Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
ADULT AND OLDER ADULTS
BED MANAGEMENT

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Author/Lead **Job Title**	Antony Ladley Clinical Lead/Bed Manager
Instigated by: **Date Instigated:**	Jeanette Jones-Bragg, Service Manager Adrian Elsworth, General Manager – Unplanned Care
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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*28.06.2022*	*New Standard Operating Procedure. Approved at ODG (28.06.2022). 06/06/23 – Confirmed fit for purpose and review date extended by 2 years (Director sign off – Paula Stabler & Gemma Pearson).*

Contents

1. INTRODUCTION

The Bed management team consists of a band 7 clinical lead/bed manager, and 3 associated band 4 coordinators. It takes responsibility for all adult and older people's admissions and transfers and works 7 days a week from 08:00 hrs to 18:00 hrs.
The bed management philosophy is to care and treat local patients from Hull and East riding within the local designated provision who have GP's that come under the care of the local ICB (Integrated Care Board) area (formerly Hull CCG and East Riding CCG area).

When capacity within Humber Teaching NHS Foundation Trust (HTFT) is reached, it will take the lead in exploring resources with HTHT by closely liaising with local units, senior manager before looking for an Out of area (OOA) provision/provider.

It does not directly gatekeep admissions, as this is done following a clear rational gatekeeping discussion with the referrer and MHCIT (Mental Health Crisis Intervention team) or CITOP (Crisis Intervention team for Older people) (see MHCIT SOP).

Bed management will also keep track of all OOA admissions; capture this on the clinical systems and notify senior managers and (where appropriate) the relevant ICB.

They will attend MDT/ward reviews by video conference if this is available and take the lead in arranging any transport required on the journey to an OOA provision.

Outside of these hours of 08:00-18:00 the responsibility for Bed management will fall to MHCIT between 18:00-08:00 for all Adult working age patients.

CITOP (Crisis intervention team for Older people) will lead on all 65 years of age and older patients between 18:00-00:00 hrs. This will then be taken over by MHCIT at midnight (00:00 till 08:00) who will manage all admissions till 08:00 hrs.

Bed management will monitor the capacity of the in-patient services by collecting this data twice a day and sending the information out to senior managers, clinicians, and wards/units.

2. SCOPE

This is for all staff who deal with the daily running and procedural support of the Bed management team who work within MHCIT, CITOP substantively and temporarily via HTFT Flexible Workforce Team.

This document will support bed management delivery across a range of disciplines including administrative, clinical, operational, and corporate. This document is for those who are involved in bed management across all bandings and senior managers. This document will support delivery of bed management through engagement with external agencies, commissioning authorities and private bed suppliers.

3. DUTIES AND RESPONSIBILITIES

Bed Manager/clinical lead Band 7- Has overarching responsibly for delivery of bed management strategy on a day-to-day basis and review of this procedure. The bed manager will report directly to the service manager of MHCIT and work closely with other operational managers and matrons to enable the bed management strategy.

Bed coordinators band 4's -will support and action the procedures along with the bed manager and various delegated tasks during the day to day running of the service.

Clinical band 7's within MHCIT and CITOP will support bed coordinators in their duties, in the absence of the bed manager.

Outside of working hours (08:00-18:00 hrs) MHCIT and CITOP services will take the lead in following this procedure as per their working hours listed.

Employees
All employees will comply with this and any other associated policies and procedures.

4. PROCEDURES

This is detailed instruction which must be followed, or steps which must be taken to implement the document.

4.1. Bed capacity within HTFT

Unit Adult	**Function**	**Bed No**
Avondale Unit	Clinical decision & Admission unit	14 mixed gender (7/7)
Millview Court	Treatment	15 mixed gender (10/5)
Westlands	Female treatment	18
Newbridges	Male treatment	18
PICU	Psychiatric intensive acre	10 mixed (7 male/3 female)
STaRs	Rehabilitation	5 mixed
Unit Older Adult	**Function**	**Bed No**
Maister Lodge	Organic patients	14 mixed gender (7/7)
Maister Court	Functional Male	5
Millview Lodge	Functional Female	9

4.1.1
This procedure has been developed to ensure that beds commissioned by Hull and East Riding ICB for residents over the age of 18 years are used in ways which are flexible and organised to ensure the highest achievable standards of patient care. For over 65 years beds at Maister Lodge/Court and Mill View Lodge should be considered with the patients' needs being assessed as to need i.e., function or organic.

This SOP is to ensure there maintains a balance between demand and availability of acute treatment and assessment in-patient capacity and to ensure patients are able to be admitted to an in-patient bed managed by Humber Teaching Foundation Trust Services (HTFT) whenever possible. The allocation of a bed should be the most appropriate to the patient's needs. Staff should consider an admission to an adult unit for over 65-year-old functional patients, should the risks and needs be better met within that service. This should be needs based rather than age based and can be considered where needs can be most appropriately met in an Adult Mental Health provision.

It is the combined responsibility of the Bed management team incorporation with clinicians to ensure acute in-patient resources are used efficiently and appropriately. Possible admissions will be to the Mental Health Unit local to the home area of the service user. Bed management will liaise with CITOP if they are exploring when a patient from older services could be considered for admission to a working age unit. A clinical frailty scale can be used to support this decision as well as consideration of risk to the person on an adult admission unit. Gatekeeping discussions should be very clearly documented within clinical notes including reasons for the rational for utilising an adult admission bed and consideration of risk. If after discussion an over 65 patient is deemed not to be suitable on an adult ward, then a more appropriate bed should be sought out of area in relation to the service users needs.

In order to ensure the effective and efficient use of all acute in-patient beds managed by HTFT, Bed management following contact with all inpatient units, hold responsibility for disseminating information on bed occupancy to the necessary teams and managers. These up-to-date bed states will be shared with the Mental Health Division and On-Call leadership team (senior managers with-in HTFT -names supplied via emergency planning)) via email between 08.00 and 09:00 hrs and 16.30 and 18:00 hrs each day Monday to Sunday.

4.2. Gatekeeping

Gatekeeping, clinically remains the responsibility with MHCIT or CITOP.

The Gate keeping process (Refer to the MHCIT SOP and HBT SOP for further details)

Providing a compassionate, supportive, and least restrictive response

In the Mental Health Division of HTFT it is good practice for MHCIT to lead on the process of gatekeeping and, in the first instance HBT will be at the forefront of these decisions as ultimately, they need to decide if a community alternative is safe and viable.

Gatekeeping is the process of a clinically focussed intervention completed by clinicians in order to facilitate the most appropriate, least restrictive outcome to meet the needs of the patient. The Bed Management Team can be involved in the process in respect of balancing capacity and demand. The process is in place to ensure equity to access appropriate care in the correct setting which supports the patient, their family & carer(s).

Aim of Gatekeeping process

The primary objective for MHCIT is to minimise harms including harm to self, harm to others, harm from others and potential unintended harms from our intervention and to help support the individual in their recovery and minimise distress using a bio psychosocial model. MHCIT (See HBT SOP) can enable people to be transferred earlier from inpatient wards and receive treatment within their homes (alternative) whilst still experiencing an acute phase of an illness, high risk period or ongoing distress.

Many service users and carers prefer community-based treatment and research has shown that clinical and social outcomes achieved by community based' treatment are at least as good as those achieved in hospital. 'Intensive' home treatment can be provided in a range of settings.

Consideration of options MHCIT consider all the options available and consider work collaboratively to find the best outcome. with patients and carers to help the individual to support their recovery, promote stabilisation of mental health and address potential risk.

We recognise that complex dynamics occur within relationships and different parties can have different views on needs and care/intervention required. However, it is important to give space to patients and carers to gain a clear understanding of the needs of both.

Families & Carers

We strongly support working closely with families and carers. Obtaining information from and listening to the concerns of families and carers (where identified and consent from patient provided) are key factors in determining risk and gatekeeping the appropriate service.

For some, hospital could have a detrimental impact on wellbeing, whereas for others it may be the most appropriate option.

Care must be individualised, collaborative and based on everyone's needs, and consideration to active care or crisis management plans and Advanced Statements should also be considered in the Gatekeeping process where available. A consideration of mental capacity to understand the need and options available as part of the gatekeeping process should be also identified and recorded if required.

In some circumstances, it may be that an initial contact alone is sufficient to support the person, manage or resolve the crisis without them needing additional care. The team may agree that a short-term crisis support plan, which may develop into a more comprehensive mutually agreed management plan.

Management plans will be developed through a Multi-Disciplinary Team setting (MDT) which extends to the involvement of the patient, significant others, family, and carer (s).

The process to consider
It is good practice to contact HBT(MHCIT) early as possible when an escalation of care needs is evident for a patient. The Home-Based Treatment Team (HBT) can formulate a plan to address short term interventions in conjunction with any pre-formulated care plans that may already be in place. The aim being to promote the recovery from crisis, support the patient, family & carer(s) with the common aim of stabilisation from the point of crisis, and re-engagement with current services. This may include inpatient services and community services.

There may be circumstances where the face to face gatekeeping process is not required, as community treatment is not deemed as a viable alternative to inpatient care. Examples of these could be:

- Service users recalled on Community Treatment Orders
- Service users on leave under section 17 of the Mental Health Act (MHA) 1983
- Planned transfer of cares from Specialist Units.
- Where a Mental Health Act assessment has already taken place.
- If a Doctor has commenced the recommendations of a MHA section and then the service user agrees to an informal transfer of care. As the Doctor has already begun to carry out an assessment and has felt that formal transfer of care would be appropriate it would not be clinically appropriate for the Service User to be seen by MHCIT staff and may delay the service user receiving appropriate care and treatment.
- Planned transfer of cares for service users who are returning from out of area (their initial transfer of care will have been expected to have been gate kept).
- Planned transfer of cares for service users who are returning from a short transfer of care to the acute trust from one of our wards, where the plan was for the service user to return to the ward once treatment was completed by the acute trust.

Exceptions
In all care events, assessment of need is required however there may be some instances where this may not have been completed. In these circumstances a statement explaining the rationale for transfer of care and the reason why a face-to-face assessment was not deemed necessary should be recorded in the electronic records. This will involve a comprehensive clinical discussion between MHCIT (where possible a HBT clinician to be involved) Clinician and the referrer to ensure all options/possible outcomes have been considered, providing a supportive, compassionate and least restrictive outcome for the patient.

Outside of normal working hours
The services that MHCIT incorporating HBT offer a 24/7 service response, therefore the gatekeeping discussion and outcome formulation can fall across both parts of the service depending on time of day and requires a common-sense approach to ensure swift and timely actions are undertaken, and that patient safety is recognised. In gatekeeping formulation, a holistic and realistic outcome should be sought.

Expectations from Referral Routes:

MHLS
It is expected that a conversation between MHLS assessing clinician will occur with HBT/MHCIT to explore the reasons for referral for admission and to explore all least restrictive options, providing an opportunity to assess for HBT interventions. A further face to face gatekeeping assessment will not be required, as the patients has already been assessed by an appropriately skilled clinician, during their crisis situation. The receiving clinician should not insist on awaiting completion of all paperwork before this discussion is had, as this can cause unnecessary delays to the patient's care, identification of intervention and impact on capacity/waiting times in A&E. The patient will have completed any treatment and therefore either medically fit or expected to be medically fit for discharge when this contact occurs.

The gatekeeping triage form should be completed by the receiving clinician, ensuring all least restrictive options have been considered and the expectations of what the referral for an admission would achieve from the patient and professional perspective. If the patient is known to a treatment team, it would be expected the MHLS clinician would have had a discussion with their keyworker (in working hours) if practicable to do so, to explore escalation of care within this service before discussion with HBT or possible admission takes place. Should there be any disagreements between the clinicians, they should follow the escalation protocol.

CMHT/Psypher

Patients who are known to a key worker and under the care of the community mental health team often present with escalating needs in the days leading up to an admission. Should the needs of the patient become more intensive, or concerns are expressed by family/carers, it would be expected the for the key worker or duty clinician (if the key worker is unavailable) to contact HBT to discuss the escalating situation, following their own review of the patient and situation. A planned joint face to face review can be planned with the HBTT, CMHT, patient & family, in the coming days to determine a collaborative plan of care, identifying the least restrictive options first, but with parameters agreed for further escalation to admission if required. There may be more than one joint meeting which occurs during this time of increased need and acute presentation.
The gatekeeping triage form should be completed by the receiving clinician, ensuring all least restrictive options have been considered and the expectations of what the referral for an admission would achieve from the patient, family, and professional perspective. The key worker (or duty clinician) would be responsible for updating the FACE risk assessment, cluster tool, ReQoL and the care plan (as required) and this should be reflective of the current level of need and presentation.

Service User known to services but no keyworker

Patients who are known to services such as DBT/liaison psychiatry etc but have no identified key worker should be referred to the MHCIT for a possible crisis assessment. The MHCIT will take a referral from the referring person and organise for a triage of their needs as a crisis response. Once the triage has been completed, normal processes within the MHCIT SOP, however this should include involvement of the referring clinician where possible.
If the patient has received a crisis assessment, the MHCIT clinician should discuss with HBTT the outcome of the assessment for a gatekeeping triage (if outside of normal hours of work for HBT, MHCIT would be responsible for completion of this document).

Any exceptions will be considered on a case-by-case basis for services with a specialist remit (see also HBT SOP).

PCMHN

Patients known to PCMHN should be escalated to the CMHT as their needs increase, for a higher level of intervention to take place. If there has been no evidence of escalation in care needs and the patient is presenting in crisis, the PCMHN should discuss with HBT to determine an appropriate way forward and formulate the least restrictive options of care provision.
If it is determined that HBT cannot safely manage the patient needs and an admission may be required, the MHCIT should complete a crisis assessment to determine the patient needs, ideally with the key worker of the PCMHN if possible.
If the patient has received a crisis assessment, the MHCIT clinician should discuss with HBTT the outcome of the assessment for a gatekeeping triage (if outside of normal hours of work for HBT, MHCIT would be responsible for completion of this document).

Others

If a patient is unknown to services or has no open referrals, they should follow the MHCIT SOP pathway for assessment.
If the patient has received a crisis assessment, the MHCIT clinician should discuss with HBTT the outcome of the assessment for a gatekeeping triage (if outside of normal hours of work for HBT, MHCIT would be responsible for completion of this document).

MHA
If a patient has been assessed under the MHA (including Section 136 assessments) , or has a CTO recall in place, the HBTT/MHCIT clinician should completed the gatekeeping triage to reflect the outcome of the assessment and identification of the admission.

4.3. Monitoring Bed Availability
The Bed management team will keep a daily record of bed states, leave beds, and patients who are out of area for each ward/Unit (appendix 3).

These bed states take 2 forms of a word document and a excel spreadsheet. While they should always correspond, they do capture ~~slightly~~ different information. Emergency planning will update bed management on who requires a Spreadsheet, and a contacts list is saved. The word document captures the format in a slightly different way and can be expanded on in narrative if required. This is sent to MHCIT and CITOP along with the units on the list.
If colleagues require both documents this is acceptable, and they are added on to the contacts saved in Bed management email.(hnf-tr.humberbedmanagement@nhs.net)

Bed management receive daily emails on capacity from major providers across the country. This is monitored in case OOA beds are needed and what the national picture is for capacity across the private sector.

4.4. Leave beds
In general leave beds can be used, however it is the duty of the MDT of the unit/ward at the point of authorising leave to determine the likelihood of the risks of leave breaking down, and to ensure appropriate safety plans are in place.

Section 17 beds may be used for new admissions, but staff must be confident that the detained patient on Section 17 leave will be able, if necessary, to return to the same ward at short notice.

AWOL beds can be used but only during periods of extreme demand. The rationale for doing so and not doing so must be clearly documented. In hours the decision to use an AWOL bed will be made by the Inpatient Consultant and Unit Manager (or their nominated Deputy) in consultation with the Multi-Disciplinary Team (MDT). Out of hours the decision will be made by the On Call Consultant and/or the On Call manager in consultation with the nurse in charge of the ward.

4.5. Discharge planning and transfers back to HTFT
When capacity within HTFT allows for patients to be repatriated, this should be done at the earliest opportunity. By attending and keeping in touch with OOA placements (as minimum once a week), this will allow any issues relating to risk to be fully explored before transfer commences. Bed management will always ask for a unit/ward to unit/ward clinical discussion to take place before this is agreed. Although this can prove disruptive to the service user's care, it remains the preferred option, with service users being discharged from their local unit benefiting from closer involvement of carers and community services and more co-ordinated discharge planning.

Following MDT reviews of patients on wards/units, they will take the lead in any discharge planning. The wards/units will notify bed management at the earliest opportunity of impending plans of discharges of when or if they occur so that any forward planning of transfers or necessary admissions can take place.

If a patient is in an out of area placement (OOA) and there is no designated follow-up, bed management will take the lead in this and make sure this is allocated within the bed management staff; to enable any further interventions if they are required. This will take place within the 3 day follow up requirement.
By attending reviews by either video conferencing or by other means of keeping up to date with OOA patients, the bed management team will ensure that, if they are open to a CMHT or relevant service, there are informed of this happening, and they will be forwarded details of where their patients are. This will enable that any aftercare follow up. The out of area placements will also be

made aware of any CMHT involvement, so that they can notify the care coordinator within the CMHT.

4.6. Out of area admissions to HTFT

If a patient from another NHS trust is assessed within our local area by local services and bed management are made aware that a possible in-patient care is required, then it is the responsibility of the assessing clinicians to make the home area aware that a in-patient bed is required.

If there was no capacity within the home area a request should come to bed management to fully explore this issue; to look to see if authorisation is given to find a suitable in-patient provider in the private sector.
If there is capacity with HTFT this can be considered by looking at the current demand being experienced. If this is found to be manageable and within capacity this can be considered and the NHS area for the patient should be notified and a plan to repatriate at the earliest opportunity.

If the patient has moved from their local area to within HTFT area and their social support is now in this area, a clinical discussion with the home area should take place where the patient is put first in terms of their recovery. If it is found that it is now in the patients' best interests to remain with HTFT area, this should be agreed and clinically recorded. The patient when they are able, should be encouraged to register with a local GP.

Requests for beds from neighbouring Trusts will only be considered if there are sufficient beds (below 85% capacity) for the patients of HTFT. Careful consideration must be taken before allowing the last bed available to transfer an OOA patient back into the local area. If this request is within working hours, it will be led by the bed management team with the band 7 clinical lead Bed manager taking the lead. In the absence of the bed manager any discussion will be led by the clinical leads within MHCIT or CITOP (band 7's, with support from the coordinators of each service (band 6). Out of hours the clinical leads within MHCIT and the coordinator of MHCIT will lead on this process

4.7. Funding arrangements when required for OOA patients

When OOA in-patient care is required due to no capacity within HTFT, the funding arrangements are as follows.

For working age adults (18-64) HTFT is responsible. Appendix 2 is used to notify senior colleagues that this happens. A DATIX is also required.

For Older adults (age 65+) and for patients requiring PICU (Psychiatric Intensive care Unit) the current arrangements are that this is funded by the relevant for the area is registered to via their GP i.e. Hull or East Riding. Appendix 1 notifies the relevant ICB and a DATIX is required.

The relevant ICB will fund an OOA placement when it is a front-line staff member of HTFT, or there are safeguarding issues, when the only alternative may be to admit OOA, or when a patient is admitted away from the local HTFT and we were not informed. Appendix 2 is required.
The standard for notifying senior managers and the relevant ICB is within 24 hours.

An Out of area spreadsheet is maintained. This captures essential information and demographics. It is located on the V drive V:\ Mental Health services\ MHCIT &MHTAT\Shared\Bed management\OATS Spreadsheet\ 2021 OATS Data Entry

4.8. Reserving beds and CTO recalls

Beds should not be reserved for patients unless the patient is on route or a bed has been allocated for a CTO (Community Treatment Orders) recall.
If there is a CTO recall that needs a in-patient facility identifying; they by default if capacity allows, should go straight to a treatment unit. If capacity at a treatment unit is full, then the Clinical decision unit for working age adults can be considered if capacity allows.

The CMHT's should email the bed management email address (hnf-tr.humberbedmangement@nhs.net) when they identify a patient needs to be recalled. Bed management will require the name, gender, NHS number, Responsible clinician and a brief description of the concerns and breaches of the CTO, so that bed management can have a starting point over discussions of priority. This will be acknowledged by email and/or further discussions as to where the placement is identified.

4.9. Transfers

To enable flow between the units/wards patients may need to be transferred. Staff within bed management are fully DMI trained and can support the wards if capacity allows to enable this to happen.

4.10. Disputes resolution

If there is any dispute over admission when a bed is available, this should be referred to the Service Manager/On-Call Manager or Modern Matrons for further advice and support. Where there are clinical concerns the Consultant Psychiatrist for the service or On-Call Consultant Psychiatrist can and should be consulted for further advice.

4.11. Referrals for patients detained under part 3 (criminal justice system) of the Mental Health Act.

Patients in a prison setting with mental health concerns and who may require an in-patient setting for further assessment and/or treatment. They would need to be transferred under the Mental Health Act (part 3). By default, due to security required, if this came to bed management it would likely be a PICU (Psychiatric Intensive care Unit) that would be required. If this is required, the pathway is that NHS England would contact ourselves to make the referral and the dedicated email address is england.hcvreferral@nhs.net. Bed management would take the lead in arranging and liaising in this regard, and if in-patient services were required, would join, and monitor the progress to see if the patient needed further transfer to acute services or return to prison.

4.12. Section 140 Provision

Section 140 is referred to in the Mental Health Act 1983: Code of Practice as the following "Clinical commissioning groups (CCGs) are responsible for commissioning mental health services to meet the needs of their areas. Under section 140 of the Act, CCGs have a duty to notify local authorities in their areas of arrangements which are in force for the reception of patients in cases of special urgency or the provision of appropriate accommodation or facilities specifically designed for patients under the age of 18. The arrangements should include details of which providers in their area can receive patients in cases of special urgency and provide accommodation or facilities designed to be specifically suitable for patients under the age of 18. CCGs should provide a list of hospitals and their specialisms to local authorities which will help inform AMHPs as to where these hospitals are. This should in turn help inform AMHPs as to where beds are available in these circumstances if they are needed."

4.13. MAPPA

Bed management supports HTFT in identifying any patients admitted that are eligible for (Multi-Agency Public Protection Arrangements) MAPPA.

Bed management supports the first stages, in identifying anyone who may be eligible by sending MAPPA names and date of birth of all patients admitted daily. These are received by email from Trust headquarters and passed to MAPPA by secure email.

If patients are MAPPA eligible and they are still in-patients, the designated unit where they are currently, is notified and are asked to fill in form (i) and send this to MAPPA. (see appendix 5)

5. REFERENCES

Department of Health (2015). Mental Health Act 1983: Code of Practice. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF.

Appendix 1: ICB notification form

Out of Contract Adult Mental Health and Learning Disabilities
Emergency care package request form
(Out of hours only)

1. Referring Clinician	**GP/Consultant Name:**	
	GP Name (if different to referring clinician)	
	Practice/Hospital name and address:	
	Current care Co-ordinator	
	Tel:	
	Email:	Hnf-tr.humberbedmanagment@nhs.net
2. Service Users Details	**Name:**	
	NHS number:	
	DoB:	
	Home Address:	
Current clinical diagnosis and legal status and presenting risks. Also include Diversity issues and any interpreter requirements		

Reason for out of area package. Please note if PICU or general acute ward is needed.	
Exit Plan eg. Agreed date for follow up and a repatriation plan back to provider service with time scales. This to include monitoring arrangements.	Bed coordinator will update and keep in contact with out of area providers.
Proposed Care Package and associated costs	
Proposed duration of Care Package or Placement (this will only be supported initially for 14 days). Thereafter a further extension request will have to be made with greater clinical detail and rationale for continued need and evidence of review.	
Transport company and agreed cost of transfer	

Name of on call manager (BLOCK CAPITALS) and signature

Date and time of approval

N.B it is accepted that this form will be filled in retrospectively but it should be submitted no later than the close of business on the first working day post placement.
SEND TO:
HULLCCG.VPT@nhs.net **Confidential, Vulnerable People Team,** NHS Hull Clinical Commissioning Group,2nd Floor, Wilberforce Court, Alfred Gelder Street,Hull,HU1 1UY
Or for East Riding
v.wilkinson-cunningham@nhs.net

Appendix 2: Out of area acute mental health emergency admission notification form

Date and time of bed search	
Date of admission if different	
Service User Name	
Gender	
Date of birth	
Address	
Lorenzo Number	
NHS Number	
CCG, i.e. Hull/ER	
Care Coordinator or needs allocating(NA)	
GP name and address	
Out Of Area ward/ Hospital	
Contact name/number of out of area ward and Hospital	
MHA status	
Diagnosis, if known	
NHS/Private out of area Hospital	
PICU /ACUTE	
Reason for OOA, i.e.: local bed not available/Staff	
Cost per bed day	
Transport used	
Agreed cost of Transport (if applicable)	
Completed by:	

	Yes	No
Gatekeeping completed	☐	☐
Local units checked for beds/HBT options exhausted	☐	☐
Regional beds check	☐	☐
NHS bed search completed before considering private hospital (all boxes are Yes but unable to do this electronically)	☐	☐

Complete Datix and email form to -
paul.johnson13@nhs.net
adrian.elsworth@nhs.net
jjones-bragg@nhs.net
hnf-tr.humberbedmanagement@nhs.net

Appendix 3: HTFT Bed States word document.

HUMBER TEACHING NHS FOUNDATION TRUST BED STATE AND PATIENT FLOW RECORD

Mental Health Bed State

Date: Time: hrs

Out of area Beds currently contracted to Humber - The figures **below** are included in the overall figures **above**

Ward	Actual Patients on unit	Vacant Beds	Patients on Leave	Planned Discharges (In next 5 days)	Number of patients admitted (Total)	Staff Spoken to
Newbridges Adult Treatment Unit (18 Male) Tel No. 335834 or 335835						
Westlands Adult Treatment Unit (18 Female) Tel No. 335647or 335646						
Mill View Court Adult Treatment Unit (5 Male, 5 female & 5 fluid) Tel No. 344539						
Avondale Mental Health Clinical Decision Unit (14 Mixed –7/7 Tel No. 617565	M – F –	M = F –	M – F –	Planned transfers M – F –	M – F –	
PICU (7 male & 3 female) Tel No. 617508	M – F –	M – F –	M – F -	**Waiting Step-Down** M – F –	M – F –	
Mill View Lodge OPMH 9 bedded functional unit. (9 female) Tel: 344537						
Maister Court 5 Functional Male Tel: 738142						
Maister Lodge OPMH (Organic) (7 male/7 female) Tel: 303794 or 303775	M – F -	M – F –	M – F –	M – F –	M – F -	
STaRS@Beech ward Tel: 336830	M - F -	M/F – 0 (Direct admissions will not be considered)	M – F –	M – F –	M – F –	

Out of Area	Adult Male acute	Adult Female Acute	Male PICU	Female PICU	Organic awaiting Maister Lodge	Functional awaiting Mill View Lodge
					M – F - 0	M – F – 0

Ward	Actual patients on the ward.	Vacant beds.	Patients on leave.	Planned discharges in next 5 days.	Total number of patients admitted.
Navigo Grimsby (Older age) 01472 256256 Opt 3	**M/F =**	**0**	**0**	**0**	**M –**

Appendix 4: Out Of Area Checklist - Acute/PICU/Older Adults

1. Has gate keeping taken place? Y/N

2. Check with relevant units that there is no bed
Y/N

3. Get the up to date Risk and Mental State Assessment, and up to date clustering score ready for sending Y/N

4. Begin search for bed using phone contacts in sop Y/N

5. Gain permission from senior manager if
Placement agreed. Y/N

6. Fax or email up-to-date Risk and Mental State Assessment and clustering Score with front sheet with our details. Y/N

Bed Located

1. Inform requesting practitioner that a bed is located, location and contact details of accepting hospital. Y/N

2. Inform accepting hospital of Humber Bed Management contact details
Y/N

3. Establish transport requirements to include acuity and safe staffing for transportation. Y/N

For informal patients always look at the use of YAS on 0300 330 0295 and give details of what is required for safe transport, if need is greater or safe transport is required sooner than can be provided by YAS seek private firm .

4 Where possible obtain consent from the service user for out of area Placement (CCG and NHS Digital forms) if unable document reasons Y/N

5. Establish address and postcode of receiving hospital facility Y/N

6. Inform requesting practitioner projected time of arrival of transport. Y/N

7. Fill in OOA form and email along with all assessment paperwork to relevant CCG Y/N
Hull service users need to be sent to Andrea Pounder (HULLCCG.VPT@nhs.net)
East Riding service users to be sent to Verity Wilkinson-Cunningham (ERYCCG.Contractmailbox@nhs.net)

8. Place all OOA information in Bed Managers tray in the office. n/a citop Y/N

9. Place service user details on OAT white board in the main Bed Management office. N/A Citop Y/N

Appendix 5: Identification of MAPPA offenders Notification process

For queries regarding MAPPA Eligibility, the Lead Clinician will e-mail SPOC Box with brief details of patient. Contact: SPOCMAPPA@humberside.pnn.police.uk Tel: 01482 578177

Please could you include the following details; this should be enough to allow the police to search for the patient on their systems;

- Name
- d.o.b
- address (current / last known)
- aliases

MAPPA Team will confirm MAPPA eligibility on e-mail under category 1 or category 2.

For Non MAPPA Eligible Patients - Staff are advised to request criminal conviction information via the Mental Health SPOC Box SPOCMentalHealth@humberside.pnn.police.uk should they require this information for the purposes of risk assessment and management.

Patients admitted to hospital through the Criminal Justice Route

MAPPA I (Notification of MAPPA Eligible Detained Patient (Mental Health) should be completed and sent to the following secure MAPPA SPOC e-mail address;

SPOCMAPPA@humberside.pnn.police.uk

The MAPPA Unit will review all MAPPA I's and complete Part 5 of the Form I and return to the Responsible Clinician.

As a statutory requirement, all MAPPA offenders should be identified by mental health services, including private and independent section providers, within 3 days of sentence. admission or transfer to hospital through a criminal justice route

When the patient is moved to another team or unit, it would be the responsibility of the receiving team or unit to update the Form I.

This is the **Accepting Nurses responsibility**

For Inpatient admissions and MAPPA eligible patients treated in the Community / Acute Mental Health Inpatients

MAPPA (i) Community / Acute Mental Health Inpatients Form should be completed and sent to the following secure MAPPA SPOC email address;

SPOCMAPPA@humberside.pnn.police.uk

The MAPPA Unit will review MAPPA (i) Community / Acute Mental Health Inpatients Form and complete Part 5 and return to the Lead Clinician.

If you would like further information regarding the MAPPA process or wish to make a referral to MAPPA, please do not hesitate to contact; **Chris Brookes, MAPPA Co-ordinator on 07840000598 or 01482578324** Chris.brookes@justice.gov.uk

Storage of MAPPA Information

A MAPPA Information clinical note has now been created in Lorenzo. Please can all staff ensure that this clinical note is used when adding MAPPA information to Lorenzo.
For any specific risk information that needs to be recorded, the Lorenzo Alerts procedure should be followed. This can be found at https://intranet.humber.nhs.uk/lorenzo-alerts-procedure.htm and has a section on MAPPA alerts.

When adding MAPPA minutes or the MAPPA I / MAPPA (i) to either system, please add a note to the document stating, "Take care on disclosure – third party information" so that it is clear to any health professional sharing information (including a Subject Access Request) contained within the Minutes, MAPPA I and/or MAPPA (i) should not be shared without the permission of the MAPPA Co-ordinator / MAPPA Chair.

Please refer to: MAPPA Protocol for Managing Mentally Disordered Offenders (Prot523) available on the intranet for further details

Appendix 6: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. **Document or Process or Service Name:** Adult and Older Adult Bed Management
2. **EIA Reviewer (name, job title, base and contact details):** Jeanette Jones-Bragg, Service Manager, Miranda House, 01482 301701
3. **Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?** SOP

Main Aims of the Document, Process or Service
To ensure there maintains a balance between demand and availability of acute treatment and assessment in-patient capacity and to ensure patients are able to be admitted to an in-patient bed managed by Humber Teaching Foundation Trust Services (HTFT) whenever possible. The allocation of a bed should be the most appropriate to the patient's needs.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	Significant efforts are made to support patients, considering their individual needs when allocating a bed for any patient.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	The Trust is committed to protect human rights and freedoms, and to protect those who have particular protected characteristics under the Equality Act 2010. The allocation of a bed will be the most appropriate to the patient's needs, which includes any disability.
Sex	Men/Male Women/Female	Low	The allocation of a bed will be the most appropriate to the patient's sex/gender needs
Marriage/Civil Partnership		Low	Applicable regardless of partnership status
Pregnancy/ Maternity		Low	The allocation of a bed will be the most appropriate to the patient's needs, this may include an out of area bed which can meet the needs of a pregnant patient.
Race	Colour Nationality Ethnic/national origins	Low	It is acknowledged that for any patients whose first language is not English, staff will follow the Trust Interpreter Policy.

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The allocation of a bed will be the most appropriate to the patient's needs.
Sexual Orientation	Lesbian Gay men Bisexual	Low	The allocation of a bed will be the most appropriate to the patient's needs.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	The allocation of a bed will be the most appropriate to the patient's needs including gender reassignment.

Summary

Please describe the main points/actions arising from your assessment that supports your decision. The standards and principles in this document uphold the principles of the Equality Act 2010 and by following the Gatekeeping process which is a clinically focussed intervention completed by clinicians in order to facilitate the most appropriate, least restrictive outcome to meet the needs of the patient. The Bed Management Team can be involved in the process in respect of balancing capacity and demand. The process is in place to ensure equity to access appropriate care in the correct setting which supports the patient, their family & carer(s).
EIA Reviewer: Jeanette Jones-Bragg
Date completed: 26/07/2022 | Signature: JJones-Bragg