental health services, which complies with regional standards and achieves agreed outcome measures.

2.5 Each Trust has a designated manager(s) or team, who is responsible for co-ordinating day-to-day bed management issues. Such a person has current knowledge of:

- the total number of beds
- the number of patients occupying beds;
- the number of beds allocated to patients on leave;
- the number of patients who have been identified as being clinicallyfit for imminent discharge;
- the patients inappropriately placed in another ward;
- the number of patients under special observations and associated risks;
- the number of admissions and discharges in a 24hr period;
- the number of patients admitted out of catchment – internal and external to the Trust;
- the number of admissions of patients admitted with a diagnosed learning disability;
- the number of patients admitted under the age of 18years;
- and ward acuity using the Regional Acuity and Dependency Tool

2.6 It is noted that this function is in place in each Trust, however different terminology is in use; Patient Flow Team is used for this document. It is recognised that such arrangements may differ between the working week and out of hour’s periods

2.7 Each Trust should ensure development of clear and explicit arrangements for pre-admission assessment procedures that recognise specific needs and pathways, such as, for those people for whom an application has been made for detention for assessment under the Mental Health (Northern Ireland) Order 1986 or persons with a co-morbid learning disability.

2.8 It is assumed that most people will be managed in community settings and that admission to a bed will be necessary only where clinical and risk factors indicate that it is necessary to do so. Before admission to an acute inpatient unit, the gate-keeping service should discuss with the referring agent whether admission is necessary or whether community based facilities, for example acute day hospital, crisis house or acute home treatment would be more appropriate.

2.9 Where a clinical decision has been made to admit a patient to an inpatient mental health bed, then the admission should take place in a timely, appropriate and sensitive manner - taking into account the needs and wishes of the patient and the needs and wishes of their carers.

2.10 Wherever possible Trusts should arrange admission to the acute mental health unit, within their Trust, closest to the home address of the patient.

2.11 The planning of discharge should commence at the point of admission. Such planning should include consideration of all agencies that might be involved in managing the discharge process and should identify the estimation of a date of discharge, around which appropriate planning can be made. Particular attention should be given to the identification and discharge planning of patients who, on assessment in keeping with the 2010 regional guidance on risk assessment and management in acute adult mental health services, demonstrate a highlevel of risk.

2.12 Bed utilisation is set out in the diagram at Appendix 1.

3.0 MANAGEMENT OF ACUTE ADMISSION WHERE NO UNOCCUPIED BED IS AVAILABLE

3.1 Each Trust should seek to manage acute patient needs within their Trust boundaries.

3.2 It is the responsibility of Trusts and Commissioners to plan for an appropriate number of psychiatric beds within their Trust area to managethe acute psychiatric needs of inpatients arising from their populations.

3.3 Trusts should ensure that they have in place robust bed management strategies to manage their existing bed complement.

3.4 It is recognised that to admit a patient to a bed already allocated to another patient temporarily out on leave, could carry with it a significant clinical risk. It is expected that the responsible Patient Flow Co-ordinatorwill be aware of the nature and extent of any risk that might be involved should a patient be admitted to a leave bed. In order to achieve this, it will be necessary for Trusts to have a policy on leave from inpatient care that is explicit about how such leave is planned and implemented. The leave policy should include the management of patients who are absent without leave and should include what to do if unexpected readmission occurs of a patient out on leave whose bed has been used.

3.5 Trusts should have escalation policies for bed management
(See appendix 2). This policy will define levels of bed usage as Level 1, 2, 3 or 4:

- **Level 1 (Green)** - A time when any foreseeable number of psychiatric admissions could be accommodated within bed vacancies in theTrust;
- **Level 2 (Amber)** - When a Trust has reached bed occupancy above 85% of their commissioned beds
- **Level 3 (Red)** - Where significant clinical risk is so great that it is not possible to accommodate any new admissions to local Trust acute beds.
- **Level 4 (Black)** –There are no beds available

3.6 Admissions of patients to other Trust areas should be exceptional. Expectations and requirements in these situations are outlined in the Regional Guidance on the Transfer of Patients and their Records between Psychiatric Hospitals (2009), Crest Guidelines (2006), Regional Protocol for the Transfer of Adult Mental Health Patients between Trusts (2021), and Guidance in the Transfer of Patients Detained under Mental Health Legislation between Hospitals in Northern Ireland and Great Britain (2019).

3.7 In exceptional circumstances there may be a vacant bed in a particular Trust but the Senior Manager on call (Level 8A or above) mayconsider that an admission is not possible, if the clinical and nursing demands of the existing inpatient population are adjudged by the Senior Manager on call with the Consultant on call, to be such that further admissions to a particular ward would be unsafe.

In such circumstances, the ward will be deemed closed to all admissions of this kind, both within and outside the Trust. Where Trusts need to close beds, for a period of time, (for example due to a fire in the ward or a decant) then this should be discussed with Commissioners and communicated to other Trusts including Out of Hours services.

In addition, the Trust Director on call should be notified and HSCB notified next working day.

4.0 MANAGEMENT OF SITUATION WHERE NO "IMMEDIATELYAVAILABLE" BED IS IDENTIFIED

4.1 The pathway described in Appendix 1 suggests that where no bedcan be found in the acute ward, then an available bed should be considered in an alternative ward such as a:

- Psychiatric Intensive Care Unit with patient consent;
- Older people's Unit (Dementia or Addictions are excluded); or
- An acute bed may be sought in another Trust area, (see Section5).

4.2 Where senior clinical decision makers (medical/nursing) have decided to transfer a patient to another specialist mental health bed in the hospital senior service managers should be informed. In such cases, managers may, in discussion with the on-call consultant(s), consider that transfer to an acute bed in another Trust would be a safer option. The reasons for such transfers should be documented.

4.3 If such a bed is found, then a patient, for whom it is most clinically appropriate to transfer there, should do so. In addition, appropriate supports should be considered for this patient in the alternative ward.

4.4 It should be recognised that such a transfer should be with the patient's consent and that all risk factors to that patient and to others should be taken into account when deciding upon the transfer.

4.5 It is best practice if decisions to transfer are considered in advanceas part of the Trust's escalation policy rather than at the time of the decision to admit the acutely ill patient.

4.6 If no such available bed can be found (across the Region), then theTrust should arrange for the creation of an escalation space (Chair/Bed/Sofa) in the acute admission facility. The creation of such a place should be made in consultation with senior medical, nursing and managerial staff, in order to ensure clinical care of that patient and all other patients is safe. It is noted that escalation spaces in wards can in itself bring significant pressures to staff and risks to patients.

This does not apply to PICU wards.

4.7 It should be recognised that from time-to-time it would be appropriate to find a place for a patient to remain where there is not a designated acute bed immediately available. Examples of such arrangements would include:

- the patient remaining in a medical assessment unit;
- in the place of assessment as long as it is safe to do so or
- admitted to the ward to remain on the unit until a bed becomes available.

4.8 Where significant clinical risk arises from such management arrangements, then a local incident review should be undertaken to understand why this has occurred and to disseminate learning.

5.0 ADMISSIONS OUTSIDE TRUST AREAS

5.1 It is recognised that from time-to-time the safest management plan will be to admit a patient to another Trust area (this includes patients toPICU). It should be recognised that such admissions carry their own risks in that communication between distant inpatient units and local community mental health teams will be less well developed and the transfer of clinically significant information in such circumstances must be carefully managed. This requires consultant-to-consultant agreement.

5.2 Where it is thought clinically necessary to admit a patient to anotherTrust, then there should be a recorded transfer of responsibility between clinical teams and managerial contact between Patient Flow Co-Ordinators. The person's own key worker and Consultant (if previously known to Mental Health services) should be informed, on the next working day. See Appendix 3 for keeping in touch arrangements.

5.3 It is the responsibility of the referring Trust to provide and forward all available information to the receiving Trust concurrent with the admission. The most recent Mental Health assessment proforma and the up-to-date Initial/Comprehensive Risk Screen tool should be forwarded on admission; this should include demographic details, case history, most recent mental state examination and reason for admission, information about current treatment and care and an up to date assessment of risks/safety plan. Furthermore, **all** relevant records should be forwarded to host Trust on the next working day.

Such communication of information must be in keeping with the Departmental guidance on Inter-Hospital Transfer of Patients and Patient Records (2009) and the Protocol for the Transfer of Adult MentalHealth Patients between Trusts (HSCB, 2021).

5.4 Where the patient is not known, it will be the responsibility of the referring Mental Health Practitioner or ASW for a detained patient to provide all available information to the receiving hospital.

5.5 In order to ensure the safest clinical practice for the patient consideration should be given to when it is appropriate to return the patient to their local unit. This will include consideration of the patient'sneeds, their clinical condition/relevant risk factors and the bed management situation within the Trust.

5.6 When it is clinically appropriate to transfer the patient, the patient'sown Home Treatment Team will assess and sign post to appropriate services.

If the patient does not require on-going acute care, the local Trust should identify the appropriate service to provide the Early Post Discharge appointment.

5.7 Trusts will wish to review occurrences of admissions outside their local area to identify reasons for this and to take preventative measure if appropriate. Admissions out of the Trust area are reported to the HSCBoard on a quarterly basis. Instances when there have been particular issues/ concerns should be brought to the Trust Bed Capacity Network

Coordinator for discussion, interpretation of the Protocol and to ensure consistent service delivery. Issues of concern and points of learning will be brought to the Regional Bed Management Network.

6.0 ADMISSION OF YOUNG PEOPLE UNDER THE AGE OF 18

6.1 It is recognised that it is never desirable to admit a person under the age of 18 to adult mental health services. It is however recognisedthat from time-to-time Child and Adolescent Mental Health Services (CAMHS) may be unable to accommodate acutely ill young people within age specific facilities.

6.2 If there are no vacancies at Beechcroft, it may be necessary to admit a young person to an adult ward. In such cases the regional CAMHS Service should be followed.

6.3 The transfer of the young person back to specialist CAMHS shouldbe regarded as an immediate priority.

6.4 Best practice is that there should be no circumstances in which a child is admitted to an adult ward outside of their own Trust area.

6.5 It is the responsibility of the specialist CAMHS services to raise an early alert when there are no CAMHS beds available.

6.6 During the admission of a young person to the Adult ward, it is the responsibility of the specialist CAMHS service to ensure that the appropriate clinical care is provided. It is the responsibility of the specialist CAMHS team to be actively involved in the person's admission and to process discharge planning.

6.7 The specialist CAMHS Psychiatrist should be presumed to take lead clinical responsibility unless otherwise agreed. If the young person is admitted under the MH Order (NI) 1986, the RMO should be a specialist CAMHS Psychiatrist.

6.8 Should there be no suitable CAMHS or local Adult bed available for the young person, it is the responsibility of the CAMHS service to make alternate arrangements to manage the safety of the young person and to continue bed sourcing.

7.0 ADMISSION OF PEOPLE OPEN TO MENTAL HEALTH SERVICES FOR OLDER PEOPLE

7.1 The original regional working group recognised that it is inappropriate to discriminate between adults of working age and those above working age. The group recognised that non-working age adults with a functional psychiatric illness, who have the same needs as peopleof working age, should be treated in a similar way. This means that this protocol applies equally to them, though an out of Trust placement for an older person will only be accepted if they can be admitted to anappropriate ward.

7.2 It is recognised that patients with dementia should not be included within this protocol and that units specifically designed for the treatmentof people with dementia should not be considered as being available forpeople with acute functional illness.

8.0 ADMISSION OF ADULTS WITH A COMORBID LEARNING DISABILTY

8.1 While it is vital that individuals with a Learning Disability have good and equitable access to mental health care, it is recognised that it is not desirable to admit the individual to an adult mental health ward unless they require Acute Mental Health Care. Break down of community placements and/or an escalation of behaviour should not be the sole reason for admission.

8.2 If there are no vacancies in appropriate designated Adult Learning Disability beds, admission to an adult mental health ward may be necessary. In such cases, Regional Guidance Trust pathway should be implemented to allow use of adult beds and ensure maximum safety of the person with a diagnosed learning disability.

8.3 There should be no circumstances where a child with a diagnosed learning disability is admitted to an adult ward mental health ward.

8.4 It is the responsibility of the specialist learning disability services to raise an early alert when there are no adult learning disability beds available.

8.5 It is the responsibility of the specialist learning disability service to ensure that the appropriate clinical care is provided. This may include the provision of qualified learning disability nursing and care staff where required. It is the responsibility of the Learning Disability team to be actively involved in the person's admission and to process discharge planning.

8.6 When admission is agreed it is the responsibility the specialist Learning Disability Psychiatrist to take lead clinical responsibility. If a patient with an established learning disability is admitted under the MH Order (NI) 1986, the RMO should be a specialist Learning Disability Psychiatrist.

9.0 MANAGEMENT OF ADMISSION

9.0 Effective bed management will require frequent review of all inpatient admissions by senior clinical decision-makers who have the power to implement discharge plans (including the power to discharge).

9.1 Throughout the patient's admission, a multi-disciplinary care plan should be developed and maintained. The care plan should include identification of risk factors and a discharge plan including barriers to discharge. Where leave is necessary, as part of the care plan, then information given to the patient about that period of leave should be recorded. The estimated date of discharge should be communicated to the patient, their carer and to other agencies involved in their care at the earliest opportunity.

9.2 Where meetings are required to manage the discharge of patientsthought to be at substantial risk of harm to themselves or to others, then such meetings should be arranged well in advance with appropriate communication to all stakeholders.

9.3 Before discharge, patients and their carers, if appropriate, should be made aware of review arrangements and of whom they should contact after discharge should problems arise.

9.4 Consideration should be given to the involvement of Home Treatment Services for facilitated early discharge, shortly after admission, and at other appropriate points throughout the period of admission.

10.0 PERFORMANCE MANAGEMENT

10.1 Trusts in co-operation with the Health and Social Care Board have developed a performance management framework monitoring bed usage by clinical teams with analysis of diagnostic groupings, length ofstay and use of facilitated early discharge procedures.

10.2 Bed management will be improved by sharing of activity data between Trusts. A live, accessible information system is being developed to provide information across the region.

10.3 A regional network is currently established for the interaction of the Lead Clinicians and the Bed Managers/Lead Patient Flow Co-ordinators in each Trust. This will ensure that each Trust is aware of the escalation status of each other Trust on a regular basis.

11.0 INTERFACE WITH GENERAL PRACTITIONERS

11.1 It is essential that General Practitioners have a single point of access for arranging psychiatric admission. Where it is agreed betweena referring General Practitioner and a local Trust (where the patient presents) that admission is necessary, it is not the responsibility of the General Practitioner to find a bed. The Bed Manager in the local Trust has responsibility to ensure appropriate care for those with acute psychiatric needs, taking into account clinical risk factors arising in the whole of the service.

11.2 Where a patient is acutely ill and requires immediate psychiatric care, then appropriate care must be delivered. There should not be awaiting list of patients in such circumstances.

Link with Trust of origin

For patients placed out of Trust it is essential that, within 3 working days, a video link/tele link/ face-to-face contact is made with appropriate clinicians/practitioners from the Trust of origin who know the patient and are able to provide background information and inform the management plan. The purpose of this is to support the exchange information and agree transfer date or discharge plan.

It is the responsibility of the Trust of origin to initiate this linkup, *reference Appendix 3.*

Out of Trust Placement.

At the daily huddles (4pm) Monday to Thursday the Bed Flow Coordinators based on the information and bed availability will agree the appropriate Trust to be contacted for an out of Trust Placement. This will be communicated to teams within Trusts by Bed Flow Coordinators. Consideration will be given to the number of ‘out of Trust’ admissions placed in any single Trust so that the burden of responsibility is shared. On Friday’s (4pm) Bed Flow Coordinators will agree a Bed Management plan for the weekend and Bank Holidays which will be circulated by the Bed Flow Coordinators in each Trust.

12.0 REFERENCES

Bamford Review (2005) A Strategic Framework for Adult Mental HealthServices

Mental Health Act Commission (England) - *Who's Been Sleeping in MyBed? The Incidence and impact of Bed Over Occupancy in the Mental Health Acute Sector (*December 2006)

DHSSPS Promoting Quality Care: Guidance On Risk Assessment And Management in Mental Health And Learning Disability Services –Revised May 2010

Royal College of Psychiatrists - *Do the right thing: how to judge agood ward.* Occasional Paper OP79 (June 2011)

National Confidential Inquiry into Suicide and Homicide by People withMental Illness Annual Report – July 2015

National Confidential Inquiry into Suicide into Suicide and Safety in Mental Health – 2021

National Institute for Health & Care Excellence (2016) Transition Between inpatient Mental Health Settings and Community or care Home Settings. NICE

CREST (006) Protocol for the Inter Hospital Transfer of Patients and Their Records

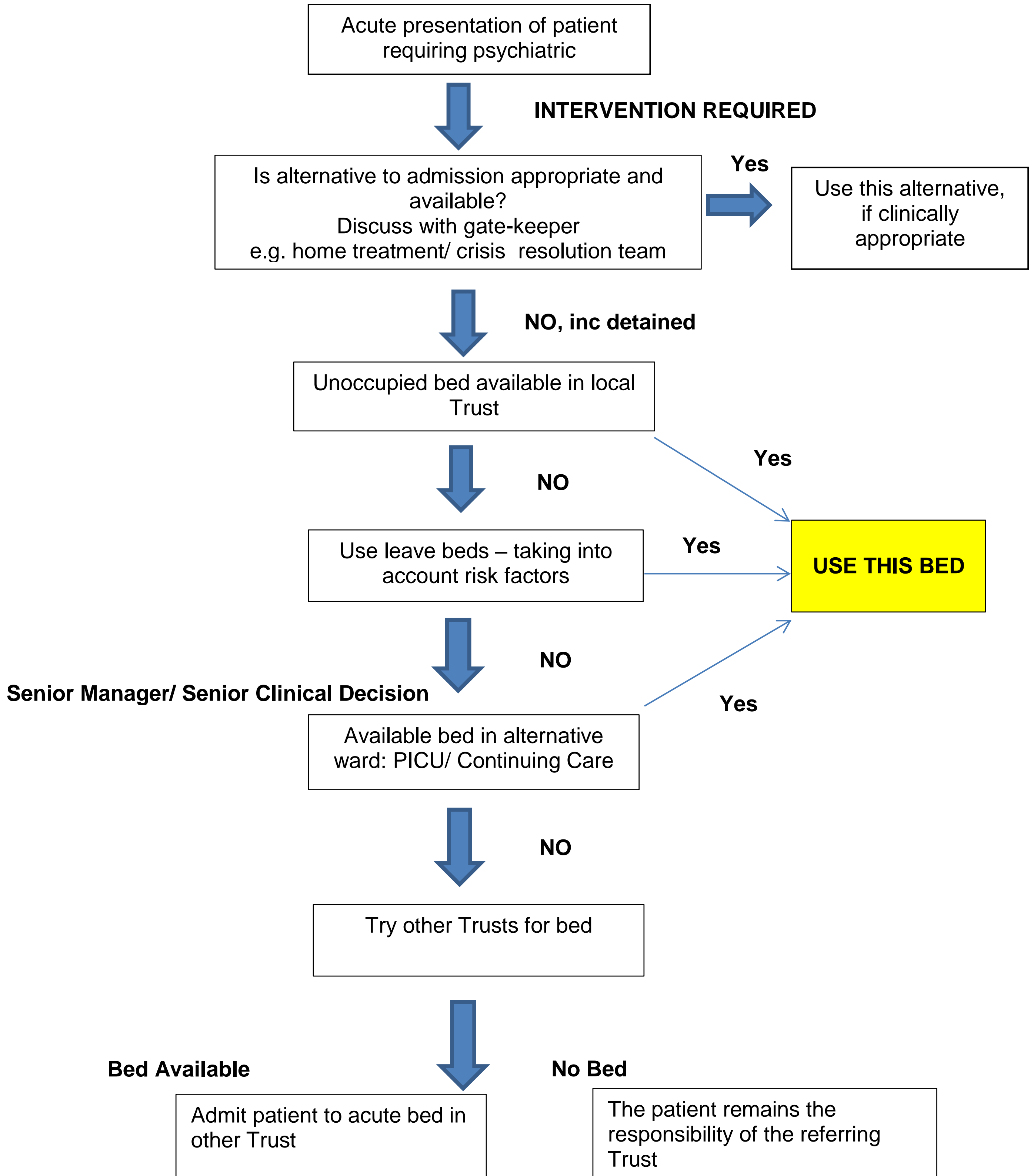
DHSSPS (2009), Guidance on the Transfer of Patients and their Records between Psychiatric Hospitals.

HSCB (2021) Regional Protocol for the Transfer of Adult Mental Health Patients between Trusts

DoH (2019) Guidance in the Transfer of Patients Detained under Mental Health Legislation between Hospitals in Northern Ireland and Great Britain.

APPENDIX 1

BED UTILISATION



Appendix 2 – REGIONAL ESCALATION PLAN

Level 1 (Green) A time when any foreseeable number of psychiatric admissions could be accommodated within bed vacancies in the local Trust. Trusts are operating within their bed capacity.

Level 2 (Amber) When a Trust has reached bed occupancy above 85% of their commissioned beds

- Issue an Amber Alert across the Trust to inform that admission beds are low;
- Ensure that Multi-disciplinary discussions are held every day from Monday to Friday to facilitate discharges and free up beds weekends (daily huddles);
- Request Home Treatment Teams to provide input/visit wards and to assess who might be discharged to home treatment;
- Use leave beds to accommodate admissions- patients on weekend leave should, where possible, return on Monday morning (not Sunday evening);
- The Regional Bed Capacity Coordinators will meet daily in the Bed Capacity huddle to explore regional contingency planning.
- Consider transfer of lower risk patients to non-acute beds to increase acute capacity

Level 3 (Red) Where significant clinical risk is so great that it is not possible to accommodate any new admissions to local Trust acute beds. Trust's may:

- Issue a Red Alert across the Trust to inform that admission beds are full;
- Ensure that Multi-disciplinary discussions are held every day from Monday to Friday to facilitate discharges and free up beds weekends (daily huddles);
- Request Home Treatment Teams to provide input/visit wards and to assess who might be discharged to home treatment;
- Consider admission to a non-acute bed (see Section 4)
- Consider admission to a vacant bed outside of the Trust area (See Section 5)
- The Regional Bed Capacity Coordinators will increase daily meetings in the Bed Capacity huddle to explore regional contingency planning.
- Create an additional space (use contingency beds) in acute wards where planned discharges are soon to occur

Level 4 (BLACK) There are no beds available. This is where measures in Level 1-3 have been utilised and continue and there is no bed available within the local Trust (including non-acute, leave, or contingency) nor planned discharges to meet demands. Trusts may:

- The Trust Director will issue an Early Alert to the HSCB
- Ensure that a Senior Manager (Band 8A or above) is involved in the management of all admission requests
- Consider use of leave beds in other Trust areas – caution is greatly advised and this must be carefully risk assessed between senior manager and consultant/consultant-on-call in both Trusts
- Patients awaiting admission may be required to remain in a place of safety or medical assessment unit until an acute bed may be allocated.

Appendix 3

Out of Area Admissions

Protocol to facilitate optimal communication between clinical teams