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Bed Management Policy

Aim

Admission to hospital may sometimes be necessary as part of a person's treatment and recovery to facilitate their care and provide a safe environment. This can be a stressful experience for the person involved, their family or carers and every effort is made to ensure that the admission is supportive and aimed towards recovery, maintaining the person's privacy and dignity throughout.

The purpose of this policy is to provide a clear framework for staff on the procedures for arranging inpatient admissions, setting out clear guidance in situations where there is a shortage of available beds within local services. The general principles of effective bed management and UHB Policy are set out in this document for all patients needing admission.

The underlying principle of this policy is that all patients requiring urgent admission to hospital, including admissions in situations of special urgency for the purpose of s.140 of the Mental Health Act, will be found a bed in the service.

The Discharge Process for all patients should begin on admission. The UHB is committed to providing safe, coordinated and timely discharge for those service users admitted to our 24-hour sites.

Objectives

This policy covers all areas of guidance to effectively manage capacity and flow for emergency and planned admissions Aims of the Policy:

- To ensure that all patients have a safe and timely admission
- To ensure that there are clear standards of practice in place to support admission to hospital
- To provide clear guidance and expectations in relation to the purpose of admission
- To ensure that the processes allow for working in collaboration with other statutory and non –statutory organisations
- To minimise variation in patient experience
- To minimise the occurrence of 'Delayed Discharge'

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- To offer guidance for the effective transfer of patients from one clinical area to another, both within and outside of the UHB

Scope

- This policy applies to all UHB staff and the management of admissions to either an acute or older adult bed within the Mental Health Clinical Board.
- It describes roles and responsibilities and how beds will be managed considering the safety of patients and staff along with patient experience.
- It will ensure communication between all parties involved in the process is clear and promotes optimum access to beds, providing timely and appropriate care and treatment to patients.

Equality Health Impact Assessment	An Equality Health Impact Assessment has been completed. The policy is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the policy and bed management. There is nothing, at this time, to stop the policy from being implemented.
Documents to read alongside this Policy	<i>Mental Health Act 1983, Code of Practice for Wales, Revised 2016</i> - Mental Health Act 1983: code of practice GOV.WALES <i>Mental Capacity Act 2005, Code of Practice</i> - Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk) <i>Responsible Authority Guidance</i> - Responsible Authority Guidance (gov.wales)
Approved by	

Accountable Executive or Clinical Board Director	<i>Mental Health Clinical Board</i>
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Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the [Governance Directorate](#).

Summary of reviews/amendments			
Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	<i>01/09/2024</i>		<i>New Document</i>

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1. Introduction

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Cardiff and Vale UHB are responsible for commissioning mental health services to meet the needs of those deemed to be resident in the area, or in cases of section 136 where the body lies. [Responsible Authority Guidance \(gov.wales\)](https://gov.wales)

This guidance has been produced to inform staff of their duties and responsibilities when sourcing a bed.

2. Duties and responsibilities

Chief Executive - has ultimate responsibility to ensure that procedures are in place for the overall implementation, monitoring and revision of this policy.

The Chief Operating Officer is the executive Director responsible for this policy, but will delegate authority for the operational implementation and on-going management of the policy to Director of Operations.

Director of Operations, Mental Health Clinical Board has a key role in providing business development support to the Directorate and Clinical Board. The post holder is responsible for the management of non-clinical staff in the Directorate ensuring staff are managed in line with the UHB's employment policies

The Director of Nursing has overall strategic responsibility for this policy in addition to ensuring that the procedures and processes for implementation are embedded.

The Clinical Directors are responsible for overseeing the implementation of the procedures and processes detailed in the policy.

Service Managers and Ward Managers are responsible for ensuring all staff are conversant with this policy and related policies and procedures.

Crisis Response and Home Resolution Teams (CRHT's) are responsible for gatekeeping all admissions

All staff (In- Patients and Care Coordinators) caring for patients should be familiar with the procedures detailed in this document. The Mental Health Clinical Board is responsible for the monitoring and implementation of this policy including review audit/review reports and the progress of any actions plans developed due to non-compliance

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3. The Shift Coordinator

The Shift Coordinator is responsible for negotiating and arranging all referrals, admissions and transfers. They will:

- Maintain and regularly update the bed management module on PARIS
- Ensure beds are used effectively, considering any risk factors that might indicate a bed is required for admissions of “special urgency” for the purpose of s140 of the Mental Health Act (see section 25)
- Ensure that all bed management activity is communicated effectively.
- Adhere to the locality principle where possible.
- Work closely with Crisis Teams, Mental Health Liaison Teams, Duty Teams, Rehabilitation and Recovery Teams and Wards.
- Check GP details, address of patients and their catchment area (Reference: [Responsible Authority Guidance \(gov.wales\)](#) and refer to section 26: ‘Patients from Out of Area.’
- Maintain good working relationships with the Police
- Identify a bed for all patients who require admission or delegate to appropriate person within CAV UHB.
- Follow procedures in relation to use of leave/AWOL beds

MHSOP shift co-ordinator

- During Monday to Friday 9:00-17:00, the MHSOP shift co-ordinator works in parallel with the directorate team and patient flow manager to co-ordinate admissions. This may include identifying patients to transfer to accommodate admissions. However potential moves must be discussed with clinical teams prior to transfer.
- Outside of these hours, the role of patient flow defers to the MHSOP shift co-ordinator and during night shift, the Adult Shift Co-coordinator. Please refer to the MHSOP section 9 of this policy “**Role of Shift co-ordinator as MHSOP Bed Manager Out of Hours**’.

4. The Patient Flow manager

The Patient Flow Manager is responsible for managing patient flow across the unit. They will:

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- Coordinate timely and efficient flow of care for patients, throughout their inpatient journey.
- Work towards eliminating barriers to timely transfer of care
- Facilitate flow through the local system
- Ensure regular and timely interactions with teams and organizations within mental health and when applicable, within the private sector.
- work with colleagues in the directorate and other partner organisations to develop clear pathways of care for in-patients with mental health needs.
- Attend daily bed management meetings to give an overview of the current bed situation and review those in out of area placements

5. Bed Management

Adult Mental Health hold a daily bed management meeting. It is the expectation that all areas contribute to this meeting. During occasions of increased pressures, the frequency of this meeting may be increased. The purpose of this meeting is:

- To review the bed capacity across the UHB.
- To review all pending referrals and projections.
- To confirm future bed availability across the UHB.
- To discuss all patients in out of area beds.
- To review all patients who have been assessed and referred for a treatment bed from the Assessment Ward and PICU.

All outcomes from this meeting are to be documented and saved on the shared drive.

MHSOP hold weekly huddles that may be increased during times of increased pressure.

6. The Assessing Team

Members of the Assessing Team may include the following:

- AMHP
- On call doctor
- Section 12
- Crisis Team

7. Emergency Assessment Suite (EAS) Assessment

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If in attendance the crisis team are responsible for identifying a bed and completion of all relevant documentation. The completion of the relevant documentation should include information provided by the assessing team.

If the crisis team are not in attendance the Consultant/SPR is responsible for completion of relevant documentation. This process should be supported by information provided by the assessing team.

8. Community Assessment

If in attendance the Crisis Team/community team involved with the service user are responsible for identifying a bed and completion of all relevant documentation. The completion of all relevant documentation should include information provided by the assessing team.

If the Crisis Team/community team involved with the service user are not in attendance discussions should take place with the Shift Coordinator to agree the most appropriate clinician to source the bed. This could include members of the Community Mental Health Teams. There is no expectation for the AMHP/Social Worker to identify the bed.

9. Sourcing a bed within the Mental Health Clinical Board

Adult Acute Hafan Y Coed

- HYC Shift Co-ordinator is on duty 24 hours a day 7 days a week and is responsible for sourcing an inpatient bed.
- Adult Shift Co-ordinator is also responsible for supporting with MHSOP admissions between the hours of 8pm and 7am.
- In certain circumstances the Shift Coordinator may delegate the sourcing of a bed to a colleague within the UHB, for example the CRHTT. This delegation MUST be accepted by the relevant team and communicated to the AMHP.

The Consultant/SPR, as a member of UHB staff, is responsible for documentation relating to the clinical assessment and need for admission if the CRHTT are not in attendance.

9.1 MHSOP +65 & YOD

- Admissions wards E10-E18 University Hospital Llandough and St Barrucs Ward, Barry Hospital.

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- MHSOP aim for all admissions to MHSOP beds to take place within working hours.
- Any clinician in MHSOP can request an MHSOP bed by submitting a bed management form to the directorate management team (Lead Nurse/Clinical Director/directorate Manager/Senior Nurses/Patient Flow via email.

MHSOP Bed Managers

MHSOP Bed Managers working hours are 09:00hrs – 17:00hrs, Monday – Friday and they can be contacted as follows:

- UHW switchboard
- Vocera – MHSOP Senior Nurse/ MHSOP Deputy Nurse/ MHSOP Lead Nurse

Process for applying for an MHSOP bed

- During 9-5 all requests for MHSOP admission from GP will need to be made to the community mental health team via SPOE, the GP line/Duty/111P2 all feed into SPOE. The community team then complete an assessment and if they believe and admission is indicated they request a bed using bed management form. Admissions can be avoided using the REACT teams and Day Hospital.
- All urgent bed requests need to be followed up with a phone call to the directorate or MHSOP Patient Flow manager or MHSOP shift co-ordinator. The directorate team and Patient Flow manager will work alongside the MHSOP shift co-ordinator to identify a bed and communicate this to person requesting the bed.
- Blank Bed management forms are available from the directorate. The completed bed management form is saved in the S=Drive for audit purposes
- No fixed abode patients are allocated to consultants via a rota system. Directorate admin or medical secretary will be aware of this rota.
- The admitting clinician must provide full and detailed verbal handover to the nurse in charge. This must take place in every admission situation, in order for the admitting clinician to discharge their duty and responsibility for holding risk. This includes relevant information about risk.

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MHSOP Bed Management List

- Patients on the bed management list are prioritised based on individual clinical risk, the location of the patient is and their social situation is considered. This is why it's important to include detailed information about risk so the directorate can prioritise the patient with the greatest need. The form must also specify if the admission is urgent/special urgency.
- Patients on the waiting list are added to Bed Management Form on Teams Channel.
- The bed management list is reviewed regularly it is very important that clinicians keep the directorate updated about patients they have on the bed management waiting list and remove them if they no longer need to be on the list. The waiting list forms part of clinical risk escalation. It is important it is accurate.

Role of Shift co-ordinator as MHSOP Bed Manager Out of Hours

- Mhsop Shift co-ordinator covers these out of hours:
Monday to Friday 17.00-19.00
Saturday/Sunday 07:00-19:00
- 19:00-7:00 Adult Shift Co-ordinator is responsible for MHSOP admissions.
- Shift Co-ordinators fulfil the duty of MHSOP bed manager out of hours.
- MHSOP shift co-ordinator on duty can be found on ROTA WATCH via Share Point. Please contact the ward directly. If you don't have access to ROTA WATCH the Shift Coordinator in Hafan Y Coed will be able to provide contact details for the MHSOP Shift Co-ordinator.
- When taking details for admission the MHSOP shift co-ordinator is expected to take the patient's name, date of birth and the referrer's contact details and advise the referrer to complete bed management waiting list form and send it to them via email. The MHSOP Shift Co-ordinator forwards this to directorate team for audit purposes.
- Shift co-ordinator searches for patient on PARIS to establish if they are eligible for MHSOP. e.g. do they reside in C&V? they are open to MHSOP (refer to AMH

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to MHSOP transition policy). If they are not on Paris and over 65 they belong to MHSOP.

- If OOH GP is requesting admission, shift co-ordinator must check the GP has ruled out physical health and completed relevant tests e.g. bloods, urine dip, physical examination. They must have reviewed the patient clinically. If there is a possible physical cause, advise GP to admit to MEAU/AU/general ward. This department can then make an onward referral to Liaison Psychiatry Older People (LPOP). Support and advice is available via in reach SHO or Consultant on call.
- For patients in the community being referred by GP OOH, if all physical health has been ruled out and the cause is likely to be a mental health issue, consider the level of risk and whether the situation could be made safe until REACT/community can assess.
- If the risks are unmanageable in the community and an MHSOP admission is the only option, check the person is consenting. If they do not consent or lack capacity to decide the requesting GP should in the first instance consult with the oncall SPR. Following discussion and if in agreement the GP/ SPR should refer to EDT to request a Mental Health Act Assessment. The AMHP may wish to further consult with the SPR before agreeing to undertake the assessment.
- Prior to referral for MHA assessment, if the community team believe an admission is likely OOH, they need contact the Shift co-ordinator to source a bed, once the shift- co coordinator has identified a bed, the community team then contact the ward nurse in charge and provide verbal handover. The team are also required to update the shift coordinator once they have referred for MHA assessment. The shift coordinator will then update nurse in charge.
- If consent is given with capacity, admit to the appropriate ward.
- This may require patients to be moved to accommodate an admission. When moving patients consider their needs, risks and whether they are under Court of Protection. If the move will unsettle affecting discharge they must not be moved. Please refer to the list of patients who must not be moved.

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- If there are no available beds consider flexing wards up.
- If all flex beds have been used, ring the shift co-ordinator in HYC to consider admitting to an adult acute bed.
- MHSOP shift co-ordinator to contact Silver on Call for authorisation for OOA and transport. Silver on call will also need to escalate to the executive on call.
- If a medical ward is attempting to admit a patient out of hours; inform the ward referrer that all admissions from medical wards to MHSOP inpatients happen via LPOP during the working week. Request the ward makes a referral to LPOP. If the patient is already open to LPOP, ask the ward to request a priority review when LPOP are back on duty. LPOP will screen the need for admission and complete a bed management form. If the person is already on the bed management waiting list, the directorate team will consider an admission during working hours.
- If MEAU/A&E require admission OOH, explore whether they can keep the person until an LPOP assessment is completed. If not, consider this as a high priority admission and source an MHSOP bed. However, if a CVUHB mental health bed cannot be sourced do not seek OOA bed. The person is in a bed and could be transferred to a medical bed then reviewed by LPOP. If unsure contact the Adult Shift Co-ordinator or Silver on Call for advice. Do factor in winter pressures/impact on A&E departments.
- If Adult shift co-ordinator has an older adult in EAS and is requesting staffing support, the MHSOP shifty should look at staffing across unit and attempt to support.
- If the police are contacting MHSOP Shifty for admission. Establish patient's name, DOB. Check they are eligible for MHSOP admission. Check the legal framework, is the person on Section 136? If so they have to attend EAS for assessment. MHSOP shifty to provide support with staff where possible. If they agreeing to informal admission inform the SHO and source a bed.
- YOD co-ordinate their admissions to St Barrucs but still need to submit a bed management form to the MHSOP Directorate as above for audit purposes.

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Respite Bed St Barruccs

- There is only 1 respite bed on St Barruc ward. If, however, there are community patients needing admission, this must take priority over respite.
- When a patient is known by the YOD team to require a respite bed, the YOD team in the first instance check the availability with the ward.
- If the ward feels the bed could be made available for the given period, the request is then made to Directorate Manager, Inpatient and Community Senior Nurse, Lead Nurse and Deputy Senior Nurse during Mon- Fri 9-5 and via email out of hours.
- Any known risks, such as relatives at risk of not accepting patient back home must be flagged at this time.
- The respite is added to the bed management file, and to Directorate Manager, Inpatient Senior Nurse, Lead Nurse and Deputy Senior Nurse and Deputy Directorate Manger and at the 8.30 meeting.
- Patients who are deemed to lack capacity to consent to respite admission will require BIM to determine this is in their best interests. This must be documented on Paris. They can be conveyed under MCA and urgent DoLS applied on their arrival.

9.2 Neuropsychiatry

- Neuropsychiatry team admit to Ash Ward. The team plan and co-ordinate admissions when beds are available. Neuropsychiatry teams will arrange their admissions.
- All admissions are planned to take place during working hours, to reduce minimise risk to service users and staff.
- Ash ward do not routinely take crisis admissions. All of their admissions are planned. Consultant and senior nurse/AHP complete assessments of patients before agreeing to add them to the BMWL

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- When urgent admission is required, (the admission criteria is met but no bed is available), the service is able to support appropriate admission to a secondary mental health facility until such a time when a neuropsychiatry bed becomes available.
- Alternatively, the referrer may be supported to action an IPFR (Individual Patient Funding Request) via discussion with WHSSC and the relevant HB in order to access an appropriate out of area placement or private provider.

9.3 Child and Adolescent Services

- HYC Shift Co-ordinator is on duty 24 hours a day 7 days a week and is responsible for identifying an inpatient bed in Hafan y Coed. This may include adolescents of the age of 16 or over.
- If all options have been explored and a bed cannot be made available in Hafan Y Coed, the referrer will contact the bed manager in University Hospital Wales (UHW) to explore availability of a bed across the UHW footprint. If a bed cannot be made available in HYC or UHW , the referrer will be required to source an age appropriate bed by contacting other local health boards and enquiring if their age appropriate bed is available for an acute admission.
- If all those options have been explored, escalation to Children and Young People’s Family Health Service (CYPFH’s) clinical board will be required.
- In certain circumstances the Shift Coordinator may delegate the sourcing of a bed to a colleague within the UHBHB for example the CAMHS team/service. This delegation must be accepted and communicated to the AMHP.
- Assessing clinicians are responsible for all documentation in relation to the sourcing of a bed.

9.4 Forensic Services

- The FCMHT operates between 08.00 and 17:00 Monday to Friday. The service does not offer any routine cover at weekends, evenings, nights or Bank Holidays. The Crisis Resolution and Home Treatment Team (CRHTT) will be asked to provide input for a service user as part of its admission

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avoidance remit after hours, though the FCMHT model of care should make this a rare circumstance.

- The CRHTT will assess clients of the FCMHT **out of hours only**, i.e. weekends, bank holidays and evenings in the following circumstances:
 - If the individual is known to the FCMHT, and is in police custody and is deemed to need a mental health assessment by the Forensic Medical Examiner (FME) or Health Care Practitioner (HCP) the CRHTT will attend with the on-call psychiatrist.
 - If the individual is known to the FCMHT, and is referred for an admission assessment by their GP or Mental Health Liaison Service, the CRHTT will undertake an admission assessment.
 - Adult shift coordinator is also responsible for supporting with admissions out of hours (17:00 – 08:00 including bank holidays and weekends) for patients open to the FCMHT.
 - In certain circumstances the shift coordinator may delegate the sourcing of a bed to a colleague within the UHB, for example the CRHTT. This delegation **MUST** be accepted and communicated to the AMHP.
 - The FCMHT are responsible for sourcing beds during service operating hours Monday to Friday (08:00 – 17:00) in collaboration with the shift coordinator.
 - The FCMHT are responsible for managing and sourcing beds for those patients (conditionally discharged) who are subject to restriction orders (S.37/41) that have been recalled to hospital by the Secretary of State for Justice. This will be achieved by liaising with the complex care and commissioning team to access out of area low secure services (if no beds are available in Hafan Y Coed – for male patients only).

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- For patients requiring admission and treatment under conditions of 'medium secure' care the FCMHT will liaise with the gatekeeping team in Caswell Clinic.

10 Bed Availability for Mental Health Act Assessments

Adult Mental Health(AMH)

Approved Mental Health Professionals (AMHPs) will contact the Shift Coordinator to provide relevant information about the patient and the circumstances of the assessment and where possible to identify a bed (i.e. police assistance, risk behaviour etc.).

MHSOP

The person making the referral for the Mental Health Act Assessment will contact the MHSOP Patient Flow Manager or Directorate Management Team who will be responsible for ensuring completion of the bed management referral form.

If there are no beds available the Shift Coordinator will escalate this to the relevant Senior Nurse Manager in hours and to silver on call out of hours.

11 Planned Mental Health Act Assessments.

During working hours:

- if at the point of mental health act assessment, it is anticipated that a bed will not be available, the Shift Coordinator will communicate the need for a bed to the relevant Senior Nurse Manager.
- If a bed has not been identified prior to the planned assessment an out of area bed must be confirmed.

12 Unplanned Mental Health Act Assessments

Unplanned Mental Health Act assessments need to be carried out as soon as possible. Such assessments may be located in the community, police stations or Emergency Departments.

- **For assessments in Emergency Departments** – If indicated the Psychiatric Liaison Team will contact the AMHP service to arrange a Mental Health Act assessment via the Duty AMHP Lead or EDT.

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For AMH the CRHTT should also be alerted at this point to see if they have capacity to attend with a view to divert admission wherever possible.

For MHSOP the person making the referral for the Mental Health Act Assessment will contact Patient Flow Manager or the Directorate Management Team and complete a bed management form.

- **For assessments in the community and police stations** - the Consultant/SPR will make the referral for a bed. The CRHTT should be alerted at this point to see if they have capacity to attend with a view to recommending community alternatives to hospital wherever possible. In the arranging of the MHA Assessment the AMHP will liaise with the CRHTT regarding their ability to attend. If the CRHTT are unable to attend the AMHP should notify the Shift Coordinator of the assessment and potential need for a bed.

In MHSOP the Consultant/SPR will source a bed via the Shift Coordinator.

- **If no beds are available within the UHB** - the Shift Coordinators or MHSOP Directorate will utilise the escalation process as above.

The UHB recognises that people who are in the community or in custody are particularly vulnerable and are treated as emergency referrals.

As such, if there is no capacity to admit locally, then the Shift Coordinator will escalate the referral to request an out of area bed.

13. Formal Admissions

All referrals for a Mental Health Act Assessment (MHAA) must include a referral to the relevant CRHTT or REACT. This process ensures that home treatment or a Crisis House admission, as an alternative to hospital admission has been considered.

When an assessment has been requested under the MHA, the potential need for a bed should be communicated to the relevant shift coordinator/MHSOP patient flow/Directorate Management Team at the earliest opportunity. CRHTT policy sets out that the team should attend ALL MHA assessments. If CRHTT are in attendance they are responsible for liaising with SC to identify bed and communicating this to AMHP.

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When CRHTT are unable to attend, SC is responsible for identifying a bed and informing the AMHP. The MHSOP REACT Team will attend where possible.

At the conclusion of the assessment, if admission is indicated and an application will be made under the MHA the applicant (generally an AMHP) must be advised by the relevant Shift Coordinator/MHSOP Patient Flow or Directorate Management Team of where that bed is located. This can be a bed locally or a private out of area bed.

If a bed is not immediately available, the assessing team and others involved in the persons care must work together to formulate an interim care plan whilst continued efforts are made to source an inpatient bed.

This must consider what steps need to be taken to safeguard the patient, others and themselves. It is the responsibility of the assessing team being led by health to ensure relevant safety plans are in place to mitigate risks until a bed can be identified.

If there is an undetermined wait for a bed and the assessing team are concerned that the risks cannot safely be managed outside of hospital the case could be determined as one of special urgency and may be transferred to the special urgency provision identified in Hafan Y Coed, University Hospital Llandough.

14. Linden House (Crisis House)

For adults of working age the UHB has access to Linden House which is an alternative to inpatient admission and offer a short stay (maximum of two weeks) in a homely environment.

The main aim of the Crisis House is to offer an alternative to hospital admission for those who can manage in a community supported setting and to facilitate early discharge from hospital.

All informal admissions should be considered for a Crisis House referral which must be agreed by the referred person.

The house cannot accept admissions in the following circumstances:

- People who have been detained under the Mental Health Act at the point of admission. However, if after an inpatient assessment has been carried out and risk are felt appropriate to manage in the Crisis House, then sec 17 leave to the house may be appropriate.

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- People who are under the influence of drugs and alcohol or whose primary diagnosis is substance misuse.
- People who are assessed as currently using illicit substances or alcohol in a non-dependent capacity should still be considered for a Crisis House admission under the proviso that they are made aware that if they do use these substances in the Crisis House, then they may be discharged from the Crisis House.
- People who are considered to be a high risk to themselves or others.

Referrals will be accepted from the relevant Crisis Team.

The Crisis House makes decisions about admission jointly with CRHTT.

15. Admission to acute inpatient beds (treatment wards)(Adults of working age)

The acute in-patient wards operate on a locality principle. This means that a number of wards are linked to community teams, offering the patient continuity of care.

All patients will usually be admitted via the Crisis Assessment Unit (Cedar), with the exception of:

- The recall of a Community Treatment Order
- A section 37 Hospital Order without restrictions and considering the nature and level of risk.
- In cases of request for direct admission for treatment from UHB consultant psychiatrists. This will need to be discussed and confirmed with the relevant Senior Nurse Manager.

16. Admission to the Crisis Assessment Unit (Adults of working age)

Cedar ward located in Hafan Y Cod, University Hospital Llandough is the Crisis Assessment ward for the UHB. All admissions should be admitted to Cedar Ward unless clinical characteristics suggest admission is more appropriate to another area.

Cedar Ward assess patients on a daily basis and will decide when a treatment bed is clinically indicated. It will be the responsibility of the Patient Flow Manager to be aware of the need for locality beds and to update the Cedar MDT on any delays in accessing a treatment bed.

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17. Admissions to the Psychiatric Intensive Care Unit (PICU). (*Adults of working age*)

The UHB has 10 PICU beds on Alder Ward located in Hafan Y Coed, University Hospital Llandough. The focus of PICU's is to manage patients who have an acute primary mental health disorder that requires intensive care in low stimulation environment.

Current presenting clinical problems form the basis for admission but must be considered in conjunction with past history of mental illness and previous risk assessment. Consideration must also be given to the benefits for a patient of a PICU admission; acknowledging relevant factors in clinical presentation

Intensive care patients are therefore usually those patients who:

- Are causing harm to other persons through violent, disturbed and/or aggressive behaviour, sexually disinhibited behaviour or who present a substantial risk of doing so and who cannot be managed in their present environment; **or**
- Present a substantial risk of serious self-harm or of suicide and who cannot be effectively managed in their present environment; **or**
- Best practice would be that all patients admitted to PICU are detained under the Mental Health Act 1983. Although It may be appropriate under certain circumstances for an informal patient to be admitted to PICU, discussion with the individual and wider MDT will be required.

If a patient is initially assessed as requiring a PICU bed, the patient will need to be referred and assessed by the PICU MDT. To assist in this process, it will be the responsibility of the referrer to discuss the referral with the relevant PICU MDT. For out of hours PICU referrals, it will be the responsibility of the Shift Coordinator to discuss and review the referral with the relevant PICU MDT. If there is a need to book an out of area bed to facilitate admission to a PICU ward, then the Shift Coordinator will follow the out of area procedure contained in section 26.

18. Referrals from a medical bed or those with a physical health need

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For individuals who are admitted to a general medical bed for which a psychiatric need is identified a referral will be submitted to the *appropriate* Psychiatric Liaison Team. Individuals over 65 will be referred to Liaison Psychiatry Older People (LPOP). Patients open to Young Onset Dementia (YOD) will be referred to the YOD Team. Based on the outcome of assessment the level of need will be determined and responded to in accordance with appropriate ongoing referrals.

In Adult Mental Health when the patient is medically optimised relevant referrals for an inpatient bed will be made and the Mental Health Senior Nurse for Physical health should be consulted to determine the required mental health bed.

In MHSOP, indication for admission will be determined by LPOP who refer to MHSOP inpatients by completing a bed management form. The person will be added to a waiting list and prioritised on level of risk.

19. Bed Management Responsibilities - Medical Bed, referrals

When an AMH inpatient is transferred to an acute medical ward for treatment, appropriate use of that bed will be considered by the Shift Coordinator, Ward Manager and relevant Senior Nurse with a view to returning the patient to the same ward for continuity of care. Following a referral from a medical ward, the Shift Coordinator will:

- Ensure that a full physical health needs assessment has been completed prior to the transfer of the patient.
- If necessary ensure a medic to medic handover takes place
- If a bed has not been identified, it will be the responsibility of the Patient Flow Manager to escalate the referral at the daily bed management meeting.
- In MHSOP, when a patient is transferred to a general medical bed or MEAU, the bed is kept open based on patient need.
- Prior to transfer the Nurse in Charge will ensure safe handover takes place using SBAR handover document and Safe to Move.
- Staff will be provided based on risk and clinical need.
- The MHSOP ward nurses will have daily contact and document the patient's physical condition and treatment on PARIS.
- Once medically fit the MHSOP nurse ensures medic to medic and nursing handover takes place.

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- If the patient physical needs outweigh mental health needs aim to close the bed after one week. The ward can refer to LPOP for support and guidance regarding mental health needs.

20. Use of Leave and AWOL Adult and MHSOP beds

A leave bed is a bed which is designated to a named patient, but that named patient is currently on leave (either an informal patient on leave, or a detained patient on Section 17 leave). This can include leave to a medical bed.

It is preferable to admit to a vacant bed rather than a leave one, but it is acceptable and expected that a leave bed will be used if it is the only option available within the UHB. Patient's belongings should be labelled and kept safe in the ward storage.

An AWOL bed is a bed which is designated to a detained patient who is absent without leave from the ward.

21. Mother and Baby Referrals

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.

The UHB does not provide specialist mother and baby facilities, a preferred placement will need to be sought following a Multi-disciplinary review and considering the views of the patient, Children and Families services.

22. Admission of young people under the age of 18

Admission of adolescents to adult services should be used as a last resort where no appropriate alternative can be arranged. This should be determined by the CAMHS duty doctor (either SPR or consultant) and discussed with the adult mental health shift coordinator.

Under 18s presenting to the Health Board in crisis often require a joint approach from the CAMHS crisis team and colleagues in the local authority. Whilst under 16s are admitted to the Children's Hospital for Wales those over 16 who cannot be safely discharged to appropriate adult care may require brief crisis admission to facilitate

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safety planning. The Health Boards designated age appropriate bed is on the acute admissions ward at Hafan Y Coed, Cedar ward.

Under 18s are assessed by the CAMHS Crisis Team (9:00hrs -00.30hrs) and/or duty core trainee in psychiatry (5pm -9am) in consultation with the CAMHS duty doctor. Decision to admit a young person to the age appropriate bed ought to be taken by the CAMHS duty doctor. Once the need for admission has been identified, this is then discussed with the Adult Mental Health Shift Co-Ordinator and admission to Cedar ward arranged if the CAMHS bed is available.

Admission to the Age Appropriate Bed of young people aged 16 and 17 may be undertaken to:

- Provide crisis admission to facilitate safe discharge planning
- For further assessment of crisis presentation when safe discharge not possible

Actions to be undertaken upon admission to the age appropriate bed:

- the young person is under constant observation in the presence of adults (constant observation may not be required in their individual bedroom following the appropriate risk assessment, however a member of staff should still be allocated outside in the event the young person wishes to leave their room and enter the adult communal area). Staffing for CAMHS close observations will be additional to Cedar ward's usual/safe staffing levels.
- The Safeguarding Team are made aware of the admission by the ward team.
- The ward team complete a Serious Adverse Incident form and a DATIX.
- The ward team email CAMHS.Crisis@wales.nhs.uk to confirm where young person has been admitted to.

Following admission, the CAMHS crisis team will contact the ward team within 24 hours to update the care plan and agree review. It may be that review will be most effective in conjunction with Local Authority colleagues to ensure safe discharge planning. Whilst a young person remains in the Age Appropriate Bed, the CAMHS team will endeavour to make daily contact with the ward team and keep admission time to a minimum. CAMHS will retain Consultant responsibility for those patients under 18 (unless 17 years and 9 months and open to an adult CMHT on Paris). If open to adult mental health services then the CRHT consultant will retain responsibility.

The Responsible Clinician for a CAMHS admission will be the Crisis Pathway for CAMHS Consultant. However if the young person has an eating disorder the Responsible Clinician will be the Eating Disorder team Consultant.

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Should a young person require a psychiatric admission to Tier 4 Adolescent Unit this decision will be taken as promptly as possible by the CAMHS team who will then make the referral to Ty Llidiard for a gatekeeping assessment.

There are three potential outcomes from the gatekeeping assessment:

1. **Admission to Tier 4 unit approved and bed available at Ty Llidiard** - the ward team can liaise with Ty Llidiard to arranged transfer of patient
2. **Admission to Tier 4 unit approved but Ty Llidiard unable to accept the young person** - CAMHS will seek the appropriate funding agreement and commence process of obtaining out of area bed
3. **Admission to Tier 4 not approved** - CAMHS team will liaise with gatekeepers. Likely need to arrange further network discharge planning meeting

23. Admission of people with Learning Disability

Learning disability should not act as a barrier to acceptance by the CRHTT as long as the CRHTT is best placed to meet the person's needs. Individuals with a learning disability will have equal access to crisis service assessments and if indicated admission. In cases where this is not immediately clear whether presenting problem is mental health or learning disability, assessments should be carried out jointly by representatives of both CRHT and Learning Disability Services in hours. Outside of normal operating hours, the CRHTT can access the Learning Disabilities on-call rota for advice regarding the on-going management of any person they assess who may fall into the remit of the Learning Disabilities Service.

Learning Disability Services should be informed of any relevant admission to the Crisis Assessment Ward as early as practicable on the next working day to enable arrangement of a review by the Learning Disability Team within five working days. Should a service user be deemed to warrant ongoing admission, the Learning Disability Team will negotiate with the ward as to the best place for care to be provided as the service user may require a speciality Learning Disability bed. Where practicable and appropriate these service users should be admitted directly to a specialist bed in the first instance.

Once it is identified that a service user requires ongoing treatment, the expectation is that an appropriate bed is found, to free up capacity on the Crisis Assessment Ward, and ensure care is provided in the right environment.

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24. Admission in cases of ‘special urgency’

24.1 Section 140, Mental Health Act 1983

Section 140 of the MHA places a responsibility on UHB’s to identify which hospitals are available in cases of special urgency. Local Health Boards 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.

Although this section does not oblige the specified hospitals to admit patients in an emergency or to maintain capacity to facilitate such admissions, a refusal to admit should only be made with good reason. If a hospital bed cannot be found for a patient who requires admission, it is the responsibility of the local health and social services authorities to provide the patient with appropriate treatment and/or care until a bed is found.

24.2 Definition of ‘special urgency’

Term “special urgency” is locally agreed to be a situation where a mentally disordered person either is so acutely unwell, or very shortly may become so, that either failure to urgently admit the person to hospital, or a protracted wait for a bed, could result in significant harm to the patient including death, to those assessing the patient, or to other persons. Significant harm is to include: the degree of suffering the person may experience, including trauma; or the degree of psychological impact they are having on others; or physical harm, which would include any health issues that could arise. Children and Young People are always assumed to be in 'special urgency' regardless of the situation. Where the person is in close contact with children, ‘special urgency’ will include a lowered threshold of impact in consideration of children’s’ vulnerability.

24.3 Cases that would not automatically qualify as ‘special urgency’ under section 140, Mental Health Act 1983 include:

- Those cases who do not meet the **exceptional clinical need** threshold would not qualify for a section 140 status based on being at a place of safety, Emergency Department or in police custody
- (or) based on recommendations for detention under the Mental Health Act alone.

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24.4 Children or Young People

Paragraph 19.59 of the MHA Code of Practice for Wales states that “In a few cases, the child’s need to be accommodated in a safe environment could, in the short term, take precedence over the suitability of that environment for their age. There is a clear difference between a suitable environment for a child in an emergency and a suitable longer-term environment. In an emergency, such as when a patient is in crisis, the important thing is that they are in a safe environment.

Such situations will arise where the child or young person needs to be admitted urgently to hospital and accordingly waiting for a bed to become available on a Child and Adolescence Mental Health Services (CAMHS) unit is not considered to be an acceptable option. However, an “emergency” should be a rare and unusual case. It is not unusual for children or young people to require unplanned admissions and accordingly local policies should be in place to ensure that such admissions are to age appropriate environments.

24.5 Potential cases of ‘special urgency’

This is not an exhaustive list but rather sets the threshold to be reached for admission status of special urgency:

- An episode of life-threatening self-harm together with a physical illness, living alone with lack of social supports and clearly identified severe mental illness signs and symptoms.
- Florid psychosis in a community setting, living alone with lack of engagement with home treatment team, non-concordance with treatment including medication combined with self-neglect and/or active agitation/thoughts of self-harm/harm to others/self.
- Patient with features of mental illness with severe self-neglect showing features of dehydration or sustained food refusal over days.
- Conditionally discharged restricted patients i.e. patients with a proven record of causing serious risk of significant harm to

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others when mentally unwell, currently non-concordant with medication, disengaged for services and showing features of relapse of mental illness.

Additional could be Living with others and presenting as a risk to others, carers burnout.

24.6 In cases of ‘special urgency’

Where it is agreed by the Assessing Team and the Adult Shift co-ordinator/MHSOP that admission under the Special Urgency arrangements are required, an AMHP is able to make an application for detention if it is anticipated a bed will become available within a reasonable time. Whilst there is no definition of reasonable time, this would be guided by a local discussion on a case by case basis within the shortest possible timeframe.

If there is an immediate risk to a member of the assessing team, then all members of the team must take reasonable steps to ensure their safety and contact the relevant authorities proportionate to the circumstances at the time.

The shift co-ordinator/MHSOP Directorate or patient flow manager needs to consider the safety of the AMHP at the place of assessment. The Adult shift co-ordinator/MHSOP Patient flow manager in collaboration with the assessing team will need to fully risk assess the situation and may need to consider safer environments for the AMHP, such as conveying patient to HYC to wait for a bed. An application under the mental health Act can be made to Hafan Y Coed to admit anywhere in the hospital with agreement of the Shift Coordinator on behalf of the Hospital Managers as long as it is safe and appropriate to do so.

When sourcing staff to be present in EAS, it will be the responsibility of the Shift Coordinator to source staff from within existing resources. This may involve sourcing staff from wards or other clinical areas.

24.7 Process for escalation in cases of disagreement regarding ‘special urgency’

In the event that there is a disagreement that “Special Urgency” applies to the patient’s circumstances, either member of staff should consider escalating the issue to their Senior Line Managers.

Shift Co-ordinator should contact the senior managers or Silver on Call for advice if required.

Respective Senior Managers will discuss the circumstances of the case and facilitate a management plan to manage risks.

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Any Datix forms completed will be reviewed by the appropriate line manager to ensure the procedure is working effectively.

In the event that a bed can't be identified for an indefinite period, liaison between the assessing team and Shift Coordinator prior to communicating with the Silver on Call is necessary to agree appropriate course of action.

24.8 Actions for the Adult Shift Coordinator, MHSOP Patient Flow/Shift Coordinator and Directorate Team

Where the Shift Coordinator assesses that the situation meets the threshold for 'special urgency', the case will be escalated as the priority for the next available bed (in the UHB or out of area).

The Shift Coordinator must remain in contact with the AMHP to keep them informed of the attempts being made to identify a bed.

The Shift Coordinator will make continued attempts to identify a bed until one is located.

If the Shift Coordinator agrees and the situation cannot be managed safely in the community, an application can be made to Hafan Y Coed and the person can be admitted to a temporary bed whilst the search for a bed continues.

24.9 Incident reporting

A Datix will be completed on behalf of the UHB if the process fails because a bed cannot be found.

The Shift Coordinator will escalate a failure to admit in cases of special urgency to the Adult Mental Health Directorate to enable notification to the Mental Health Clinical Board during working hours. Out of hours the matter will be escalated to Silver on Call.

24.10 Follow up

Patients who have been determined as cases of special urgency remain the responsibility of the UHB, in relation to on-going reviews and follow up.

25. Admission to Out of Area Beds MHSOP and Adult

25.1 Direct Admissions to Out of Area Beds

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The use of an out of area bed is viewed as a short-term solution to address the lack of bed availability locally. As such it is expected that all patients in out of area beds are returned locally as a priority.

In AMH it is the responsibility of the assessing team to contact the Crisis Team when undertaking the following assessments:

- Admission avoidance
- Mental Health Act
- Section 136

The Crisis Team will notify the Shift Coordinator of any ongoing assessments and identify if there are any beds available in Cardiff and Vale UHB. The Crisis Team will feedback to the assessing team

In MHSOP the assessing team must submit a bed management form marked urgent. It needs to include as much information and detail as possible regarding clinical risk and patient need. They need to follow up with a phone call. Community teams may be asked to help the directorate team source an out of area bed.

25.2 Identifying a bed

All patients who require admission will be found a local bed wherever possible. If there are no available beds within the UHB contact must be made with the relevant Bed Managers of neighbouring UHB's to attempt to identify an NHS bed first:

- Swansea Bay University Health Board
- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board
- Powys Local Health Board

25.3 Private beds

Prior to consideration of a private bed the responsible funding organisation must be conclusively established.

If a private bed is required for a patient from out of area authorisation **MUST** be sought from the relevant Health Board who will be required to complete the relevant funding forms.

25.4 Authorisation

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If all other options have been exhausted authorisation will be required to use a private bed. During office hours authorisation will be obtained from the Service Managers and out of hours, the Shift Coordinator will liaise with the Silver on call.

Upon approval the authoriser (Service Manager/Silver on Call) is required to notify the following by email:

- Directorate Manager, Mental Health Clinical Board
- Service Manager, Inpatients, Mental Health Clinical Board
- Assistant Finance Business Partner, Mental Health Clinical Board

25.5 Referral

Once a bed has been identified It is the responsibility of a member of the assessing team to complete the necessary referral/ referral paperwork (not AMHP or Independent S12 Doctor). Referral forms can be sourced from the relevant provider and must be sent via secure channels in accordance with GDPR and UHB policies and procedures.

25.6 Unable to identify a bed

In AMH when it is not possible to identify an out of area bed, the Shift Coordinator will escalate to Adult Mental Health Directorate to enable notification to the Mental Health Clinical Board during working hours or the Silver on Call out of hours to discuss alternative options.

If MHSOP are unable to source an OOA bed this will be escalated to the MHCB.

25.7 Inpatients

For those being transferred out of area in order to create a bed it is the responsibility of the Nurse in Charge to identify a Qualified Nurse to follow the process described above in order to identify the bed for inpatients. If further support is required contact should be made with the Shift Coordinator.

The Patient Flow manager will notify the Local Authority when a person is moved out of area post admission.

Once the bed has been identified all relevant referral paperwork must be completed and sent to the relevant provider by the identified Qualified Nurse ensuring the Senior

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Manager for Inpatients is copied into all communications. It is the responsibility of the identified Qualified Nurse to follow up on the referral status and handover at the end of the shift.

Upon acceptance of the referral the ward will be required to arrange transport in line with Cardiff and Vale UHB usual practice. If further support/ authorisation is required, this should be obtained via the Shift Coordinator.

In MHSOP it is highly unlikely that a settled patient would be transferred to an out of area bed.

25.8 Crisis Team in Attendance (AMH) (for adults of working age)

It is the responsibility of the Crisis Team to follow the process described in 3.2 – 3.3.2 in order to identify the bed for a person who requires direct admission to an out of area bed if they were involved in the assessment. If further support is required contact should be made with the Shift Coordinator.

Once the bed has been identified all relevant referral paperwork must be completed and sent to the relevant provider by the Crisis Team. It is the responsibility of the Crisis Team to follow up on the referral status.

Once the referral has been accepted the Crisis Team will be required to arrange transport in line with Cardiff and Vale UHB usual practice via known providers. If further support/authorisation is required, this should be obtained via the Shift Coordinator.

25.9 Crisis Team Not in Attendance (AMH)

It is the responsibility of the health authority to follow the process in order to identify the bed for a person who requires direct admission to an out of area bed. If further support is required contact should be made with the Shift Coordinator.

N.B. It is not the duty of the Approved Mental Health Professional (AMHP) at the MHA assessment to identify/source the bed.

Once the bed has been identified all relevant referral paperwork and telephone discussion must be completed by a member of the assessing team and sent to the provider ensuring the Shift Coordinator and Senior Manager for Inpatients is copied into all communications.

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The Shift Coordinator will follow up on the referral status. Once the referral has been accepted the Shift Coordinator will be required to arrange transport in line with Cardiff and Vale UHB usual practice.

25.10 When a local bed can't be found, process for escalation

During 8am-8PM, it is best practice to identify a bed via Adult Shift Co-ordinator or MHSOP Directorate Management Team at the earliest opportunity, prior to MHA.

All options have been explored to review all beds and appropriate transfers made to accommodate admission.

If there are no available beds within the UHB then shift co-ordinator or MHSOP patient flow manager will escalate this through senior and lead nurse structure. Authorisation for OOH bed will need to be granted by the directorate management.

Out of hours, once all options have been explored to review all beds and appropriate transfers made to accommodate admission, the Shift Coordinator will escalate to Silver on call to seek authorisation for out of area bed.

This should be sought within routinely commissioned pathways in the first instance. If no bed is available within neighbouring health boards, a bed should be sourced with an alternative provider- (Local NHS beds or private hospitals).

The commissioning care assurance performance system (CCAPS) should be consulted to identify available bed space in private providers. CCAP's identifies rankings of provider quality and where possible the highest-ranking provider should be referred to in the first instance.

Where an out of area bed has been used in case of special urgency a Datix will need to be completed by shift co-ordinator, out of area Teams channel should also be updated to allow senior team to review this at their earliest opportunity and consider provisions to return to a local bed.

25.11 Detained patients from out of area

A Detained patient from out of area refers to a person detained under the Mental Health Act as an inpatient in Cardiff and Vale UHB rather than in their own area.

Prior to MHA assessment, it is best practice for a member of UHB staff (who could be determined by the Shift Coordinator) to make an initial enquiry with the Responsible Health Authority regarding bed availability and to inform the health board/trust and

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local authority the MHA is taking place. Every effort should be made to repatriate Out of Area (OOA) patient to their local health board.

Where a bed in their local health board is available, the AMHP is responsible for ensuring the patient is safely conveyed to destination and to ensure the conveyance form is completed. They will need to liaise with the relevant health board to agree the process for transport.

In the case of special urgency, where a bed is not available the assessing Doctor is required to advise the adult shift co-ordinator or MHSOP of the specific type of bed required based on clinical presentation and risk.

Adult Shift Co-ordinator to discuss the following options with Directorate teams or Silver on Call to inform them of situation and that they are organising OOA bed. Also contact senior manager/on call from patient's health board/trust call to inform them OOA bed and transport is being sourced.

Shift Coordinator to liaise with AMHP throughout the process, communicate risks clearly and consider safety of AMHP, where possible provide staff support or convey patient to a designated place of safety.

25.12 Prior to transfer

Whilst arrangements are being made to source the bed, discussions need to take place between the assessing team who are sourcing the bed and Shift Coordinator as to the most appropriate setting for the individual to wait, considering staffing requirements and risk assessments.

25.13 Arranging Transport

Once the need for a hospital admission has been established, it is important that all parties work collaboratively to make the necessary arrangements for the patient conveyance.

The appropriate method of transfer is to be determined by the assessing team further to a Risk Assessment being undertaken and could include:

- Staff transfer
- Taxi
- Ambulance
- Secure Transport

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If authorisation is required, this can be obtained via the Adult Directorate Management Team in hours or via the Shift Coordinator out of hours.

The AMHP will be required to provide the relevant conveyance documentation. If the AMHP does not have access to the technology to complete the relevant documentation then the AMHP can delegate to another appropriate person.

Transport can be arranged by contacting the authorised companies in order (*list is not exhaustive*) – **Appendix 3**

If all of the above are unavailable and conveyance cannot be delayed until a time they are available then Prometheus authorisation can be sought via the UHB Executive team in hours or Silver on Call out of hours. Prometheus is only to be used when absolutely necessary due to huge cost implications. Therefore, it's use will require a much higher level of justification and scrutiny than the other providers. **Prometheus 24 HOUR BOOKING LINE 0800 009 6668**

In hours authorisation from the relevant Service Manager is required. If you are unable to contact the relevant Service Manager then any of the Service Managers can provide authorisation.

If none of the Service Managers are available authorisation should be sought from the Directorate Manager and in the event that you are unable to contact any of the above authorisation can be sought from the Senior Nurse Managers (starting with relevant areas) followed by the Lead Nurse.

1. **Relevant Service Manager**
2. **Any Service Manager**
3. **Directorate Manager**
4. **Relevant Senior Nurse Manager**
5. **Any 8a Senior Nurse Manager**
6. **Lead nurse**
7. **Mental Health Clinical Board**

Out of hours Silver on Call will provide authorisation.

Please copy Directorate Manager into all authorisation emails in order to maintain accurate records and track invoices.

25.14 Follow Up

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Patients who need to be admitted to an out of area bed remain the responsibility of the UHB and Local Authority, in relation to on-going reviews and follow up.

It is the responsibility of the person/team who sourced the bed to follow up and monitor the patient whilst in an out of area bed. This could be the following:

- Inpatient ward where patient was admitted prior to transfer
- Crisis Team
- CMHT Care Coordinator currently involved
- MHSOP Patient Flow Manager/ Shift Coordinator and/or Directorate Management Team

An inpatient who has been placed out of area should remain on the resident wards board for monitoring and follow up. Whilst no longer an inpatient the resident ward must ensure that the individual is discharged from the bed state.

Follow up will remain with the Crisis Team for 2 weeks if they were a member of the assessing team and revert to the appropriate locality ward for updates in line with the inpatient admission pathway and to attend remote ward rounds. The Crisis Team will notify the Patient Flow Manager of any out of area placements that have taken place out of hours and over the weekend.

If the Crisis Team were not a member of the assessing team follow up will be provided by the Crisis Team~~Discharge Liaison Team~~ for a 2-week period and then revert to the locality ward for updates in line with the inpatient admission pathway and to attend remote ward rounds.

The Patient Flow Manager will follow up and monitor all out of area placements dealt with by the Shift Coordinator where the Crisis Team were not in attendance and the individual is not allocated a UHB care Co-ordinator.

It is suggested that contact is made with the placement for a progress update at least 3 x per week on a Monday, Wednesday and Friday. Paris must be updated accordingly.

The Shift Coordinator will be the point of contact regarding follow up. The Shift Coordinator may delegate follow up to an appropriate member of staff who will be required to provide timely updates.

The Inpatient Senior Nurse will provide cover for patient flow in the absence of the Patient Flow Manager, for the Adult Mental Health Directorate.

25.15 Role of the Care Coordinator

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All patients who have been admitted and have an allocated Community Team must be regularly followed up by their Care Co-ordinator or nominee from their local service – this includes, where necessary, attending ward rounds and meetings in relation to their patient.

The Patient Flow Manager will send a notification to the Care Coordinator to ensure attendance where required.

This is also true for MHSOP. The Care Co-ordinator needs to remain involved particularly on mental health wards where admissions aim to be short.

25.16 Daily Bed Management Meeting

All out of area placements are reviewed on a daily basis by the appropriate managers from the Adult Mental Health Directorate.

A database recording the placement details is held on CAV_MH SOC and Shifty Teams Channel. The ~~Discharge Liaison Team~~ Patient Flow Manager is are responsible for maintaining this list.

There are rarely any MHSOP patients in OOA beds. However, this would be discussed in weekly MHSOP huddles or more frequently if required.

25.17 Attendees

Those required to attend the Daily Out of Area Management Team Meeting are:

- Lead Nurse, Adult Mental Health Directorate
- Directorate Manager, Adult Mental Health Directorate
- Locality Service Managers, Adult Mental Health Directorate
- Inpatient Locality Senior Nurse Manager, Adult Mental Health Directorate
- Patient Flow Manager, Adult Mental Health Directorate

25.18 Review

A review of all those in out of area beds will take place. An overview of the current bed situation will be received. The group will review those in out of area beds, considering the following:

- Cost of placement
- Length of time patient has been out of area
- Speciality required to bring patient back
- Any other barriers delaying return to Cardiff and Vale

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In order to mitigate any negative impact on the patient by being placed in an out of area bed consideration should be given to repatriating before accepting new admissions.

If no beds are available and an admission is required then an out of area bed should be sought if clinically appropriate.

26 Following admission: key areas of practice

A number of key areas of practice have been identified that impact significantly on effective and efficient bed management.

26.1 Facilitating early discharge

It is widely accepted that early discharge is achieved by identifying clearly the purpose of admission as soon as a patient is admitted to a ward.

It is expected that after 72 hours, there will be an agreed Expected Date of Discharge by the ward and community team in consultation with the patient and their associated Carer, Nearest Relative or Next of Kin.

The CRHTT and REACT are able to facilitate discharge to home treatment, and it is recommended that appropriate patients are referred at the earliest opportunity.

All patients who are deemed to be ready for discharge will be discussed at the ward board rounds/MDT meetings and at the daily bed management meeting.

26.2 Interface with community-based services

When a patient who is known to community services is admitted to inpatient services (either a ward or crisis house), the community team must be contacted by the ward/crisis house within 24 hours of admission, or the next working day.

Within 72 hours, the Care Co-ordinator or the Community Team will have a clinical discussion with the ward to:

- Clarify Purpose of admission;
- Agree an Estimated Date of Discharge (to be recorded on case notes)
- Identify carers or any other support systems.
- Identify any obstacles to discharge and plan to resolve these.

It is the expectation that there will be a clinical planning discussion on the ward within 7 days of admission.

27 Transfer of all patients detained under the Mental Health Act

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The UHB 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.

28 Delayed Transfers/Discharges (MHSOP and AMH)

A delayed transfer of care occurs when a patient is clinically optimised and ready to leave acute care and is delayed. A patient is ready for transfer when:

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

For patients of No Fixed Abode, the council responsible for the patient is the council in whose area they reside. This is irrespective of whether the patient lives on the street or in a hostel.

Asylum seekers and others from overseas should be listed under the council in which they currently reside. It is the responsibility of this council to decide whether they are eligible for social services.

Ward Managers and Consultants are responsible for highlighting individual cases that they believe to be delayed to the Patient Flow Manager.

These are then escalated to the Mental Health Clinical Board via the weekly Delayed Pathways of Care Meeting (DPOC).

There are a variety of means by which services should aim to tackle the issue of delayed discharges in a timely manner by:

- Identifying the purpose of admission prior to admission and care planning accordingly at the earliest opportunity
- Beginning the process of discharge planning on admission
- Identifying any potential barriers to discharge as early as possible
- Weekly MDT discussions
- Reluctant Discharge Policy

In MHSOP delays are identified and actioned in:

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- 8.30am staffing meeting which takes place three times per week
- Twice weekly huddles with community team, patient flow and directorate management
- MHSOP also has a designated patient flow team which consists of social workers and social work assistants. This team works with the patient flow manager and complex care and commissioning team to discharge clinically optimised patients.

29 The use of Bed and Breakfast accommodation

Bed and Breakfast accommodation may be used as a last resort when the only reason for remaining in hospital is due to lack of immediate accommodation being available. The decision to use a hotel will be based on a full clinical risk assessment, involving community and in-patient teams.

Stay at the hotel will be for a time limited period whilst services are actively trying to find appropriate accommodation.

The UHB has approved the use of the Bed and Breakfast and agreed that the maximum length of stay recommended must not exceed 2 weeks. If there is a request to extend the length of stay, this must be discussed with the Bed Management Team and an entry must be made in the case notes. There must be a clear entry in the case notes regarding follow up arrangements during their temporary stay at this hotel.

30 Closing a ward to admissions

30.1 Planned and unplanned ward closures

Where a ward closure is planned (e.g. for refurbishment), prior agreement must be obtained from the Head of Operations, Mental Health in consultation with the Chief Operating Officer (COO).

In an emergency situation (e.g. infection outbreaks, or inadequate staffing to manage a ward safely), a decision to close a ward to admissions during working hours may only be agreed by the Head of Operations (following escalation via the Directorate Manager).

Out of hours, the Shift Coordinator will escalate to the Silver on-Call, who in turn will escalate to the Executive on Call.

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

30.2 Un-availability of individual beds/bedrooms

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

Where it is felt that a room is un-useable this must be escalated to the Ward Manager and Shift Coordinator or the Silver on-Call out of hours. Following senior review, the Head of Operations, Mental Health and COO will be updated about the bed closure. The Directorate Manager will escalate to the Director of Estates for early resolution. Daily updates will be provided in the Bed Management Meeting.

31 Patients presenting on site (MHSOP and AMH)

A small number of patients present themselves at inpatient units, requesting support, including admission to that unit or other specialist psychiatric services. These may be patients who are already known to the services or those who have had no previous contact with the service.

If and when this occurs the Shift Coordinator should be contacted in conjunction with Security if required.

If the patient is known to the service, the Shift Coordinator should first try to establish who is involved in their care, by asking the patient and by checking their case notes.

- (i) If the patient is known to the service then they should, in the first instance, be encouraged to contact their Care Co-ordinator (if they have one).
- (ii) If the patient is currently under the care of the CRHTT/REACT and open to their caseload, then the CRHTT/REACT staff need to be involved.

If the patient is not known to the service, the Shift Coordinator should conduct a brief assessment in order to signpost to the most appropriate service. This could include a request for further assessment by the CRHTT or in the case of MHSOP, the most appropriate community team.

All action taken should be documented in the patient's case notes and the Patient's Consultant, Care Coordinator/Community Team and GP, should be informed.

32 Admission of Cardiff and Vale UHB Staff

In the event that a member of UHB Staff who resides in Cardiff and Vale requires admission to a mental health facility, this will be treated with sensitivity and should be discussed with the Head of Operations, Mental Health and Chief Operating Officer.

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Consideration should be given to asking a neighbouring HB to facilitate the admission in consultation with the staff member who requires admission.

Where possible, a staff member should have an advance directive in place to assist assessing clinicians in identifying the most appropriate place to admit them.

33 Dissemination and Implementation Arrangements

This document will be circulated to all managers who will be required to cascade the information to members of their teams. It will be available to all staff via the UHB intranet. Managers must ensure that all staff are aware of its contents and understand what it means for their practice, as part of their responsibility.

34 Equality Statement

Cardiff and Vale UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups. We have undertaken an Equality Health Impact Assessment, we wanted to know of any possible or actual impact that this policy may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no impact to the equality groups mentioned. Where appropriate we have taken the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equalities and human rights legislation.

35 Monitoring Review and Audit Arrangements

The Adult Mental Health and MHSOP Directorate Teams are responsible for monitoring this policy including delays in the discharge of patients and taking appropriate action. This policy will be reviewed every three years or sooner if a significant change in practice is identified.

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Appendix 1

St John Ambulance Cymru

Mental Health Conveyance

If you are a designated person Call - 03300-586591

St John Ambulance Cymru,
 Priory House, Beignon Cl,
 Cardiff CF24 5PB
www.sjacymru.org.uk

Registered in England and Wales. Charity number 250523.





 @SJACymru


 GIG CYMRU NHS WALES
 Local Services
 Cyflwynwch! Cymunedol
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 Cymunedol ysb:

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Useful Contact Names and Numbers

Name	Internal	External
VOCERA – state name of person, for example: call shift Coordinaoor call Beech Ward Nurse in Charge etc.....	5555	029 20745555
Shift Coordinator – EAS	24691	029 21824691
HYC Reception	24700	029 21824700
UHW Switchboard	100	029 21747747
Adult Mental Health Directorate Office	24968	029 21824968
MHSOP Directorate Office/Bed Managers	25777 25776	029 21825777 029 21825776

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Authorised Transport Providers

1. St Johns Ambulance – see appendix on contents page

03300-586591

2. EMED

0300 777 44 77

3. Securcare

01656660749 or 07951788730 - Andrew.tucker@securcare.co.uk

4. SSC Secure Transport

07958372471 – info@sscsecuretransport.co.uk

5. MARS Secure Ambulance

02082073764 or 07446420634 - Info@marsnursing.com

If all of the above are unavailable and conveyance cannot be delayed until a time they are available then Prometheus authorisation can be sought via the UHB Executive team in hours or Silver on Call out of hours. Prometheus is only to be used when absolutely necessary due to huge cost implications. Therefore, it's use will require a much higher level of justification and scrutiny than the other providers. **Prometheus 24 HOUR BOOKING LINE 0800 009 6668**

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Appendix 4

ESCALATION PROCESS: AGE APPROPRIATE BED

