Essex Partnership University
NHS Foundation Trust

EPUT Capacity, Flow and Escalation Policy

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OPERATIONAL POLICY SUMMARY

Optimising flow through the system supports individuals to receive inpatient care at the right time, in the right place and for the right duration and thereby supporting patient safety and experience.
This policy serves to support the delivery of a consistent approach and is informed by national guidance. It seeks to set out the whole system response to escalation in operational pressures.

NHS Mental Health LTP Ambition (by 2023/24) is that the therapeutic offer from inpatient services will be improved by increased investment in interventions and activities, result in in better patient outcomes and experience in hospital. This will contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings.

Together the Care Act, the Mental Health Act and the Mental Capacity Act set out what organisations must do, each Act has a set of distinct yet overlapping guiding principles, which include:

- that people must be involved in decisions about their care as fully as possible
- that people's wishes should be taken into account
- that people should be treated in the least restrictive way possible.

THE TRUST MONITORS THE IMPLEMENTATION OF AND COMPLIACE WITH THIS OPERATIONAL POLICY IN THE FOLLOWING WAYS:

- SENIOR OVERSIGHT HUDDLE
- EXECUTIVE SAFETY OVERSIGHT

SERVICES	APPLICABLE	COMMENTS
TRUSTWIDE	YES	

THE DIRECTOR RESPONSIBLE FORMONITORING AND REVIEWING THIS POLICY IS:
THE EXECUTIVE DIRECTOR OF MENTAL HEALTH

EPUT Capacity, Flow and Escalation

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EPUT Capacity, Flow and Escalation

1.INTRODUCTION.

1.1 The scope of this policy is to support a whole system approach to manage patient flow, demand and capacity. Particular attention will be paid to reducing variation in admission with focus on 'place based' admissions for patients to their local area, the principles of purposeful admission and discharge pathways. Each of these areas of focus are intended to support the patient admission to the right place, at the right time and for the right duration. Improvements to patient flow in healthcare settings are understood to contribute to an increase in patient safety and it is vital that any improvements to patient flow do not compromise patient safety or system reliability.

1.2 AIMS

This policy sets out to support the delivery of a consistent and communicated approach to patient flow across EPUT Mental Health services. The system is multi factorial and reliant on procedural, structural and behavioural responses from many teams and professionals.

The flow and capacity agenda is supported by the work of the purposeful admission and therapeutic care steering group with oversight provided via the Senior oversight huddle and executive safety oversight group. Focus on Patient flow is situated as a key safety priority for the EPUT Executive team.

1.3 NHS Long Term Plan

The NHS Long Term Plan builds on the priorities established in the Five Year Forward View and sets out how the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting and sets out new, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities sets the NHS's priorities for care quality and outcomes improvement for the decade ahead.
The focus remains on building capacity within community services to reduce demand and release capacity from the acute sector and inpatient admission with an emphasis on boosting 'out of hospital' care. Underlying principles are to ensure care delivery models are both resilient and sustainable.

1.4 Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages. March 2020

'COVID-19, and the national measures being announced to delay the spread of the epidemic will inevitably have a significant impact on both demand for and capacity to deliver support for people with mental health needs, a learning disability or autism. The impact on people's mental health will endure beyond the epidemic'.

The document outlines:

- Robust access assessment arrangements are important to ensure the most acutely unwell patients receive the care they require in a timely way.

- It is important to discharge as many patients as possible where it is safe and clinically appropriate to do so. Enhanced focus on delayed discharges at this time will support throughput.

This may mean providing additional support, including making reasonable adjustments.

- In preparing for and responding to COVID-19, staff in mental health/ learning disability and autism providers may need to make difficult decisions in the context of reduced capacity and increasing demand. These decisions will need to balance clinical need (both mental and physical), patient safety and risk. Due to the need for rapid decision- making, providers may choose to use an existing patient panel or an ethics committee to advise on decisions.
- When considering plans, providers should consider not just patients' vulnerability to the physical infection but vulnerability stemming from mental health needs, a learning disability or autism too. People will be at risk of mortality through suicide, injury through self-harm and of self- neglect, so changes to services need to have patient safety as the paramount concern.
- Partnership working is crucial, and responses will need to be co-produced where possible. To both maximise the use of community assets and to draw on the insight and expertise of partners, response plans will need to be developed alongside patients, families, carers, voluntary community sector (VCS) organisations as well as neighbouring mental health/ learning disability and autism providers. This will include planning within an NHS-led provider collaborative, with social care partners, the criminal justice system, commissioners and education providers for children and young people (CYP).
- Providers will need to maximise delivery through digital technologies to ensure continuity of care where patients are asked to isolate and in response to reduced staff numbers or mobility. Digital technology can also be used to support continuity of social contact for patients, families and carers.
- Providers should bear in mind the longer-term impact of the pandemic and associated impacts on the mental health needs of the population and seek to minimise changes that impact on the capacity and capability of the system longer term.

The following 3 aspects will form the framework for the EPUT Capacity, Flow and Escalation operating model:

  - Creating Flow: Provide services to meet demand
  - Flow: reduce variation and improve reliability
  - Increase responsiveness to problems in patient flow.

2. CREATING FLOW: PROVIDE SERVICES TO MEET DEMAND.

2.1 SURGE MANAGEMENT AND RESILIENCE TOOLKIT (SMART)

EPUT have implemented SMART as the tool to support patient admission demand and repatriation. The platform provides a local and system-wide overview of operational

pressures and via a series of dashboards enables EPUT to track patient flow between care settings, as well as an in-day view of current demand and capacity, mapping of all patient admission referrals and repatriations from a range of providers and services. This can include acute trusts, community settings, other mental health trusts or providers, section 136 suites (HBPOS). The mental health capacity management view provides an overview of adult mental health bed and Section 136 demand and capacity. Dashboards provide information at Provider, Integrated Care System (ICS) and Regional level, and support improved patient journeys through data transparency and shared situation awareness.

EPUT Bed Management team will enter the required bed occupancy and capacity data into SMART as informed by Clinical Matrons and Service Managers on the daily safe staffing and bed occupancy sit rep calls (see appendix 5)

Urgent Care Pathway teams will update SMART in real time for patient admission demand in Community and Acute Hospitals (See appendix 4).

2.2 OPEL ALERT STATUS:

SMART will offer an indicative Operational Pressures Escalation Level (OPEL) alert status (see appendix 8). By adopting this SMART indicative OPEL, EPUT are aligned in the trigger points for each OPEL alert status offering consistency in reporting with National and Regional Mental Health providers.

The EPUT OPEL Escalation framework (see appendix 9) sets out the communication responsibilities and actions to be undertaken by each team and service line in order to maintain patient flow and sufficient capacity to meet demand. In the event of heightened OPEL Alert the recovery actions and system communication required is set out.

2.3 SAFE STAFFING AND BED OCCUPANCY SIT REP.

EPUT hold a minimum twice daily (AM & PM) review of inpatient and urgent care pathway staffing to ensure adequate staffing to maintain patient safety and provide effective care. During OPEL alert status 3 and 4 a third (midday) call is added. Each Call is chaired by a clinical matron or operational service manager who is responsible for decisions made.

Each clinical matron will review their wards to ensure staffing is sufficient and implement local mitigation as required. This mitigation detail is added as professional judgement by the Clinical Matron to SAFE CARE. Where it is not possible to mitigate locally, the Clinical Matron will raise on the Sit Rep and wider locality, multidisciplinary mitigations actioned.

Chair of the sit rep will identify the Staffing RAG Rating and trigger staffing escalation actions as indicated (see appendix 9).

At each call, Chair will then focus on current bed occupancy/ capacity and anticipated patient movement. Bed management will collate the verbal information provided by clinical matrons and service manager for each ward (see appendix 5) and the occupancy status of each Health Based Place of Safety (HBPOS). Bed management will update this information

on SMART 3 times daily. Escalation actions required for closed beds will be identified by the chair.

Following the summary of available bed capacity, the Bed Management Team will be asked to display the admission demand.

Chair of the Call will review each Patient, identifying those where:

- Face to face gatekeeping has been completed and acute admission indicated.
- Pending Home Treatment team face to face gatekeeping
- Mental Health Act assessment outcome is pending
- Transfer of care from assessment unit to treatment ward is required.

Informed by ward staffing, ward acuity/activity and ward capacity Chair of the call will identify a ward for each pending admission based on clinical priority. Principles of locality place based admission to be considered and facilitated where possible, however patient safety remains highest priority. In addition, North Patients for admission to South Beds are to be admitted to Basildon treatment wards where possible.

Where there is insufficient capacity to facilitate all admission demand, the Chair is to seek assurance from Home Treatment Team (HTT) that there is sufficient community mitigation and safeguards in place to continue with community intervention as alternative to admission with review at next sit rep.

HTT are to raise as a priority for admission those individuals for whom HTT are unable to provide adequate mitigation and/ or there is escalating risk presentation.

If required, Chair to lead discussion focused on clinical prioritisation for admission.

Clinical Matron/ Service Manager agreement for admissions and transfer of care to be confirmed on the call and arrangements for clinical handover confirmed.

Indicative OPEL Status to be provide by SMART tool and Chair to confirm and clarify all OPEL escalation actions required.

Following each call the Chair is to communicate OPEL Status and escalation actions needed via PANDO.
Sit rep reporting template of both patient and non-patient decisions made and the rationale to be completed and stored in shared drive (see appendix 7).
All Patient records are to be updated on SMART following the Sit Rep Call. To include narrative on actions, delays and mitigations in place pending admission.

- Bed Management team to update SMART for agreed patient admissions.
- MHL/HTT to update SMART re: delays and mitigation/safeguards in place.

Bed Management team are to forward MST diary invites to additional participants for escalation calls as determined by escalation actions – set out by chair.
Matrons/ Service Managers are to feedback to Ward Managers and Community teams agreed patient transfers and admissions.
Clinical teams are to ensure comprehensive clinical handover to receiving ward is completed prior to transfer/admission.

Bed Management are to facilitate agreed patient movement and communicate progress (transport booking ETA etc.).

2.4 FLOW SUPPORT (BED MANAGEMENT TEAM)

The EPUT bed management team operate 8am until 8pm 7 days each week.
The team is present on each safe staffing and bed occupancy sit rep call and leads on collating the information verbally handed over by clinical matrons/service managers regarding bed occupancy and capacity. Bed Management team then enter this detail into SMART.
The bed management team maintain communication with ward teams across the day, gathering updates on patient discharge and leave to facilitate smooth flow of patient admissions.
In line with the 'who pays' National guidance, the bed management team accepts detail of requests for admission for all patients with a GP within Essex. The detail of admission demand is shared by the bed management team on the (3x daily) Sit Rep call where the clinical chair is responsible for all decision making regarding admission. Bed management also inform the sit rep Chair of patients in Essex acute hospital from other CCG localities.
Information regarding pending Mental Health Act assessments is provided to bed management by locality AMHP Hubs to be raised by bed management team on sit rep calls.
The Bed Management team lead on all communication and liaison for out of area patients with neighbouring Trusts and CCG's supported by escalation to the clinical chair of sit rep and locality leadership teams.
The bed management team facilitate the communication around admission by connecting refers to admitting wards in order for clinical handover to take place, ensuring transport is arranged and updating SMART.
Following escalation to Director for authorisation to admit to Out of Area (OoAP) the bed management team will complete referrals and IPPA funding forms. Bed management will maintain an accurate log of all OoAP and ensure this information is added to SMART.
A daily written handover detailing all admission demand and outcomes is maintained and forwarded at the end of each working day to locality site coordinators, operational clinical managers, on call managers and EPUT leadership team. This includes guidance for on call managers who are encouraged to participate in daily PM sit rep to support in out of hours decision making.
The bed management function passes to locality site coordinators between 8PM and 8 AM.
A comprehensive handover from locality site coordinator to bed management team detailing all out of hours activity demand is forwarded to bed management team each morning.

2.5 AMHP HUB

Referral for Mental Health Act (MHA) Assessment will in all but exceptional circumstances be made following intervention from EPUT community teams. MHA assessments should be planned and collaboratively undertaken with the patients care team and supported by the Home Treatment team who will explore opportunities for an alternative to inpatient

admission. All least restrictive alternatives must be explored with Community Consultant or Clinical Manager prior to referral for MHA assessment.

Essex County Council AMHP Hub will participate in Daily Safe Staffing and Bed Occupancy Sit reps, updating on pending MHA assessment demand (inc. S.135 MHA).

Local Authority AMHP Hubs will communicate with one another to agree clinical priority for execution of MHA S.135 warrants to EPUT HBPOS. EPUT will be kept informed of these discussions and priority warrants.

3 FLOW: REDUCE VARIATION AND IMPROVE RELIABILITY

3.1 Home Treatment Model: Home First model of acute care.

All admissions will be 'gatekept'. This process will involve assessment and formulation of a treatment and support plan. This formulation will indicate where care and treatment will be provided, either as a community alternative to admission or inpatient admission.

All referrals where admission to inpatient services is a consideration will have a face to face gatekeeping assessment completed by a senior clinician (Band 6 or above). This gatekeeping assessment will focus on opportunities for a community intervention as a preferred alternative to inpatient admission.

The gatekeeping assessment will be accepted by the receiving team in accordance with the Trusted Assessor model and where the assessment indicates an inpatient admission will be used as the working care/treatment plan for the initial stage of admission.

Where the Individual is known to the community team referrals will only be accepted following an up to date review by that team which has been undertaken shortly before the referral and that the review relates to the current episode of concern.

Each referral for admission will have a clearly defined purpose including an articulated understanding of why this need cannot be met in the community. Alongside the purpose of admission, the referring gatekeeper will provide an indicative duration for the admission and clarify all barriers to discharge. All admissions will be supported by a comprehensive assessment which will be inclusive of social circumstances. Any accommodation needs will be identified enabling early resolution at the point of admission and prevent avoidable delays.

Home Treatment teams will complete face to face follow up assessment and review of all Informal admissions within 72 hrs of admission and actively identify with the ward MDT those Individuals where Home Treatment are able to support earliest safe discharge over a 7 day period.

EPUT Home treatment teams will adopt a trusted assessor model, completing assessments and agreeing discharge intervention for neighbouring EPUT Home Treatment teams.

Core to the function of the Home treatment teams is supporting both community alternatives to admission and earliest safe discharge. Home Treatment teams will attend clinical meetings and ward reviews regularly to support leave and discharge planning.

The efficient and effective operation of the home treatment service is dependent on flow through its own pathway. The Zoning model will underpin the principles of patient flow and only those Individuals who are within the Red Zone or have recently moved to amber will be seen within the Home Treatment Service. The Home Treatment service will also utilise service user outcome based care plans to support step – down.

It is recognised that to facilitate this flow; capacity necessarily has to be created within the community pathways. The community pathways will also adopt flow and capacity processes and procedures, utilising zoning model and case load capacity monitoring dashboards.

3.2 **Transfer of Care between Wards**

In addition to a verbal clinical handover, the Assessment unit (AU) or transferring Treatment ward team will ensure all documentation regarding clinical risk presentation, observation levels and care planning is available to the receiving ward prior to Patient transfer. Receiving ward will review this documentation and seek clarity from the transferring ward/AU where needed prior to patient arrival.

The transfer of care documentation will be completed by the transferring assessment unit or treatment ward and forwarded to the receiving ward (see appendix 11). This will also include an inventory of personal belongings.

All transfers will have a transport risk assessment completed and appropriate transport and escort arranged based on this.

All registered staff will also be able to access patient clinical information via the Health Information Exchange portal (HIE).

Transfer handover form will be completed at point of transfer to inpatient wards.

The transferring ward /AU will update the clinical system (Paris/Mobius) to end the admission episode on transferring ward/AU to enable new episode of care with the receiving ward to be commenced.

3.3 **Purposeful admission – Inpatient Care**

The series of principles below have been created by clinical teams as core to ensuring all admissions are purposeful (see appendix 15):

- Reasons and Purpose of admission is clearly documented in Gatekeeping entry.
- Reason and purpose for admission issues are proactively managed and detailed in the care plan (My Care My Recovery)

- All transfers of care from MHAU to Treatment ward will have clearly defined and documented purpose for treatment admission included anticipated duration of admission informed by consultant and MDT assessment and review.
- Every day should be valuable (R2G)
- An expected date of discharge is set at admission.
- Patients reporting positive experience/ satisfaction.
- People are empowered. Service user and carer input is central to all aspects of discharge planning arrangements.
- Timely, safe and appropriate discharge planning, the result of good care planning from the decision to admit to providing post discharge support.
- The practical and social reasons influencing the admission have been raised / addressed
- Availability of less restrictive alternatives to inpatient admission such as acute focused Home First/Treatment services offering an alternative to inpatient admission.
- Overarching care plan that includes joined up community and inpatient care.
- Inappropriate readmissions to hospital
- All MDT are committed to improving the acute care pathway and engaged with improvement initiatives.
- The process of ward reviews/ward rounds offers the most effective use of resources to maximise therapeutic engagement time.
- A focus on recovery approaches, social inclusion and community engagement is evidenced throughout the acute care pathway to promote individual recovery.
- Patients have a therapeutic experience
- Safer Care Bundle Principles are embedded into practice.

3.**4 Inpatient (Functional) Model.**

All admissions into Inpatient wards are to be admitted for an assessment period and reviewed by Consultant Psychiatrist within 72hours of admission. All admissions are to be purposeful with agreed goals for the admission.

The following Safer Care bundle principles are core to the admission pathway (See appendix 12):

- Every Person to have a daily senior review.
- Meaningful expected date of discharge (EDD) to be set within 72 Hrs of admission and shared with Individual and families/carers
- Flow of patients from inpatient to community to begin at earliest opportunity. HTT Active engagement in promoting earliest safe discharge; prompt referral for community services if Person previously unknown.
- Care Coordinator is to actively engage with admission by participating in 1st week review, to support discharge planning and understanding of barriers.
- MDT Review of all extended length of stay (LOS) – Review of all Patients with extended LOS 28+ days.

Each locality will host a weekly senior inpatient and community review and discharge planning meeting (see appendix 14) chaired by the Operational Service manager and informed by Red 2 Green NHS improvement methodology (see appendix 13) to ensure:

- All admissions remain purposeful and are focused on progression towards earliest safe discharge.
- Barriers to discharge and challenges experienced in community care are shared and understood.
- All community and inpatient actions required to facilitate smooth and timely discharge are communicated and agreed.
- Clarity and agreement for post discharge follow up arrangements (within 48hrs) and discharge plans.
- Identify delayed transfer of care patients requiring escalation within wider health and social care system.
- To hold one another to account for delivery of actions and agree escalation actions as needed.

As part of this meeting the Red to Green (R2G) level of constraint will be understood and escalation actions implemented:

- Ward level constraint – requiring inpatient operational leadership escalation
- Trust level constraint – requiring inpatient and community operational leadership escalation
- System level constraint – requiring senior (service manager/associate director) escalation with system partners.

Please refer to appendix 20 for EPUT System escalation to support in delay prevention and resolution of system delayed transfer of care.

In addition, each locality will hold a joined up High intensity user group (see appendix 16). This forum will review the plan of intervention for all frequent and high intensity users of mental health services in the locality to ensure comprehensive and joined up care plans are in place across service lines and pathways. This forum will also support clinicians managing complex risk by acting as a consultation forum. Membership includes inpatient and community clinical leadership and management.

4. INCREASE RESPONSIVENESS TO PROBLEMS IN PATIENT FLOW

4.1 **Discharge Coordination.**

Each locality will have identified discharge coordination support. The emphasis of this role is to support inpatient and community teams in the smooth and timely transfer of care from inpatient to community service and working to prevent delayed transfer of care (see appendix 17).

On admission discharge coordination teams will complete a screening on barriers to discharge, this screening will inform actions needed (see appendix 19). Discharge coordination teams will offer support to wards and community teams where there is clearly a defined pathway to resolution of delay and lead the most complex multi-agency discharge planning.

Weekly delay escalation calls will be held to include community and inpatient teams in addition to Social Care leadership teams and Health and Social Care commissioning. Escalation of actual and potential delayed transfer of care will be raised with the focus on supporting resolution of identified barriers to discharge and agreeing joined up actions. Action logs will be completed and circulated identifying key actions, owner and timeframe for completion

Please refer to appendix 20 - EPUT escalation structure for delayed transfer of care

Discharge teams will be responsible for ensuring accurate reporting of delayed transfer of care on clinical systems (Paris and Mobius).

Discharge pathways are to include system support available from community voluntary services in addition to EPUT community services. Each locality has good connections to the local services and Discharge coordination teams can signpost as needed.

Discharge teams are completing a series of pathways and processes for application in ensuring that patients considered to have No Recourse to Public Funds (NRPF) are supported in line with legal requirements. A series of pathways, dependent on the needs of the patient and potential hurdles to assessing these needs is in development. These pathways discuss common barriers seen in challenging appropriate, timely discharge of patients with NRPF status.

Funding is available to support in admission avoidance and facilitating earliest safe discharge by working in partnership to support people who do not require inpatient mental health support and do not have accommodation (see appendix 18).
The over- arching aim of this funding is to ensure:

- That no one is admitted to mental health hospital where lack of housing is the priority need.
- To support timely, safe discharge from hospital.
- To reduce likelihood of readmission.

On a monthly basis, supported by EPUT performance team, the Discharge Coordination leads will complete a review of all patients with an extended (28+ days) length of stay (LOS) to provide assurance that each individual patient with an extended LOS has a clear treatment plan and remains in active treatment with progression towards discharge. Where it is unclear or further MDT review is indicated this will be escalated to Medical and Operational leads.

4.**2 Multi Agency Working**

Creating flow is dependent upon multi agency working. Liaison with Housing, Police, Local Authority and Community Voluntary Services facilitates both multi agency planning to enable service users to remain in their own home and to facilitate earliest safe discharge. Whilst essential to the flow it is recognised that effectiveness is consequent upon the formulation of good collaborative partnerships and the priority demands of these services.

EPUT will host Multi Agency Discharge Events (MADE see appendix 25) which bring together system partners to:

- Support Inpatient Flow across the system
- Recognise and unblock delays
- Challenge, improve and simplify complex discharge processes.

Guidance and protocols for completing required documentation for funding panels can be found on the EPUT INPUT along with associated training (see appendix 26)

4.3 **Out of Area Private Admissions.**

EPUT are committed to the elimination and sustainability of Zero inappropriate Out of Area Placements (OoAP) being used by March 2022. To support this ambition authorisation for all inappropriate admissions will need to be sought from Mental Health Inpatient Director (or Associate Director in absence) or Director On Call.

Whole system flow and purposeful admission is key to achieving and maintaining this ambition although it essential this is balanced against patient safety.

Care Coordinators are expected to maintain contact with each Patient and placement provider during an OoAP admission, holding an oversight of clinical progression towards discharge and supporting earliest safe discharge planning.

Dedicated discharge coordination maintain oversight of all placed in OoAP ensuring referral for previously unknown patients are completed to community teams, identifying individuals benefitting from priority repatriation to Essex and supporting to resolve barriers to discharge.

To support in achieving Zero inappropriate OoAP EPUT have developed contracted appropriate OoAP beds with private providers in Essex. These appropriate admissions are underpinned by a series of quality and continuity principles which allow for reclassification by NHS E (see appendix 24).

Principles of continuity
1. Clear shared pathway protocols between units/organisations – particularly around admission and discharge
2. An expectation that a person's care co-ordinator: • visits as regularly as they would if the patient was in their most local unit • retains their critical role in supporting discharge/transition
3. Robust information-sharing, including the ability to: • identify cross-system capacity • access full clinical records with appropriate information governance where necessary
4. Support for people to retain regular contact with their families, carers and support networks: e.g. this might be achieved with optional use of technology, transport provision, etc

Quality Assurance Principles (QAP) for appropriate OAPs in East of England

A set of ten quality assurance principles are recommended. If all ten of the below principles can be evidenced, in addition to the continuity principles, it will enable an inappropriate OAP to be considered as an appropriate OAP:

QAP1	Only deemed a clinically appropriate placement for a service user who lives in local catchment areas of independent sector mental health provider
QAP2	Dedicated Qualified Staff (DQS) in place whose role is to monitor the clinical support, patient experience and length of stay for each service user. This includes the estimated date of discharge (EDD). This should include attendance at scheduled reviews taking place on specific days and times.
QAP3	DQS are the link between private provider and ensure the services users contact and support from the relevant NHS provider Community Team/Community Consultant.
QAP4	DQS report directly to the relevant Lead Nurse and meet face to face twice a week
QAP5	Daily overview (involving Local Authority colleagues), for all NHS provider beds including service users at the private provider
QAP6	Weekly reports are provided to senior clinical leadership team of progress and any issues e.g. facilitating treatment/ discharge that require support to unblock.
QAP7	Colleagues at the independent sector/ private MH provider have read only access to NHS provider EPR and relevant communication platform (e.g. MS Teams)
QAP8	The independent sector/ private provider participates in internal Quality and Safety Reviews which report through appropriate safety committee and NHS Trust board

QAP9	Admission and Discharge activity of all beds/OAPs and those with identified private providers are provided on a daily basis to clinical teams; including NHS provider Execs and Commissioners.
QAP10	NHS Trusts work to negotiate a reduction in costs for block booking to ensure cost effectiveness. This may also include additional cost agreements such as reduced/zero admin costs, transport costs or other associated care costs. As an example, NSFT have negotiated a 6% reduction in the usual day rate for ISP beds used in area.

4.4 Community teams

The overarching philosophy within the EPUT community services is that of a person centred recovery model enabling service users to receive care as close to home as is practicable and of a nature and type which accords with their individualised outcome based care plans. Within this model the role and importance of carers, family members and informal networks is equally acknowledged and where practicable supported to maintain their caring role. It is fully acknowledged that this support element is crucial in supporting 'out of hospital' care for those who use our services.

Hospital admissions should therefore only be considered when the assessment and /or treatment need of an individual and or risk cannot be delivered within this community context for reasons of complexity and/or risk can only be delivered subject to detention under a section of the mental Health Act.

All admissions must therefore be purposeful, with all members of the MDT having a shared clarity as to the purpose and proposed outcome. This plan should also, wherever practicable include proposed intervention type and length of stay.

Those admitted and not previously known to community services will referred and prioritised for allocation by the community team.

4.5 Post Discharge Follow Up.

Discharge from inpatient to community services can be a time of increased risk of self harm and suicide. Evidence from the 2019 confidential inquiry into suicide and homicide by people with mental illness showed that most post discharge deaths by suicide occurred in the first week after leaving inpatient care, with the highest frequency on the third day after discharge.

Key drivers for post discharge follow up within 72 hours.

- Reduced risk of suicide for high risk service users immediately post discharge
- Improved cross – pathway care coordination and discharge planning thereby reducing avoidable readmissions
- Reduced variation in practice in managing the transition from inpatient to a community service enabling improved communication and linkage between teams.
- A better, safer experience for service users, families and carers.

Ambition for shorter follow up period:

- Whilst the NHS standard contract is for post discharge follow up to be completed within 72 hours EPUT have set an ambition for post discharge follow up to be completed with 48 hours of discharge.
- Each individual should leave hospital with the date, time and venue of the post discharge follow up confirmed. Community teams will communicate and change to these arrangements including reasons for any delay.
- The Home Treatment Team will be responsible for completing the post discharge follow up within 48 or 72 Hours for any patient discharged from the Assessment units.
- Community Care Coordinator/Team will be responsible for ensuring post discharge follow up is completed within 48 or 72 Hours for patients discharged from treatment wards
- See appendix 22 for actions and appendix 23 for scope of quality post discharge follow up

A 48/72 hour follow-up cannot be carried out on the date the patient is discharged – regardless of how early in the day the discharge occurs.

Day 0 – Patient Discharged	**Day 1 Post Discharge**	**Day 2 Post Discharge**	**Day 3 Post Discharge**
Post discharge follow up cannot be made on this day (regardless of what time patient discharged)	Ward Team to complete 24 hour post discharge telephone call.	Community team to complete face to face post discharge follow up. Telephony follow up should be the exception.	48hour Post discharge follow up breached – Community teams to ensure post discharge follow up completed.

Midnight Clock Starts | Midnight 24 Hours | Midnight 48 Hours | Midnight 72 Hours

4.6 Sustainability

Monitoring and oversight of patient flow is essential and this will be provided by the Associate Director of Flow and Operational Transformation reporting to the Senior Oversight Huddle and Executive Safety Oversight Group.

Awareness and training at the point of implementation is essential to maintaining successful outcomes and this will be provided via the Inpatient Quality and Safety forum.