Access to mental health inpatient services (all ages)

A Compact between Mental Health and Acute Trusts, Local Authorities, ICBs, NHS England, NHS Improvement, London Ambulance Service and Police services

Access to mental health inpatient services (All ages)

A Compact between London's Mental Health and Acute Trusts, Local Authorities, CCGs, NHS England, NHS Improvement, Ambulance Service and London's Police services

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2	07/06/2022	Judith Fairweather	Amendments to Section 7.2 issue 'Identifying, and making arrangements for, an alternative local placement when a patient is awaiting admission'	Page 37 – References to CMS and SMART updated. Clarification added for CMS reporting timeframes.
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2	06/07/2022	Ian Darbyshire	Amendments to Section 7.1.4 CYP MH Escalation Process	Page 36 – Escalation process added for a child or young person waiting for a Tier 4 bed.
2	11/07/2022	Judith Fairweather	Addition of Who Pays? Guide updates	Page 23 – Guidance added for transition payment arrangements
2	11/07/2022	Judith Fairweather	Figure 3 amended	Page 22 – References to CCG updated to ICB as per changes in Who Pays?
2	11/07/2022	Judith Fairweather	Updated Escalation Framework	Pages 34 & 73 – Escalation Framework updated to include notification to Director of Nursing (Level 3) and escalation to CEO (Level 4)
2	25/07/2022	Judith Fairweather	Appendix 5 added	Addition of Appendix 5: Surrounding Counties MoU
2	08/08/2022	Judith Fairweather	Addition to Section 4.2.3. Waiting for admission to inpatient care	Page 18 – clarified responsibility of bed management to source and secure hospital beds.
2	15/08/2022	Judith Fairweather	Addition	Page 43 - monitoring patient flow in and out of emergency pathways
2	17/08/2022	Ian Darbyshire	Addition	Page 20 – admission process for young person with a diagnosis of a Learning Disability and/or who is on the Autistic Spectrum (LDA)
3	16/02/2023	Katie Lunn	Wording amendment	Amended all reference of 'repatriation' to 'transfer'
4	04/01/2024	Katie Lunn	Wording amendment Addition	Replaced all reference of 'DTA' with 'from time of arrival' Page 19 & 77 – clarify responsibility around prison pathway
5	01/02/24	Katie Lunn	Wording Amendment Addition	Updated section 4.2.1 to reflect MHCAL process Added MHCAL process chart to Appendix 3

Compact signatories

Association of Directors of Adult Social Care (London)
Association of Directors of Children's Services (London)
London's Mental Health Trusts
London's Acute Trusts
London Ambulance Service
London's 32 CCGs
Essex Partnership University NHS Foundation Trust
Hertfordshire Partnership NHS Foundation Trust
Berkshire Healthcare NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation
Kent and Medway NHS and Social Care Partnership Trust
Oxford Health NHS Foundation Trust
Cambridge and Peterborough NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
Southern Health Foundation Trust
Solent NHS Trust
Isle of Wight NHS Trust
Sussex Partnership Foundation Trust
British Transport Police
City of London Police Force Metropolitan Police Service
NHSE London
NHSE South East
NHSE East of England

The organisations that are signatories to this Compact have made a commitment to work together across so that people in mental health crisis have timely access to a Health-Based Place of Safety and mental health inpatient care and treatment when they need it.

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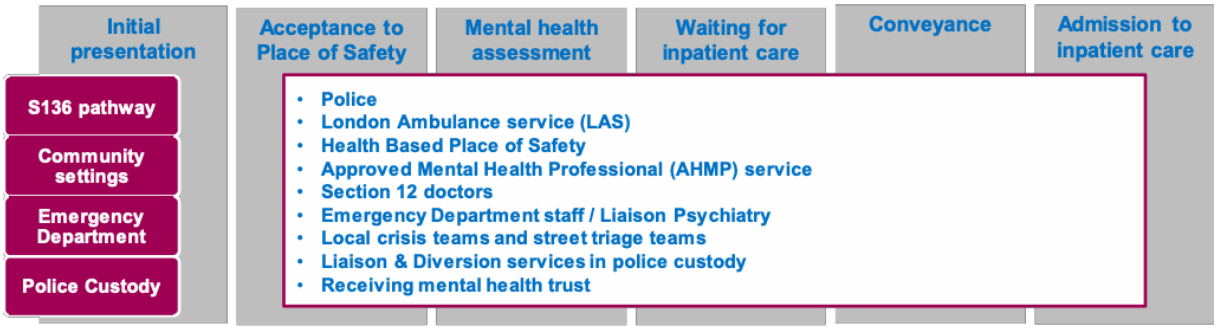
1. Summary

This Compact is intended to establish a common understanding of what is expected from each part of the health and care system in providing access to mental health inpatient facilities, including Health-Based Places of Safety, for patients in mental health crisis. The Compact is not intended to apply to access to services or facilities available in the community without the need for inpatient assessment or potential need for assessment.

Drawing on existing regulations and policies governing mental health services in England, as well as existing good practice, the Compact outlines the roles and responsibilities of individual organisations along all children and young people and adult patient pathways to admission (Figure 1).

Figure 1: Individual organisations with roles along the pathway



The Compact outlines maximum waiting times and timeframes for key stages along the patient pathway. It also provides a framework for capacity management and a escalation process to support access once individuals are waiting to be admitted. It also includes reporting requirements to make capacity pressures more transparent and to facilitate shared learning across the system.

It is intended that the principles contained in the Compact will be adopted by individual organisations and reflected in their local systems and planning.

The following principles apply to the acceptance of an individual into a Health-Based Place of Safety (HBPoS):

- Individuals detained under section 136 of the Mental Health Act (MHA) should be conveyed to the closest Health-Based Place of Safety.

- If a local Health-Based Place of Safety does not have capacity (which is monitored via SMART) to receive an individual, it is that facility's responsibility

to ensure the individual is received into a suitable place of safety in a timely manner, and that local Surge Services are updated.

- Once a place of safety has been identified and agreed to have capacity, police and ambulance staff should not have to wait more than 15 minutes.

- Acute and Mental Health Trusts should also have an escalation process in place to expedite issues once an individual is waiting to be accepted.

- Matters should be escalated to Surge Services[1] if an individual has been waiting more than 4 hours for a HBPoS from the time an initial request for access was received by the Acute or Mental HealthTrust.

- Commissioners and Acute and Mental Health Trusts should monitor and discuss utilisation of Health-Based Places of Safety at regular intervals.

The following principles apply to admissions to mental health inpatient services:

- Individuals in crisis should have a physical and mental health assessment and a care plan in place within 4 hours of arriving at a HBPoS or emergency department, or from the point of referral to the local crisis team or liaison and diversion service.

- If the outcome of a mental health assessment is that an individual needs admission, that person should be admitted to hospital as soon as possible following the time of arrival, and within 12 hours at most.

- If the outcome of a mental health assessment (either informal or MHA assessment) is a clinical decision that the individual needs inpatient admission, this should be formally recorded from time of arrival.

- Time of arrival to discharge is measured from the point of arrival in ED to discharge, admission or transfer for MH patients presenting in ED. These are identified using MH related diagnosis codes or Chief Complaints Time of arrival is *not* the time at which a vacant bed has been found and the patient is awaiting transport.

- Individuals should be admitted into care in a location that best serves their interests, and that is as close to their chosen location as possible, which can promote their recovery and support on discharge.

- Admission should not be refused or delayed due to uncertainty or ambiguity as to which ICB is responsible for funding the care.

[1] Surge Hub/Services includes proactively leading the local response to pressure surges by constantly monitoring pressure in the system. This ensures that all parties take appropriate action to manage surges in activity, and that all stakeholders focus on pressures across the system so that they can respond in a timely manner.

- Acute and Mental Health Trusts should also have an escalation process in place to expedite issues once an individual is waiting to be admitted, if a bed is not immediately available.

- Matters should be escalated to Surge Services if an individual has been waiting more than 6 hours to be admitted to inpatient care.

- All delays of more than 12 hours to admit to inpatient care should be formally investigated and reported to NHS England and NHS Improvement. If the breach occurs out of hours, reporting to NHSE must occur the next working day.

- Commissioners and providers should monitor and discuss bed occupancy levels in their local organisations and with their Surge Services, and providers should update these daily on the Capacity Management System (CMS).

2. Introduction

Individuals presenting in mental health crisis should have timely access to effective intervention as an alternative to hospital. However, access to a Health-Based Place of Safety and/or inpatient care and treatment may also be needed.

Inconsistent decision-making and a lack of transparency, around capacity management and escalation, can result in delays to access and the individual's care and treatment.

These delays can result in the service user becoming more distressed and unwell, as well as increasing clinical risk when they are at their most vulnerable. They may also have consequences for the service user's family and/or carers, as well as increasing pressure on other local services.

To support timely access to inpatient care for service users, their family and/or carers, a common understanding has been developed. This Compact sets out the roles and responsibilities of individual organisations along patient pathways to admission, and details principles for a collaborative approach to capacity management and escalation.

It is intended that the Compact will be agreed and adopted by individual organisations and reflected in local systems and planning. For example, Acute and Mental Health Trusts should ensure that their own systems and protocols for capacity management and escalation reflect the principles set out in this Compact.

Section 10 of this document provides a comprehensive list of useful reference materials.

The Compact also draws on:

- existing protocols for access to acute facilities, for those admitted with physical health needs
- Updated S136 specification (click here)
- several London Mental Health Trusts' own escalation protocols
- international examples

Reports of past incidents involving lengthy waits have also been considered.

3. Scope

The Compact applies to access to Health-Based Places of Safety and mental health inpatient care in London and all signatories.[3] It covers services for all ages – children and young people (CYP), adults and older adults – who present in mental health crisis.

A 'place of safety' is used when an individual of any age has been detained under section 135 or section 136 of the Mental Health Act 1983. Places of safety are defined under the Mental Health Act 1983.

A mental health crisis can be defined as a situation that the person experiencing the crisis or anyone else believes requires immediate support, assistance and care from an urgent and emergency mental health service due to an apparent risk.

There are many possible causes or triggers of crisis. For example, some people experience adverse life events that include psychological, physical or social elements that may require an urgent or emergency response from mental health services. All crises will be different in their cause, presentation and progression.

The Compact is applicable to:

- Mental Health Trusts including listed surrounding counties
- London Acute Trusts with designated Health-Based Places of Safety and/or emergency departments
- London's Police services
- London Ambulance Service
- London's Integrated Care Boards
- London's Approved Mental Health Professional (AMHP) services
- London's Surge Services

[2] Healthy London Partnership, section 136 pathway and service specification: https://www.healthylondon.org/wp-content/uploads/2017/10/Londons-section-136-pathway-and-HBPoS-specification-updated-Dec-2017.pdf December 2017

[3] Designated Health-Based Places of Safety in London for people detained under section 136 of the Mental Health Act can be found on the Care Quality Commission's Website: http://www.cqc.org.uk/content/map-health-based-places-safety-0

It is *not* directly applicable to services and facilities available in the community that do not provide acute inpatient care. However, it may be of interest to teams involved in the provision of other services, including:

- street triage teams
- mental health crisis lines
- community mental health teams
- General Practice (GP)
- third sector organisations supporting those with mental health needs

The Compact does not currently explicitly cover pathways for patients who meet the Transforming Care criteria, i.e. people with learning difficulties and autism, who display behaviour that challenges, including those with a mental health condition.

Care and Treatment Reviews (CTRs) are an integral component of the care pathway for this group of patients. The CTR will assess whether an individual's care and treatment can be provided in the community, and so ensures that individuals get the right care, in the right place, that meets their needs. NHS England has published CTR policy and guidance.

The national plan – Building the Right Support – provides a wider framework to enable commissioners to develop services for people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition.[4]

The Compact does not explicitly include detailed mapping of patient pathways for perinatal mental health services. Perinatal mental health services for London - Guide for Commissioners, published by the Healthy London Partnership in January 2017, provides a useful overview.[5]

4. Patient pathways to admission

4.1. Overview

Individuals in crisis can present in community, acute or criminal justice settings. Figure 2 (below) provides a high-level overview of the main pathways into inpatient care for those presenting in mental health crisis, including admissions via section 135 of the Mental Health Act.

[4] Building the Right Support: https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf
[5] Perinatal mental health services for London – Guide for Commissioners: https://www.healthylondon.org/wp-content/uploads/2017/10/Perinatal-mental-health-service-for-London.pdf

4.2. Roles and responsibilities: overarching principles

This section contains overarching principles at key steps in the pathway to ensure roles and responsibilities are clear, so that individuals get timely access to inpatient care when they need it.

This section should be read in conjunction with Appendix 1, which details the roles and responsibilities of individual organisations along the four main pathways to inpatient care:

- proposed admissions from community settings, including via section 135 of the Mental Health Act
- presentation at an emergency department
- detention in police custody
- via a section 136 pathway

In addition, national processes are in place governing access to children and young people's inpatient services and adult secure services.[6] These processes are outlined in Appendix 4. The pathways described in the Compact are not intended to be exhaustive clinically, but instead focus on pathway aspects where roles and responsibilities have been unclear in the past and may have contributed to admission delays.

In addition to the principles set out below, there are a number of aspects which should be highlighted from a service user's perspective. These aspects relate to the service user's experience, which can affect the overall timing of the pathway and potentially the admission decision itself:

- treating service users with compassion and dignity
- making every effort to access and follow an individual's pre-existing crisis care plan, where there is one
- explaining service users' rights to them, and giving them information about what is happening and what to expect over the course of the pathway
- seeking and listening to service users' views
- giving service users verbal updates about expected waiting times on their initial presentation to a service, and at regular intervals thereafter, especially if delays are anticipated
- informing those closest to service users about the person's whereabouts, and enabling service users to talk to friends, family or other people who are important to them, if they wish to do so
- referring and/or signposting service users to the care and support they need in the community, following treatment and/or an inpatient admission.

It is expected that all health and social care staff have been trained to spot the signs of potential abuse or neglect, and listen to concerns raised by patients (and their carers or families), and that they should understand their role in responding, including

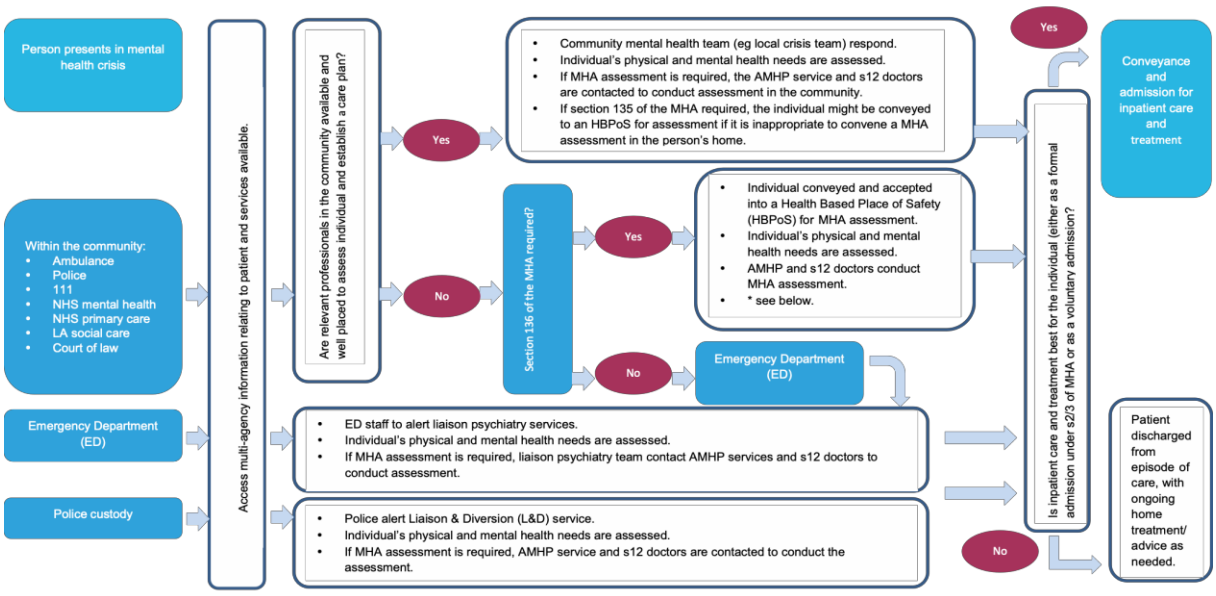
[6] NHS Commissioning - Adult Secure Services: https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-c/c02/

having a working knowledge of local adult and children's safeguarding arrangements. Further principles regarding safeguarding are set out in the Mental Health Code of Practice (2015).[7]

The remainder of this section discusses specific responsibilities of individual organisations along the care pathway to mental health inpatient care, covering:

- access to Health-Based Places of Safety
- mental health assessments
- waiting for access to inpatient care, including boundaries of responsibility between Mental Health Trusts for accepting individuals for admission
- conveyance and admissions to inpatient care

Figure 2: Overview of pathway into inpatient care for individuals presenting in mental health crisis



In cases where a S136 is applied the individual could still go to ED if there were emergency physical health needs or if there is no HBPoS capacity

[7] Mental Health Act Code of Practice (2015), paragraphs XXX1-XXXIV: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

4.2.1. Access to a Health-Based Place of Safety[8]

Initial requests for access and acceptance onsite

Organisations commissioned to provide a HBPoS should have a dedicated, single telephone contact available 24 hours a day, 7 days a week, 365 days a year.[9] This telephone number should be made available to partner agencies. In London, the Mental Health Clinical Advice Line (MHCAL) operates as a single phone number that the police call to gain advice prior to placing someone on a S136 or, if the person is already under a S136, to find the closest S136 suite available. Please note that all references to MHCAL refer to the London process for accessing HBPoS.

Before an individual is detained under a section 136, the police must phone ahead to the MHCAL to seek guidance and advice on whether the individual should be placed under a section 136, and signpost to alternative services where appropriate. If the individual is placed under a S136, the MHCAL will secure a HBPoS where available, and confirm whether the facility is able to receive the individual. The facility coordinator should be informed of:

- the circumstances of the detention and behaviours since
- use of weapons or crime
- suspicion and degree of drug or alcohol intoxication
- ambulance service involvement and their medical assessment
- risks to the individual and others
- any physical health needs, including injury

Failure to phone the MHCAL to secure a suite may result in the person being unable to be accepted on arrival, resulting in avoidable delay.[10] For those detained under section 135 and requiring assessment, the AMHP should phone ahead to confirm the facility has capacity for the individual.

When the HBPoS informs the MHCAL, police, ambulance service and/or AMHP service that it has capacity, this means it is able to receive the individual as soon as they arrive on site. Actions should be taken to preserve this capacity. If, in exceptional circumstances, the HBPoS becomes unable to accept the individual, the person who has requested access should be informed as quickly as possible and an alternative identified by the facility coordinator.[11]

If an alternative place of safety is not identified prior to arrival, police will notify staff of their arrival, which signals the start of the s136 24-hour detention period. The person will be kept in custody, with ambulance support where appropriate, until an alternative place of safety has been identified. The time the person arrives at the first

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[8] The principles in this section have largely been drawn from Healthy London Partnership's Mental health crisis care for Londoners: London's section 136 pathway and Health-Based Place of Safety specification (2016). It is important to note, however, that Health-Based Places of Safety can be used for Mental Health Act assessments for individuals detained under section 135 as well as section 136 of the Mental Health Act.

[9] Mental Health Crisis Care for Londoners: London's section 136 pathway and Health-Based Place of Safety specification (2016), pages 24 and 26 (specification reference 1.4).

[10] Mental Health Crisis Care for Londoners: London's section 136 pathway and Health-Based Place of Safety specification (2016), page 26 (specification reference 1.3).

[11] Mental Health Crisis Care for Londoners: London's section 136 pathway and Health-Based Place of

Safety specification (2016), pages 24 and 28 (specification reference 1.11).

place of safety (this could be an A&E department) is the point the s136 24-hour period is deemed to have started.
A capacity management tool via SMART is available to support the process of identifying a Health-Based Place of Safety by indicating each site's real-time capacity.

An individual detained under section 136 of the Mental Health Act should be conveyed to the HBPoS that is closest to where the person is being detained. Conveyance should be by ambulance[12] for the purposes of medical screening. The individual is still in the custody of the police, who must therefore accompany them to the HBPoS and who retain overall responsibility. Clinical judgements, however, must be made by appropriate clinical staff e.g., paramedics, with support if necessary from mental health nurses in the ambulance clinical 'hub' or local mental health triage lines.

It is not unlawful to use police transport as a last resort. For example, if the individual is violent, this can provide an appropriate rationale for police conveyance. It may be necessary for the highest qualified member of an ambulance crew to ride in the same vehicle as the patient, with equipment to deal with immediate problems and an ambulance following directly behind.

Similarly, where the ambulance service has identified that there is likely to be a significant delay (>60 mins), they should communicate this to the police and transport in a police vehicle can be considered, following notification of the ambulance service and if practicable the Duty Officer, or if unavailable, a supervisor. In both cases when this occurs it must be properly documented.

Similarly, if an AMHP and doctor(s) decide that it is inappropriate to convene a mental health assessment in a person's home on entry under section 135 of the Mental Health Act,[13] the AMHP may make arrangements to convey the individual to the closest HBPoS where there is capacity to admit, for that assessment to take place.

A decision that it is inappropriate to convene an assessment in a person's home should consider who else is present, particularly if the person is distressed by the assessment taking place in these circumstances. Decisions by an AMHP and doctors should be made in consultation with the police.

For individuals detained under section 136, LAS should attend within 30 minutes (or 8 minutes if the individual is being physically restrained). Once the individual has been conveyed to a place of safety, an initial assessment should be completed by the HBPoS team within one hour of the individual's arrival.[14]

[12] The use of ambulance service should always be considered first. However, it is not unlawful to use police transport. For further guidance see: Mental Health Crisis Care for Londoners: London's section 136 pathway and Health-Based Place of Safety specification (2016), page 29.
[13] Mental Health Act Code of Practice (2015), paragraphs 16.7-16.8.
[14] Mental Health Crisis Care for Londoners: London's section 136 pathway and Health-Based Place of Safety specification (2016), page 29 (specification reference 2.1).

If transfers between HBPoS sites, including ED, of an individual under s136, are required, these are the legal responsibility of an AMHP, police officer or someone who has been authorised by one of the two. However, co-ordination of the conveyance should be undertaken by the Mental Health Trusts or Acute Trusts and led by the s136 coordinator. In the case of a medical emergency after police have left the site, the person's medical needs should be prioritised and the AMHP notified as soon as possible after the transfer.

Police and ambulance staff should not have to wait more than 15 minutes to access the health-Based Place of Safety. Adequate, dedicated clinical staff should be available at all times, to ensure staff members are not removed from their duties in inpatient wards.

Expectations when there is no capacity to accept a person onsite

If the closest Health-Based Place of Safety does not have capacity to receive an individual, it is that facility's responsibility to ensure the individual is received into a suitable place of safety in a timely manner, working with their local Surge Service.

When facilities are unable to receive an individual, the facility should be familiar with the closest alternatives and *their* current availability. The facility coordinator at that facility should find an alternative or escalate the matter as per the Trust's own escalation protocol, whether the individual is from the area or not.[15] (See Sections 5 and 6 for further guidance on capacity management and escalation.)

A Health-Based Place of Safety should not refuse to accept a person unless the Trust's escalation protocol has been enacted (see section 6 for further guidance on escalation). This also applies to requests to accept a child or young person. An exception to this would be when the HBPoS team feel unable to meet the physical needs of the individual, which is discussed in further detail below.

Effective systems should be in place to manage capacity at the place of safety, including discharge planning, possible alternatives to admission, and demand planning (see section 5 for guidance on capacity management). Health-Based Places of Safety should also have arrangements in place to cope with periods of peak demand, using other parts of the hospital, neighboring Health-Based Places of Safety, or suitable alternatives.[16]

It is important that Health-Based Places of Safety are used as dedicated areas for mental health assessments and protected accordingly. They should not be used as overflow inpatient bed capacity where service users receive treatment and on-going care.

A person requiring an assessment under the Mental Health Act should not be refused access to a Health-Based Place of Safety on the basis there are no or few inpatient beds available onsite.

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[15] Mental Health Crisis Care for Londoners: London's section 136 pathway and Health-Based Place of Safety specification (2016), page 24.
[16] Mental Health Act Code of Practice (2015), paragraph 16.36.

Health-Based Places of Safety should not be expected to accept a person waiting to be admitted into inpatient care following a mental health assessment in the person's home under section 135 of the Mental Health Act.

Diversions to emergency departments including for reasons of intoxication

If a facility coordinator and Health-Based Place of Safety team feel unable to meet the physical needs of the individual and think that they need to go to the emergency department, staff at the health-Based Place of Safety have the right of refusal to the site. However, concerns about the ability of the health-Based Place of Safety team to meet the person's physical needs should always be escalated to an on-call doctor e.g. on call Higher Specialty Trainee (SpR), Core Trainee (SHO) or Associate Specialist. The on-call Consultant could be approached for mediation or consultation if an agreement has not been reached, but the final clinical decision as to whether the individual requires medical assistance at the emergency department lies with the doctor at the health-Based Place of Safety. Staff should discuss their specific concerns, and any additional assessment or intervention that is required.[17]

If someone appears to be drunk and showing any aspect of incapability (e.g., not being able to walk unaided or stand unaided) which is perceived to result from that drunkenness, then that person must be treated as drunk and incapable. A person found to be drunk and incapable by the police should be treated as being in need of medical assistance at an emergency department or other alcohol recovery service. The same applies to those who appear to be intoxicated by drugs to the point of being incapable.[18]

If the person is intoxicated but not showing any aspect of incapability and is detained under section 136, they must be conveyed to the locally-agreed Health-Based Place of Safety by the ambulance service. The Health-Based Place of Safety must not conduct tests to determine intoxication as a reason for exclusion to the site; this should be based on clinical judgement. It is the responsibility of the appropriate doctor at the HBPoS to decide whether the individual requires medical assistance at the emergency department. Case studies in previous guidance provide further detail on different scenarios relating to intoxication.

Under exceptional circumstances when an individual under section 136 presents at an emergency department with no physical needs (e.g. due to limited Health-Based Place of Safety capacity), the emergency department should not refuse access unless a formal escalation process has been enacted and the department has been closed to all patients. On arrival at the site the police must remain with the detainee until the emergency department/HBPoS staff have accepted the responsibility for the individual's custody and transfer of section 136 papers. If accepted by emergency department staff they should carry out the Mental Health Act assessment rather than transfer the individual to a Health-Based Place of Safety.

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[17] London mental health crisis commissioning guide (2014), page 7.
[18] Mental Health Crisis Care for Londoners: London's section 136 pathway and Health-Based Place of Safety specification (2016), page 34 (specification reference 2.26 and 2.27).

An emergency department can itself be a Place of Safety within the meaning of the Mental Health Act. Individuals detained under section 136 may require protracted physical health treatment or care in an Emergency Department, and where appropriate the Acute Trust should take legal responsibility for custody for the individual for the purposes of the mental health assessment being carried out.[19] Before emergency department staff accept formal legal custody, they must satisfy themselves that they are aware of the likely risks that the person presents and that their own staff can safely manage these.

Police officers will provide the necessary support needed unless there is a mutual agreement between the department and the police officers that they are able to leave.

If an individual is taken to ED, but legal responsibility not transferred, the police and ED staff must liaise and decide the most appropriate support for onward conveyance to the HBPoS. This may be an appropriately equipped transport or a member of staff from the Liaison Psychiatry team. Further details on the role of ED in the s136 pathway are found in Section 3 of the guidance.

Emergency departments should have a dedicated area for mental health assessments which reflect the needs of people experiencing a crisis.[20]

Use of police stations as places of safety

A police station should only be used as a place of safety in specific exceptional circumstances for adults. A police station must never be used as a place of safety for children under the age of 18.[21]

4.2.2. Mental health assessments

Individuals in mental health crisis presenting in an acute, community or criminal justice setting should have had a response by a mental health service within one hour of referral.[22] A response should consist of a patient review to decide on the type of assessment needed and arranging appropriate resources for that assessment. The initial response may also include consultation with an AMHP service.

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[19] Mental Health Crisis Care for Londoners: London's section 136 pathway and Health-Based Place of Safety specification (2016), page 24.
[20] London mental health crisis commissioning guide (2014), page 7; Mental Health Crisis Care for Londoners: London's section 136 pathway and Health-Based Place of Safety specification (2016), page 45 (specification reference 3.19).
[21] Policing and Crime Act 2017 (provisions came into effect 3 April 2017) https://www.gov.uk/government/publications/circular-0012017-policing-and-crime-act-provisions-commencing
[22] This principle has been established previously for acute pathways for adults and the section 136 pathway. For the acute pathway, see: Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence Based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance.

Unless there are clinical grounds for delay, individuals presenting in crisis should have a physical and mental health assessment and a care plan in place within 4 hours either of arriving at a Health-Based Place of Safety or emergency department, or from the point of referral to the individual's local crisis team or liaison and diversion service.[23] This timeframe excludes situations when a warrant is sought under section 135(1) of the Mental Health Act to facilitate the assessment.

If the outcome of a mental health assessment is that the person requires admission, the person should be admitted to hospital as soon as possible following the time of arrival.[24]

If an individual requires formal assessment under the Mental Health Act, the AMHP service should be contacted as quickly as possible to coordinate the mental health assessment (unless agreed otherwise locally).

The legal duty to assess falls on the AMHP service for the area where the person is located when the assessment is needed.[25]

Unless there are clinical grounds to delay the assessment, the AMHP and section 12 doctors should attend within 3 hours of being contacted to conduct assessments.[26] This timeframe excludes situations when a warrant is sought under section 135(1) to facilitate the assessment.

Assessments under the Mental Health Act must not be delayed due to uncertainty regarding the availability of a suitable bed.

Local Authorities are responsible for ensuring that sufficient AMHPs are available to carry out their role under the Mental Health Act, including assessing individuals to decide whether an application for detention should be made. A 24 hour service that is able to respond to patients' needs should be in place. Provision of dedicated AMHPs should be sufficient to meet needs, especially in out-of-hours periods.

ICBs and NHS England are responsible for ensuring that doctors are available in a timely manner to examine individuals under the Mental Health Act when requested to do so by the AMHP.[27]

[23] This principle has been established previously for acute and community pathways for adults, and also the section 136 pathway. For the acute pathway, see: Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence Based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance; for community pathways, see London mental health crisis commissioning standards and recommendations (2014).

[24] Mental Health Act Code of Practice (2015), paragraph 14.91.

[25] This excludes situations where a person has already been detained under s2 of the Mental Health Act, and an assessment is needed to determine whether detention under s3 is now required. In such cases, the legal duty to assess falls on the original team recommending detention under s2.

[26] Mental Health Act Code of Practice (2015), paragraph 16.47.

[27] Mental Health Act Code of Practice (2015), paragraph 15.9.

[28] 24/7 urgent and emergency mental health liaison in acute hospitals – Part 2. NHS England (2016)

4.2.3. Waiting for admission to inpatient care

Responsibilities for securing an inpatient bed

The doctor(s) undertaking the mental health assessment are not responsible for sourcing and securing a hospital bed. The bed manager (or staff equivalent) of the receiving Mental Health Trust should work closely with assessing doctors and AMHP to secure a suitable bed.[30] The bed manager will need to enact a formal escalation process in circumstances where a bed is not available to accommodate the service user.

The AMHP plays a vital coordination role in securing an inpatient bed when decisions have been made to detain a person under the Mental Health Act. ICBs should provide an accurate list of hospitals and their specialisms to local authorities, to help inform AMHPs as to their location.

To promote parity between physical and mental health, no individual should be waiting to be admitted for more than 12 hours from Arrival at an Emergency Department. All delays of more than 12 hours should be reported and investigated accordingly. (See Section 8 for reporting requirements.)

All individuals – including adults, and children and young people – should be admitted into care in a location that best serves their interests. This means making every effort to place individuals as close to a location of their choice, such as their home or family, which can promote their recovery and support on discharge.[31]

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[29] Mental Health Act Code of Practice (2015), paragraph 14.77.
[30] Mental Health Act Code of Practice (2015), paragraph 14.89.
[31] The Mental Health Act Code of Practice states that commissioners and providers should work together to take steps, with appropriate input from section 12 doctors and AMHPs, to place individuals as close to a location that the person identifies they would like to be close to (home, or close family friend or carer). Mental Health Act Code of Practice (2015), paragraph 14.81.

Boundaries of responsibility between Trusts for accepting adult inpatient admissions[32]

An adult patient should be accepted for admission by the Mental Health Trust responsible for care where the person is usually resident.[33] If a service user considers themselves to be resident at an address (e.g. at a hostel or other temporary residence), then this should be accepted as the individual's usual residence. Acceptance for admission should not be subject to proof of address (e.g., a tenancy agreement or utility bill). If the person's place of residence is unknown or they cannot provide an address, then the Mental Health Trust closest to where the person has been assessed should accept the admission. Prisons are not a place of residence. Any treatment provided by a Mental Health Trust to a prisoner must be discounted when considering which Trust is responsible for ongoing mental health care and treatment. This means that upon release the prisoner would be deemed to be a resident in accordance with their assigned/chosen residency upon release.

If the person's place of residence is unknown or they cannot provide an address, then the Mental Health Trust closest to where the person has been *assessed* should accept the admission, unless the assessment followed detention under S136, in which case the Mental Health Trust closest to where the patient was *first detained under S136 by the police* should accept the admission. This will also apply when a patient is waiting in ED if there is no S136 availability.

The above will also apply to where the patient committed a crime and arrested, but taken to another custody/remanded in prison in another areas. The trust closest to where the person has been *assessed* should accept the admission.

There are two possible exceptions to the principles outlined in the paragraphs above. The first is when a person presents a long way from home. If it is not in the person's best interests at the time to convey them to the receiving Trust, the Trust closest to where the person has been assessed should admit them temporarily.

The second exception is in situations where a person has received inpatient care within the past six months, or is receiving after-care under section 117 after-care or is on the caseload of a community team for treatment (not merely assessment). In such cases, if a transfer of care under the London Transfer Agreement has not been initiated by the referring trust, and the patient has expressed a preference to be cared for by the trust providing ongoing care, then they should be admitted by that trust. In all other cases the default arrangement in the paragraphs above will apply.

Appendix 2 contains scenarios to illustrate how these principles should work in practice for adult admissions.

Additional considerations for admissions of under 18s, including transitional arrangements[34]

Child and Young People's Mental Health (CYP MH) Inpatient Hospitals are highly specialised services with the primary purpose of assessing and treating severe and

[32] The discussion in this section excludes adults requiring secure care and CYP requiring non-secure or secure care where national access arrangements already apply.
[33] This may be different to the geographical area where the individual is registered with a general

practice (GP).

[34] The discussion in this section relating to transitional arrangements for under 18s has been drawn from Healthy London Partnership's Improving Care for Children and Young People with Mental Health Crisis in London: Recommendations for transformation in delivering high-quality, accessible care (2016), page 18.

complex mental health disorders. It is important that admission operates within a pathway of care, involving local community teams. This avoids protracted stays, the development of dependency on inpatient treatment, and loss of contact by the young person with their family and community.

Before a young person with a diagnosis of a Learning Disability and/or who is on the Autistic Spectrum (LDA) is admitted to an inpatient bed a Care Education & Treatment Review (CETR) must have taken place.

In the event of a young person presenting in crisis, and where there is no time to arrange a CETR, the Local Area Emergency Protocol (LAEP) should be invoked and a LAEP meeting must take place that includes the key people involved in the young person's care.

If a pre admission CETR or LAEP has not taken place, then a Root Cause Analysis (RCA) is expected to be completed.

Prior to admission, the child or young person's capacity to consent to be admitted into hospital must be assessed, in line with the Mental Health Code of Practice (2015).

In addition, it is important that the CYP MH inpatient team works closely with the referring team, and any other agencies involved in conducting the assessment and formulating a care plan. It is the role of the community services and the access assessor to explore alternatives to admission and assess the suitability of the individual for inpatient treatment.

At present, 18 years of age is the typical cut-off for access to and management within CYP MH services. There is an expectation that transition planning will have started between CYP and adult services in the 6 months prior to the person becoming 18.

This may pose a particular challenge when a young person presents in mental health crisis a few weeks before their 18th birthday. Guidance suggests that it is not good practice to admit a young person to an adolescent unit within a few weeks of their eighteenth birthday if they will then need to be transferred to an adult ward.

Pre-existing quality standards exist[35] which permit the short-term admission of a young person aged between 16 and 18 years old to an adult bed in an emergency. They apply if a suitable CYP MH bed is not available or where the adult bed is the most appropriate environment. It is assumed that this decision will be made within the clinical governance parameters and the appropriate executive director authorisations of the admitting Mental Health Trust. Appropriate staffing and support arrangements should be put in place to support young people placed in adult settings, and appropriate consideration must be given to any potential safeguarding issues.

Children and young people at transition ages do face additional problems if they require admission into a medical inpatient setting and have to choose between an adult medical ward or children's (paediatric) ward. They should be able to express a preference and have that preference taken into account.

Expectations when a receiving Trust cannot identify a suitable bed

As part of business continuity plans, it is important that Mental Health Trusts have effective systems in place to manage bed capacity, including discharge planning, possible alternatives to admission, and demand planning. Capacity management is discussed further in Section 5.

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[35] Statutory notification, regulation 18(2)(h) any placement of a service-user under the age of eighteen in a psychiatric unit whose services are intended for persons over that age where that placement has lasted for longer than a continuous period of 48 hours. cqc.org.uk

A Mental Health Trust should not refuse to admit a person before enacting a formal escalation process. This should include freeing up capacity at the Trust site(s) and finding a suitable placement in a nearby NHS or private inpatient facility. See Section 7 for further guidance on escalation.

If several individuals are waiting to be admitted, admissions should be prioritised on the basis of clinical judgement and what is in the service users' best interests. Admissions should be regularly reassessed and reprioritised on the basis of a full clinical risk assessment. There should also be on-going liaison with the provider requesting admission and/or police in case the person's condition deteriorates or improves while they are waiting to be admitted.

If a Mental Health Trust cannot secure a suitable bed to accommodate the individual, even after enacting the formal escalation set out on page 36, the Mental Health Trust closest to where the person has been assessed should admit the person.

Commissioners' responsibilities for funding care

Commissioners' responsibility for funding mental health care is governed by the principles contained in the *Who Pays? Guidance*.[36] This sets out the responsible commissioner arrangements, based on a patient's registered GP practice. The Compact recognises that a number of ICBs and STPs have local arrangements in place to determine provider responsibility, based on a patient's usual place of residence. The Compact supports these local arrangements.

Admission should not be refused or delayed due to uncertainty or ambiguity regarding which commissioner is responsible for funding the care.[37]

In situations where the responsible commissioner does not align with the area of the admitting Trust, recharging arrangements should be in place between commissioners so that funding follows the service user. This is to ensure that people are treated in a location that best serves their interests.
(See Who Pays Guide section 14.8 guide in appendix 5 inclusive of ongoing patient care and discharge below)

Figure 3 – Who Pays Guide

Who Pays Guide

The Who Pays guidance sets out responsible commissioner **not responsible provider**
A provider that holds a written NHS Standard Contract for certain services with one commissioner must, under Service Condition 6, accept certain referrals to those services from any commissioner, even one with which it holds no written contract. **This applies to any referral or presentation for emergency treatment** (where the provider can safely accept the referral)
All trusts need to follow this guidance to avoid lengthy delays to admission. The rules for determining the responsible Commissioner are:

Ref.	Description
1.	GP first
2.	Where no GP then apply the usual resident test (this applies to homeless people also)
3.	The 'usually resident' test must only be used to establish the responsible commissioner when this cannot be established based on the patient's GP practice registration;
4.	'Usually resident' is different from 'ordinarily resident'. If a person is not ordinarily resident in the UK and not covered by an exemption in regulations then they are liable for NHS hospital treatment costs themselves. The 'usually resident' test may still be needed to establish the responsible commissioner for non-hospital services;
5.	The main criterion for assessing 'usual residence' is the patient's perception of where they are resident in the UK (either currently, or failing that, most recently). The same principles apply in determining usual residence for determining which ICB has responsibility for arranging care for a patient.
6.	Where the patient gives an address, they should be treated as usually resident at that address.
7.	Certain groups of patients may be reluctant to provide an address. It is sufficient for the purpose of establishing usual residence that a patient is resident in a location (or postal district) within the ICB geographical area, without needing a precise address. Where there is any uncertainty, the provider should ask the patient where they usually live. Individuals remain free to give their perception of where they consider themselves resident. Holiday or second homes should not be considered as "usual" residences.
8.	If patients consider themselves to be resident at an address, which is, for example, a hostel, then this should be accepted. If they are unable to give an address at which they consider themselves resident, but can give their most recent address, they should be treated as usually resident at that address.
9.	Another person (for example, a parent or carer) may give an address on a patient's behalf.
10.	Where a patient cannot, or chooses not to, give either a current or recent address, and an address cannot be established by other means, they should be treated as usually resident in the place where they are present.

Transitional arrangements for payment

Where a patient is detained in hospital for the first time on or after 1 July 2022, responsibility for commissioning and payment will be determined by the following:

- NHS England will be responsible for commissioning and payment for any period where the patient is treated by a prescribed specialized service.
- The originating ICB responsible for commissioning and payment will be determined on the basis of the **who pays guidance** referenced on page 24 of this document.

The originating ICB will then retain responsibility for commissioning and payment throughout the whole period of initial detention (including any period where the patient is no longer detained.) including voluntary or repeat detentions until the patient is finally discharged from s117 aftercare - regardless of where the patient is treated or placed, where they live or which GP practice they are registered with.

For patients already detained in hospital or receiving aftercare before 1 July 2022, transitional requirements (first set out in September 2020 Who Pays?) continue to operate and any subsequent further detentions or voluntary admissions – until the patient is discharged from s117 aftercare.
If on 1st September 2020:

- A patient had been discharged from detention and was already receiving s117 aftercare, funded in part or whole by a CCG, that CCG (and its successor ICB where applicable) will remain responsible for funding the aftercare.
- A patient was detained in hospital funded by a CCG, that CCG (and its successor ICB where applicable) will be responsible for funding the full period of detention and any necessary NHS aftercare on discharge.
- A patient was detained in hospital funded by NHS England, the CCG/ICB which will be responsible for funding any further detention in a CCG/ICB-funded hospital setting and any necessary NHS aftercare will either be NHS England or the originating ICB applied at the point of the patient's initial detention in hospital[1]

Other operational considerations to facilitate timely admissions

When a person is likely to require admission at a different location to where they are being assessed, the AMHP and/or sending Trust should alert the receiving Trust as early as possible. The AMHP and/or sending Trust should maintain contact with the receiving Trust, e.g. by providing updates to projected timeframes and the person's condition, as appropriate.

If local arrangements require local community crisis teams to screen admission decisions within other Trusts before a person can be admitted locally, arrangements should be in place to ensure that process is swift.

In the case of shift changeovers, handovers between staff responsible for bed management should cover details of individuals awaiting admission from community, acute and criminal justice settings.

4.2.4. Conveyance and admission to inpatient care

If an admission under the Mental Health Act is required at a different location, the AMHP is responsible for arranging conveyance, with support from others as needed.[38]

Before the individual is transferred, the AMHP should ensure that the receiving Trust is expecting that person, and has been informed of the expected time of arrival.

The s12 doctors and AMHP should ensure that a full risk assessment is made available to the receiving Trust as part of their overall assessment. The AMHP should provide an outline report for the receiving Trust at the time the person is admitted. This should give reasons for the application to detain and any practical matters about the person's circumstances which the hospital should know. The sending hospital should also transfer medical records to the receiving Trust.

Conveyance between hospitals should occur within one hour of an AMHP's authorisation to transfer. A longer timeframe may be required if secure transport with escort is required.

Conveyance can be pre-booked online for all planned community Mental Health Act assessments. The Non-Emergency Transport Service (NETS) is available 9am-10pm, 7 days a week, 52 weeks a year.

5. Monitoring capacity and mitigating actions

Acute and Mental Health Trusts should have formal processes in place for managing capacity when pressure is building to mitigate individuals having to wait long periods for acceptance to Health-Based Places of Safety or admission to inpatient care. Processes should be structured with clear triggers for escalation actions to be taken. Suggested triggers and escalation actions are listed below. This list is not intended to be exhaustive, and there may be other triggers tailored to local needs.

Trusts should also refresh their processes for managing capacity at regular intervals, for example, to build in learning from internal Quality Improvement (QI) programmes or shared learning from other Trusts (see also Section 8). Such reviews might include approaches to daily capacity planning, bed management, and discharge planning.

5.1 Possible indicators of building pressure

Indicators of building pressure on capacity within a HBPoS or on inpatient beds should be monitored and used to trigger escalation actions. A&E Delivery Boards also have escalation frameworks and triggers for system pressure in line with OPEL Guidance (2016)[39]. Examples of high level trigger points that might be used are outlined in the table below.

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[38] Mental Health Act Code of Practice (2015), paragraph 17.9.

[39] NHS England and NHS Improvement, Operational Pressures Escalation Levels Framework, October 2016

Increased demand	**Local crisis teams / Liaison Psychiatry:** demand for these services reaches levels that are higher than planned. A possible indicator is that teams are taking longer than 4 hours from referral to respond and assess individuals presenting in community and acute settings. **AMHP services / s12 doctors:** demand for these services reaches levels that are higher than planned. A possible indicator is that teams are taking longer than 3 hours from referral to attend and start assessments.
Decreased supply	**Availability of Health-Based Places of Safety:** an individual Trust's place of safety is at significant risk of reaching capacity. For units with capacity for two or more assessments, a possible trigger for escalation is when the unit is only able to accommodate one more admission. For others, escalation actions might be taken as soon as the unit becomes occupied and/or once it has been occupied for a specific period (e.g. 2-3 hours). **Inpatient bed capacity:** individual Trusts approaching or reaching levels of bed availability outside of the anticipated norms. The Royal College of Psychiatrists recommends an average occupancy rate of 85%.
Waiting times	Significant risk of an individual waiting for more than 4 hours to access a Health-Based Place of Safety. Significant risk of an individual waiting for more than 12 hours to be admitted for inpatient care from a Health-Based Place of Safety, or a community, acute or police custody setting.
Staffing	Actual or predicted staff sickness, absenteeism or vacancy reach a point at which safe, effective care is likely to be compromised. Baseline to be specified by Trusts in local plans.

5.2 Escalation to manage demand and capacity

Actions can be taken to ease capacity pressures at Health-Based Places of Safety and within inpatient care units. They should be taken as early as possible when pressures start to build, to minimise the need to delay or deny access. This list focuses on initiatives that can be taken in the short term, but also includes initiatives that might be taken over a longer time frame.

Mental Health Trust: Managing and reducing demand
Where appropriate, maximise use of alternative pathways prior to admission. For example, community-based pathways such as crisis houses or crisis cafés may be suitable for specific service users. Third sector offerings could also be considered. AMHP services might be consulted for suggested alternatives.
If a service user returns from leave earlier than planned, consider whether it is appropriate for them to go back on leave with additional support from community mental health teams.
Mental Health Trust: Improving supply
Ensure progress of all admissions, discharges and transfers as planned.
Take actions to ensure scheduled discharges and transfers are handled as swiftly as possible (see also Support Services below).
Activate bed management 'huddle' involving staff responsible for bed management and clinical directors to review all inpatients individually and agree appropriateness of continued stay in light of current and predicted levels of activity.
Consider discharge of service users with medically approved overnight leave who are able to be discharged home safely with family support and/or increased support from community mental health teams.
Identify service users who could be discharged early with increased follow-up by community mental health teams.
Explore options for transferring service users including both intra- and inter-hospital transfers.
Open all possible escalation beds onsite
Review and reschedule planned maintenance (where applicable).
Explore whether capacity is available at other sites within the Trust (where applicable).
Explore opportunities with other Trusts and private providers for access to additional beds.
Review length of stay (LOS) and causative factors for increases in bed occupancy.
Identify any admissions that were unnecessary and provide feedback to the referrer.
Analyse causation factors for service users who are repeatedly admitted.
Analyse causes of delays to transfer of care (DTOC).

Leverage on a wide support base in bed management meetings to support discharge and reduce the risk of re-admission, e.g. include representatives from community mental health teams, local crisis teams, social services and other advisors on housing, employment, financial services and immigration.
Mental Health Trust: Improving supply through support services
Pharmacy told to prioritise all discharge prescriptions for service users awaiting discharge.
Facilities and porters tasked to prioritise cleaning and transfers.
Patient transport services told to prioritise transfers (discharges) over other work.
If environmental issues are causing reduced capacity, alert facilities and estates to assess whether repairs can be conducted immediately.
Mental Health Trust: Staffing / Changes in acuity
Monitor staffing levels and continue to ensure vacancies are filled.
Consider whether staff can be reallocated from other services.
Consider cancelling staff leave, training courses, and re-direction of clinical staff from managerial duties to front line care.
Community Mental Health teams
Increase support to individuals recently discharged or on leave.
Increase support and/or communications to other service users within the community to prevent admission.
Acute Trusts (including EDs and Liaison Psychiatry Teams)
Where appropriate, carry out Mental Health Act assessments in emergency departments for individuals who are already present in the department receiving physical health care (instead of transferring them to a Health-Based Place of Safety for the assessment).
Where appropriate, accept admissions diverted from other local Health-Based Places of Safety without sufficient capacity for a service user.
Where appropriate to individual user needs, liaison psychiatry services to consider use of alternative pathways in place of admission.
Local Authorities
Where appropriate, social care teams to increase support and/or communications to service users at home to prevent admission
ICBs
Support Mental Health Trusts and the wider system to put in place escalation measures and mitigating actions, as required.
Work with partner ICBs with regard to patient flow and support Trusts' requests for Extra Contractual Referral (ECRs) where necessary.

6. Handling of temporary closures for planned works and in emergencies

There should be arrangements in place to manage the planned or emergency temporary closure of capacity within a Health-Based Place of Safety or inpatient unit. Such arrangements should form part of standard business continuity policies and procedures.

6.1. Planned works

NHS Trusts may occasionally need to close services temporarily to enhance service provision, e.g. during building or electrical works, or to change the location of service delivery.

During closure it is crucial that service users still receive high quality care, delivered in the most effective and efficient manner. Closures must therefore be well planned, well communicated and well managed across all key partners and stakeholders.

Trusts should therefore undertake the following:

- planning and assurance
- engagement and communications

6.1.1. Planning and assurance

The decision to temporarily close capacity within a HBPoS or inpatient unit should be taken only when unavoidable, and such a closure should be subject to robust planning. Careful consideration, effective engagement, and system collaboration at an early stage, will help develop a robust operational plan for the period of closure, and so mitigate risks to patient care, key partners and the wider system.

6.1.2. Engagement and communication

All partners across the health and care system must be informed at the earliest opportunity of the intention to temporarily close capacity. Engagement should include any organisation within the local health economy likely to be affected by the closure, e.g. neighbouring Mental Health Trusts, local Acute Trusts, London police services, LAS, local and neighbouring AMHP services, and local crisis and community mental health teams. Communications to AMHP services should include Directors of Adult Social Services, who can cascade information to their local AMHP teams.

At least four weeks' advance notice should be given, depending on the scale of closure and the urgency of the work being undertaken. This will ensure that closure plans are inclusive and take into account the requirements of other partners' services that will be directly impacted by the closure.

A nominated lead for the planned closure should be identified by the Trust, and contact details shared across the system and organisations affected.

6.2. Emergency closures

As with planned closures, it is important that emergency closures are well communicated across all key partners and stakeholders, so that service users continue to receive high quality care, delivered in the most effective and efficient manner.

In the event of an emergency closure of a mental health inpatient unit or HBPoS, a Trust should notify all organisations within the local health economy likely to be affected by the closure, at the earliest opportunity (see Section 6.1.2. above).

Information on capacity management tools should also be updated appropriately. For example, a Trust's bed availability should be updated on the Capacity Management System (CMS). Updates should also be made to other available local capacity management systems.

Contact should also be made with local Surge Services in the first instance and then NHS01 in the event of an emergency closure affecting a significant part of London, e.g. all inpatient capacity at a single Mental Health Trust. This will enable the appropriate response and management from London's Emergency Preparedness, Resilience and Response Team.

7. Escalation processes

Trusts must have their own escalation protocols in place, to enable timely access for individuals in urgent need of care. These protocols should include a clear timeline with responsibilities and expected actions, setting out at what stage senior managers will be made aware, including on-call directors and the Chief Executive. This escalation should also include the relevant commissioner, Surge Service and NHS England (London, South East and East of England). Timeframes, triggers and actions for internal escalation protocols are outlined in the sections below.

Trusts should share their escalation process with their local Surge Services, local police, AMHP services, relevant emergency department staff and other local partners, so they understand the Trust's internal processes. As part of this process, Trusts should establish clear lines of communication with local system partners. These should provide contact details for facility coordinators/bed managers and a senior manager within the Trust, in the event that there is a dispute that requires urgent attention (see Appendix 3 for an example in the context of a Health-Based Place of Safety).

A number of the actions outlined relate to commissioners, who should ensure that these responsibilities are reflected in their own planning. This includes making arrangements for Trusts to make contact out of hours.

7.1. Escalation within a Trust

The following principles should be reflected in a Trust's escalation protocols for Health-Based Places of Safety and inpatient facilities.

7.1.1. Roles and responsibilities

There should be a nominated role within each Trust that is responsible for initiating and coordinating the escalation process: escalation relating to an inpatient care facility should be initiated by the receiving hospital's bed manager (or staff member with responsibility for bed management); for access to a HBPoS, escalation should be initiated by the HBPoS facility coordinator in liaison with the hospital bed manager (or equivalent).

The on-call manager and on-call director should be available to offer advice, and to support escalation actions where needed, using internal processes prior to escalating to local Surge Services.

The on-call manager and on-call director within the Trust should have been involved before any clinical decision is taken to refuse access to a HBPoS or inpatient care facility.[40]

The bed manager/facility coordinator should work collaboratively with those making the request for access. Bed managers local to where a patient has presented might also work with Trusts closer to a patient's home, to support swift placements, including for non-Londoners.

If there is ambiguity or disagreement in relation to which Trust will accept a person, and this cannot be resolved swiftly by the bed managers/facility coordinators, a formal escalation process should be enacted by the Trusts involved (see timings below).

7.1.2. Health-Based Place of Safety: Expected timeframes and escalation actions

If a HBPoS is already occupied when access is requested, the facility must:

- review any service user(s) currently admitted to the place of safety
- review any delays in transfers from the place of safety (where applicable)
- consider transferring a current user to elsewhere onsite
- take steps to identify alternative places of safety with capacity for the incoming individual

Matters should be escalated from the facility coordinator to senior staff within one hour of an individual waiting for acceptance.

[40] As stated in section 4.2.1, if a person is refused access to a Health-Based Place of Safety site and diverted instead to an emergency department because the team feel unable to meet the physical needs of the individual, then this should always be escalated to an on-call doctor. The on-call consultant could be approached for mediation or consultation if an agreement has not been reached, but the final clinical decision as to whether the individual requires medical assistance at the emergency department lies with the doctor at the Health-Based Place of Safety.

7.1.3. Inpatient facilities: Expected timeframes and escalation actions

Timeframes for escalation and associated actions within a Trust should be designed so that 12-hour delays to inpatient care do not occur (see also Reporting Requirements, Section 8).

Consideration must be given to the fact each local area is set up differently and CAMHS may not be based in all acute hospitals. Therefore, there is an expectation that CAMHS and Adult Psychiatric Liaison Teams in each area will interface accordingly.

Where a Mental Health Trust is unable to identify a suitable bed for an individual, recognised escalation actions are expected.

Firstly, bed availability onsite and at the Trust's other sites (if applicable) should be confirmed, by:

- identifying vacant beds, including a physical headcount of all the service users in each unit to confirm whether all beds are occupied
- ensuring progress of all discharges and transfers as planned
- advising support services to prioritise actions relating to discharges and transfers (e.g. pharmacy, facilities and porters, patient transport services)
- opening any short term leave and 'sleepover' beds
- opening beds of any service users who have absconded
- opening beds of any service users who are due to return from leave in the morning
- opening any other possible escalation beds onsite and at the Trust's other sites

Options for creating capacity onsite and at the Trust's other sites should then be explored:

- If a person returns from leave earlier than planned, it may be appropriate for them to go back on leave with additional support from community mental health teams.
- Discharge could be considered for service users with medically approved overnight leave who can be discharged home safely with family support and/or increased support from community mental health teams.
- Intra- and inter-hospital patient transfers might be considered.
- A review of all inpatients individually, to agree on the appropriateness of their continued stay in light of current and predicted levels of activity, and consider whether any of them could be discharged early with increased follow-up by community mental health teams.

Finally, an attempt should be made to secure an inpatient bed with a private provider within the local area.

Senior staff should support escalation actions, and may be able to expedite issues causing delayed admission. For example:

- If there is no potential space for a person requiring admission, the bed

manager/facility coordinator at the receiving Trust should escalate to their manager (or the on-call manager) within one hour of the time of arrival, outlining what actions have already been taken to identify capacity for the individual.

- After 2 hours from the time of arrival, the manager should escalate to the on-call director if there is no potential space for a person requiring admission.

- If there is no potential space for a person after 4 hours from the time of arrival, the matter should be escalated to the Chief Operating Officer (COO) or the on call Director (or nominated deputy), if their approval is needed, or their support would help to secure a placement with another provider.

- At the point which a patient remains in ED or police custody for 24 hours+ waiting to be admitted to an acute mental health bed, the COO/on call Director should escalate to the Chief Executive Officer (CEO).

Note:

In extreme circumstances where safety is compromised due to pressure in an acute trust ED where the patient has presented, the expectation is for the mental health trust to accelerate the timescales and assist with risk sharing. Which could be the provision of 1-1 RMN support.

Figure 4 and contains an overview of the escalation process when someone is waiting for admission to inpatient care.

Figure 4: Escalation when an individual is waiting for an inpatient admission / transfer

Roles and responsibilities

CEO Escalation to the Chief Executive for all patients waiting 24hrs+ for an admission / repatriation

NHSE/I. For critical incidents such as business continuity, trusts **must** follow normal protocols.

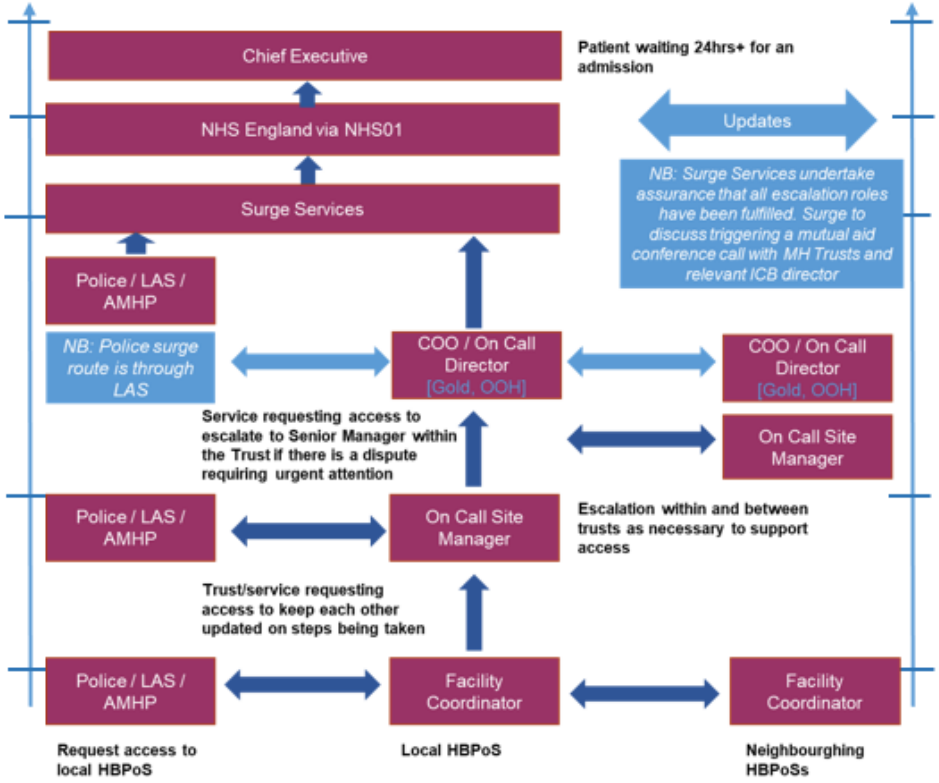
Surge Service (where relevant). Timing: Call to be **received after six hours** have passed since time of arrival:
But straight away if SI. Issue to resolve:
- Outstanding issues need to be unlocked

Level 3 On Call Director. Timing: To be actioned within **four hours** of time of arrival. Issues to resolve:
- Local patient requires inpatient bed
- Non local patient requires inpatient bed
- Other outstanding issues need to be unlocked

Level 2 On Call Manager. Timing: to be received after **one – three hours** after bed managers actions. Issues to resolve:
- Local patient requires inpatient bed
- Non local patient requires inpatient bed
- Other outstanding issues need to be unlocked

Level 1 Facility Coordinator. Timing: Calls to be made (clinician to clinician) **within one hour** post time of arrival. Issues to resolve:
- Local patient requires inpatient bed.
- Non local patient requires inpatient bed.
- Other – non bed related issue.

Note: Patient admission **should not be refused or delayed** due to uncertainty or ambiguity about who is responsible for funding the care



Timeline

Follow normal protocol all 12 hour breaches to be reported to UEC team

After 6 hours -
Escalate to Surge Services

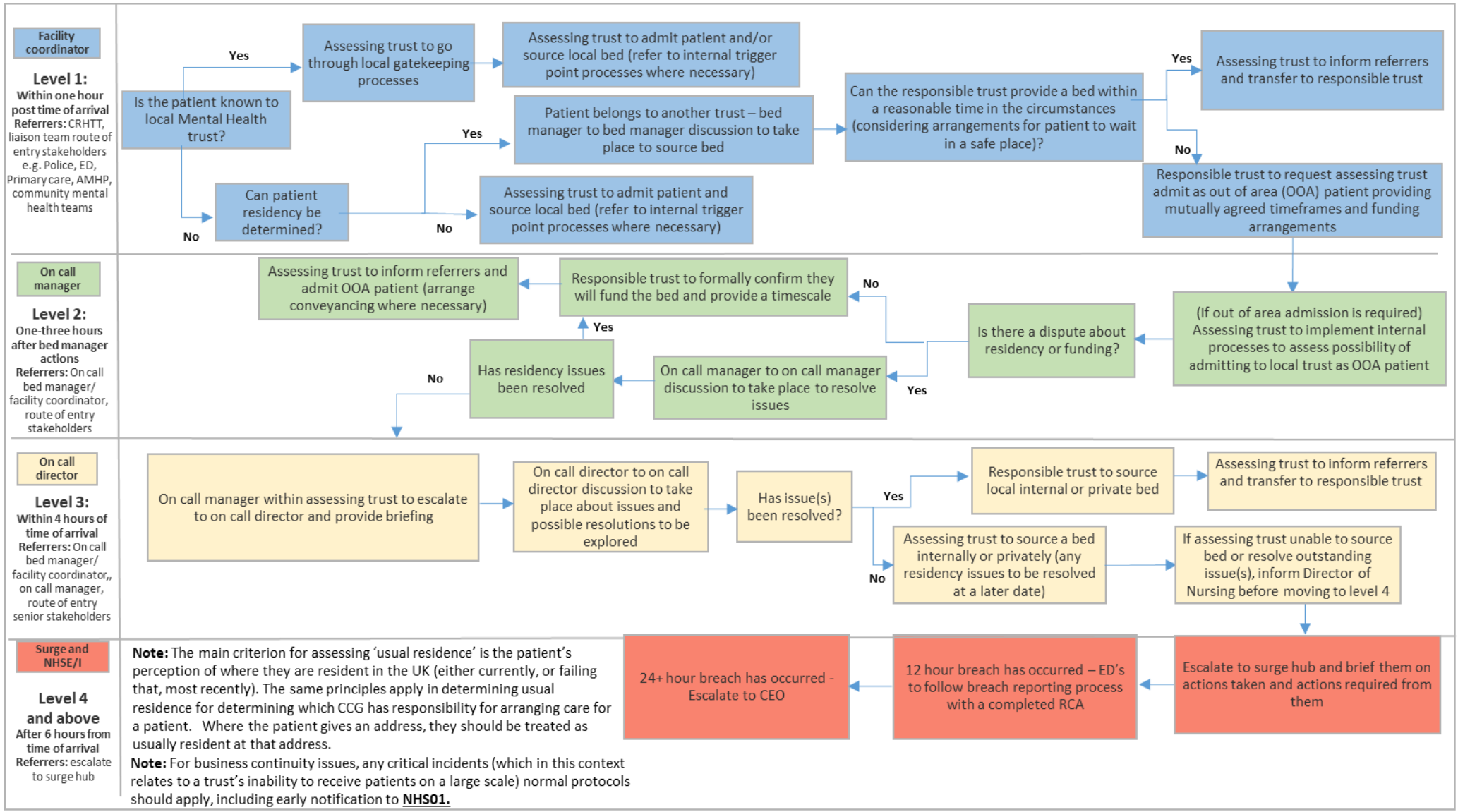
Level 3: Within 4 hours -
Escalate to On Call Director

Level 2: Within 1 to 3 hours –
Escalate On Call Manager

Level 1: Within 1 hour of when a decision to admit has been made – local clinician to clinician request for access to be made

* Time of arrival to discharge is measured from the point of arrival in ED to discharge, admission or transfer for MH patients presenting in ED. These are identified using MH related diagnosis codes or Chief Complaints .

Figure 5: Mental Health Compact Escalation Framework



7.1.4 Children and young people escalation process

Since October 2020 NHS England has delegated the commissioning task to Provider Collaboratives of which the Lead Provider Trust is central to ensuring that capacity is available for those young people requiring admission from their local populations and this is reflected in the escalation process.

When escalation is initiated, a consolidated email group will be created with the individuals working on the case, as well as those identified as being involved in the different tiers of escalation.

Figure 6 gives an overview of the escalation process for a child or young person waiting for a Tier 4 bed.

Figure 6: Escalation process for children and young people into inpatient services

7.2. Escalation between providers

Health and social care providers should escalate matters between them as necessary, to avoid any delays to patient access, by:

- resolving uncertainties regarding which Trust (or provider) should accept a patient
- identifying capacity for alternative placements locally, when a Trust has no capacity to accept a patient awaiting admission
- alerting other services when capacity has been reached at a HBPoS, so that they are forewarned and can plan accordingly.

Each of these is discussed further below.

Issue	Escalated actions
Resolving uncertainties regarding which Mental Health Trust should admit an individual for inpatient care	If it is unclear which Trust will admit an individual, bed managers should attempt to resolve issues between them swiftly, drawing on support or escalating to their managers and/or on-call directors as needed. If an individual has been waiting to be admitted for 3 hours because of uncertainty in relation to which Trust should accept them, e.g. due to their age or place of residence, this should be escalated to Trust Chief Executives for resolution. If agreement cannot be reached, the matter should be escalated to the relevant commissioners (see Section 7.3).
Identifying, and making arrangements for, an alternative local placement when a patient is awaiting admission	Bed managers / facility coordinators should liaise regularly with their counterparts to determine whether - and where - capacity exists within local areas. Contact details for bed management teams for each facility should be shared between Trusts and kept up-to- date. Trusts should also have access to information on inpatient bed occupancy via SMART or other online Capacity Management System (CMS). CMS are tools used for reporting and monitoring day-to-day pressures.. Bed updates should be made by Mental Health Trusts at a **minimum** of three times per day preferably around 10am 2pm and by 6pm. There is also a national portal for CAMHS capacity.

	Trusts with Health-Based Places of Safety may have access to capacity information through capacity management tools available locally
Alerting others when capacity is reached	When a Health-Based Place of Safety reaches capacity and is no longer able to accept any individual, the facility coordinator should advise facility coordinators in neighbouring Trusts and local police teams, giving a projected timeframe during which capacity is likely to be created. Providers should also give each other advance notice when temporary or emergency closures are required for planned works (see Section 6 for further guidance).

7.3. Escalation to relevant commissioners

Matters relating to delayed admissions should be escalated to the local Surge Service in the first instance, and the relevant commissioner(s) as needed, to resolve issues causing delays. Examples of incidents that should be escalated to commissioners are provided below.

In most cases, the relevant commissioner will be the commissioning ICB and/or NHS England (Specialised Commissioning), e.g. where the matter relates to a child or young person awaiting admission, or to adult secure services.

Issue	Escalation actions
Resolving uncertainties over which Mental Health Trust will admit a person	If an individual has been waiting more than 4 hours to be admitted into inpatient care because of uncertainty in relation to which Trust should accept them, e.g. due to their age or place of residence, and the Trust Chief Executives have been unable to resolve the matter between them (see Section 7.2 above), the issue should be escalated from the Trusts to their commissioner. The relevant commissioner(s) should either advise their Trust to accept the patient, or work with the affected Trusts and other commissioners to decide which provider is best placed to admit the individual. In circumstances where a Trust admits an out-of-area person (even temporarily), commissioners should ensure that appropriate recharging arrangements are in place between commissioners, so that providers are compensated accordingly.
Resolving uncertainties over which Local Authority's AMHP service should attend to coordinate an assessment	If care is being delayed because of uncertainty in relation to which AMHP service has responsibility for an individual, this should be escalated to the Trust's commissioner immediately (and certainly as soon as the Trust has been waiting for 2 hours or more for attendance by a local AMHP service). The commissioner should then make contact with the Local Authorities concerned to attempt to resolve the issue. The commissioner should report back to the Trust once the issue has been resolved.

Issue	Escalation actions
Alerting commissioners to bed capacity issues and seeking support if capacity pressures reach critical levels	If bed capacity pressures are expected to reach critical levels (e.g. bed occupancy is predicted to reach 95% or more and remain at that level for several days), the Mental Health Trust should alert their commissioner(s). Where appropriate, the commissioner(s) may be able to support the Trust to take mitigating actions. For example, the commissioner may need to facilitate increased support from community mental health teams or social care, which could help prevent further admissions or expedite planned discharges. Alternatively, the commissioner may decide that it is appropriate for users to be diverted away from the Trust to other providers for a temporary period, until capacity pressures are relieved. If a decision is taken to divert users elsewhere for a period, the Trust should notify other parts of the system, including neighbouring Mental Health and Acute Trusts, and (where applicable) the police, LAS, and AMHP services, giving a projected timeframe in which issues will be resolved.

7.4. Escalation to Surge Services

Matters should be escalated to Surge Services when an individual has been waiting for the periods set out below, and attempts have been made to resolve the issue through escalation within and between Trusts (and commissioners, where relevant). Contact should be made with Surge Services once an individual has been waiting:

- more than 4 hours for acceptance into a HBPoS, from the time an initial request was made by police/LAS/AMHP to the local HBPoS, or
- more than 6 hours for admission to inpatient care, from the time of arrival.

If a service user or CAMHS patient is waiting longer than 6 hours for a bed, in line with the escalation framework, local Surge Services will convene a conference call between the Mental Health Trust Gold, the Acute Trust Gold and the on-call ICB Director. They will review the situation and confirm that all options for providing a bed have been explored. Where no decision has been made that will lead to an admission taking place within the required timescales, Surge Services will support the decision-making. This could include mandating a decision around responsibilities for admission, finding a bed, and/or funding of care.

NHS England (London, South East and East of England) will monitor and report a range of aspects regarding patients' waiting times, bed occupancy and utilisation, and the volume and nature of escalation calls to Surge Services. These will be shared with various stakeholder groups.

8. Reporting requirements

The Mental Health Code of Practice requires local recording and reporting mechanisms to be in place to ensure the details of delays in placing people - including the impacts on users, carers, provider staff, and other professionals - are reported to commissioning leads. It states that these details should also feed in to local demand planning.[41]

This section sets out reporting expectations across London. A regular meeting of system partners to share learning at a pan-London level is also proposed.

Local monitoring and reporting	**Reporting of delays, and shared learning, at a local level** Local system partners should meet regularly to discuss the effectiveness of working arrangements amongst local system partners. Standing agenda items should include incidents involving delayed access to Health-Based Places of Safety and admissions to inpatient care. Delays of more than 4 hours to a HBPoS, and delays of more than 6 hours into inpatient care, should be captured in organisations' internal reporting systems and discussed at meetings. Meetings should also be used to share experiences of incidents that were resolved effectively. **Capacity utilisation** To aid local demand planning, commissioners and Mental Health Trusts should monitor bed occupancy levels and patterns for their areas. Commissioners and Trusts should also regularly discuss incidents involving 12 hour delays to admission, bed capacity issues, probable causation factors, and mitigating actions taken. Metrics such as average bed occupancy, average length of stay, re-admission rates and delayed transfers of care (DTOC) should feed into these discussions as they may provide useful insights for the Trust's capacity utilisation. Utilisation of Health-Based Places of Safety should be similarly monitored and discussed, including the volume of diversions to alternative places of safety.

[41] Mental Health Act Code of Practice (2015), paragraph 14.86.

Reporting of 12 hour delays	Whilst not automatically an SI, there should be consideration as to whether a 12 hour delay fulfils the criteria for a Serious Incident as defined in the Serious Incident Framework 2015 (or its successor framework)[42]. If so, it must be the subject of a robust investigation. If, in the course of the investigation, it is decided that a formally-reportable SI has occurred, the reporting and investigation process for an SI should be followed, including use of STEIs. Notification of partners, e.g. NHS England (London) and NHSI, should still take place. Where a 12 hour breach is believed to have occurred, a Trust should: • report the incident to NHS England and NHS Improvement teams and the relevant commissioner • review the person's journey to confirm a 12 hour delay • provide an initial report to NHS England and NHS Improvement on the cause of the delay within ten working days, using the standard reporting form • provide a final report to NHS England and NHS Improvement. Joint investigation and reporting of 12 hour delays is required where two or more Trusts were involved in the delay.
Reporting of SIs	Delays and re-directions in accessing Health-Based Places of Safety or inpatient care should be reported by Trusts on STEIS, where the criteria for a serious incident are fulfilled, as per the Serious Incident Framework 2015 or its successor framework. Re-directions should include: • those between Health-Based Places of Safety and/or emergency departments, e.g. due to age, level of intoxication, or level of acuity • those to other providers due to capacity issues onsite • those into police custody

[42] Serious Incident Framework, 2015: https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

9. Monitoring Patient Flow in and out of Emergency Pathways

There is strong emphasis in the Long Term Plan on community transformation and that this transformation will deliver earlier intervention. As such a set of metrics will be developed to monitor whether we as a system are reducing the number of patients entering the emergency pathway. The metrics will also help us to understand whether patients who seek crisis intervention are being managed effectively, and in a timely manner through the system as a whole.

Below are **examples** of the type of metrics we will be seeking to develop collectively:

1. Reduction in known community patients presenting in crisis
2. Reduction in the number of multiple assessments conducted
3. The number of people jointly worked with the Voluntary Care Sector/ supported by a peer support worker.

10.End Notes

The contents of the Compact have been developed on the basis of existing regulations and policies governing mental health services in England and/or London, including:

- The Mental Health Crisis Care Concordat. Department of Health and Concordat signatories (2014)
- London Mental Health Crisis Commissioning Guide. Mental Health Strategic Clinical Network (2014)
- London mental health crisis commissioning standards and recommendations. Mental Health Strategic Clinical Network (2014)
- Mental Health Act: Code of Practice 1983. Department of Health (2015)
- Mental health crisis care for Londoners: London's section 136 pathway and Health-Based Place of Safety specification. Healthy London Partnership (2016)
- Improving care for children and young people with mental health crisis in London: Recommendations for transformation in delivering high-quality, accessible care. Healthy London Partnership (2016).

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Appendix 1: Patient pathways to admission

Proposed admissions from an emergency department

Pathway	Individual at ED	MHA assessment	Waiting for access to inpatient care	Conveyance and admission to ward
Key actions	Individual presents at an emergency department appearing in need of immediate mental health care. **ED department staff** Complete a preliminary assessment covering physical assessment, personalised risk assessment and observations on behaviour and mental state. Refer those in need of mental health care to the Liaison Psychiatry team as quickly as possible (or community CAHMS specialist if the individual is under 18 years old). If needs are unclear, advice should be sought from the Liaison Psychiatry team. A mental health assessment should not be delayed for delivery of physical health treatment unless there are clinical grounds for delay (e.g. a physical condition is suspected of leading to or significantly worsening a disturbance of mind). Consideration should be given to a parallel and concurrent mental health assessment and treatment by medical staff. A shared care plan should be agreed between named mental health liaison and emergency department staff, including the timeframes for assessment and treatment of both aspects. **Liaison Psychiatry team** The Liaison Psychiatry team should see the individual within one hour of receiving a referral	**AMHP / s12 doctors / Acute Trust** A formal assessment under the Mental Health Act decides whether formal detainment under s2/s3/s4 of the Mental Health Act (MHA), voluntary admission or a referral to community services is best for the individual. Where possible the assessment should be done jointly by a doctor approved under section 12(2) of the MHA and an AMHP, although the need to coordinate should not delay the process. Assessment from a second doctor is also required for a formal detention and admission under s2/s3. **A Mental Health Act assessment should commence within 4 hours** of the individual's arrival at the emergency department, unless there are clinical grounds for delay. An assessment should not be delayed due to uncertainty around bed availability. Occasionally the AMHP may decide they need to return to re-interview the person to decide on an appropriate course of action. **AMHP service** The AMHP has overall responsibility for coordinating the assessment, unless agreed otherwise locally. This includes arranging the s12 doctor(s). **The legal duty to assess falls on the AMHP service for the area where the person is located when the assessment is needed.**	**Liaison Psychiatry team / AMHP** If the outcome of the assessment is that admission is required, **the person should be transferred to hospital as soon as possible.** Liaison Psychiatry / the AMHP should make contact with the receiving Trust to confirm capacity for the individual. The receiving Trust will usually be the Trust responsible for care in the location where the person is usually resident. Finding a bed is formally the responsibility of the doctors concerned, but usually this is delegated to the bed manager (or equivalent) of the receiving Trust, with support from the AMHP. Both the doctors and AMHP making the assessment should provide a full risk assessment to the receiving Trust as part of their overall assessment. Liaison Psychiatry / the AMHP should maintain regular liaison with the receiving Trust, including alerting them if the person's condition deteriorates. Liaison Psychiatry / the AMHP have a duty to take reasonable care for the person's health and safety until they are admitted to the receiving Trust. **Receiving Trust** Inform Liaison Psychiatry / the AMHP that they are the responsible Trust for the individual, and provide a timeframe for admission. Admissions should be prioritised on the basis of clinical need.	**AMHP service** If the individual is to be admitted formally, the AMHP is responsible for arranging conveyance to the receiving hospital, with support from the Acute Trust. Method of transport should be chosen in consultation with other professionals and following a risk assessment. Before the individual is moved, the AMHP should ensure that the receiving hospital is expecting the patient and has been told the likely time of arrival. The AMHP should provide an outline report for the receiving Trust at the time the patient is first admitted, giving reasons for the application to detain and any practical matters about the person's circumstances that the hospital should know. If admission is voluntary, arranging transportation is the responsibility of the emergency department staff / the sending Trust. **Receiving Trust** Ensure all relevant information is received about the patient, including any history of restraint whilst in the emergency department. **Liaison Psychiatry team** The Liaison Psychiatry team should support the transfer of physical health care documentation from the emergency department to the receiving Trust.

Pathway	Individual at ED	MHA assessment	Waiting for access to inpatient care	Conveyance and admission to ward
	from the emergency department. This should ascertain the urgency of need, the type of assessment required and the resources needed for that assessment. If a decision is taken that a formal Mental Health Act assessment is needed, the team should alert the AMHP as quickly as possible. Where there are no clinical grounds for delay, within 4 hours of their arrival at the emergency department, the individual should receive a care plan. It is recommended that this cover both a full biopsychosocial assessment, and an urgent and emergency mental health care plan. The individual should also be en route to their next location if geographically different, have been accepted and scheduled for follow-up care by a responding service, have been discharged because the crisis has been resolved, or have started a formal Mental Health Act assessment (with the exception of individuals being detained under section 136, whose formal Mental Health Act assessment should have been completed within the 4 hours).	**S12 doctor(s)** If admission is likely, one of the s12 doctors should be employed by the Trust responsible for care for the geographical area where the patient is being assessed. The second doctor should have previous acquaintance with the person or be a s12 doctor. **Liaison Psychiatry team** The Liaison Psychiatry team have a key role in supporting the formal mental health assessment. For example, they should support the liaison with the medical team to establish any mental health history relevant to the physical assessment, decide and act on any safeguarding concerns, and provide the s12 doctor and AMHP with information from the initial mental and physical health assessment. One of the team doctors may also participate in the assessment itself as one of the s12 doctors.	Treatment should not be refused or delayed due to ambiguity as to which ICB is responsible for funding an individual's healthcare. Ensure full risk assessment for the individual has been provided. This should cover whether the individual requires constant supervision, and whether the individual is subject to restraint or on-going restraint by police officers. (On-going restraint + mental illness = medical emergency) Maintain liaison with Liaison Psychiatry / the AMHP, undertaking continuous reassessment and re-prioritisation of admission, based on full clinical risk assessment, including any deterioration of the individual as a result of delay in receiving treatment. Delays in accessing an inpatient bed should be escalated per the Trust's protocol.	

Proposed admissions from the section 136 pathway

Pathway	Initial detention and access to Health-Based Place of Safety	Conveyance	Initial acceptance to place of safety	MHA assessment	Conveyance and admission to ward
Key actions	Individual appears to be suffering from mental disorder and to be in immediate need of care or control. Police officer thinks it necessary for the interests of that person, or for the protection of other persons, to remove that person to a place of safety. **Police** Where practical, police officers should consult with a mental health professional before detaining the individual. Local arrangements may be a 24/7 mental health triage / crisis line service. Consultation can provide further information about the individual - including whether the individual is known to mental health services and whether they have a crisis care plan in place - and may signpost alternative services in the community that best meet the individual's needs. If a decision is made to detain, the police should call an ambulance. Police must be explicit in using the terms 'section 136' and 'restraint' to ensure the appropriate triage category is applied by LAS. Police should also phone ahead to the closest Health-Based Place of Safety (HBPoS) to confirm whether the site is able to	**LAS** Paramedics complete a medical screening and decide whether the individual needs treatment at the closest emergency department. If an emergency department is not required, LAS convey the individual to the HBPoS identified as having capacity for that individual. **Police** Police must still be in attendance whilst LAS convey, either in the ambulance or following closely behind. Police and LAS should communicate details of the individual's situation to the HBPoS. Police should also maintain regular liaison with the HBPoS, confirming whether the individual is to be treated at the closest emergency department, and confirming capacity at the HBPoS site or alternative identified by HBPoS staff. Police should check with the HBPoS that an Approved Mental Health Professional (AMHP) service has been arranged by HBPoS staff for the formal mental health assessment. **HBPoS** Regular liaison with police / LAS to confirm capacity at	**HBPoS** Trust formally accepts the individual into the HBPoS, Form '434' is transferred to HBPoS staff from the police. **Police / LAS should not have to wait more than 15 minutes to access the site.** Individual's time of arrival at, and admission to, the HBPoS should be recorded. 24 hour detention limit begins at the time of the individual's arrival at the HBPoS. If the individual is taken to an emergency department first, the 24 hour detention commences on arrival at the emergency department. Clinical staff should be present to meet the individual on arrival and receive a verbal handover from the police / LAS. **Initial mental and physical state assessment should occur no later than one hour after arrival.** If HBPoS staff feel unable to meet the individual's physical needs, the individual can be transferred to an emergency department. A person should only be transferred if it is in their own best interests. If the individual is transferred, an appropriate	**AMHP / assessing doctors / HBPoS** A formal assessment under the Mental Health Act decides whether formal detainment under s2/s3/s4 of the Mental Health Act (MHA), voluntary admission, or a referral to community services is best for the individual. Where possible the assessment should be done jointly by a doctor approved under section 12(2) of the MHA and an AMHP, although the need to coordinate should not delay the process. Unless it is clear that the person will not require an admission, the AMHP should also arrange for a second doctor to examine the individual. Occasionally the AMHP may decide they need to return to re-interview the person to decide on an appropriate course of action. **The formal assessment should be completed within 4 hours** of the individual arriving at the HBPoS, unless there are clinical grounds for delay. An assessment should not be delayed due to uncertainty around bed availability. Once the outcome of the mental health assessment	**AMHP service** Both the doctors and AMHP making the assessment should ensure that a full risk assessment is made available to the receiving Trust as part of their overall assessment. If admission is required at a different location, the AMHP is responsible for arranging conveyance with support from the HBPoS (and police if needed). Transport should be chosen in consultation with other professionals involved and following a risk assessment. Before the individual is transferred, the AMHP should ensure that the receiving hospital is expecting the patient and has been told the probable arrival time. The s136 power is not released until a bed is found. If 24 hours is exceeded, the s136 detention comes to an end and the individual told that they are free to leave. The period may be extended to 36 hours by a doctor, but only on clinical grounds. **HBPoS / Receiving Trust** Finding a bed is formally the responsibility of the doctors concerned, but this is usually

Pathway	Initial detention and access to Health-Based Place of Safety	Conveyance	Initial acceptance to place of safety	MHA assessment	Conveyance and admission to ward
	receive the individual. Failure to phone ahead may result in the person being unable to be accepted on arrival. **London Ambulance Service (LAS)** - Once contacted, **LAS should attend within 30 minutes (or 8 minutes if the individual is being physically restrained** or where clinical information provided is of concern). Expected delays should be communicated to police. If these are significant (> 60 minutes), police may consider transporting the individual in a police vehicle. **HBPoS** If the closest HBPoS does not have capacity to receive the individual, the facility coordinator at the site should advise of an alternative HBPOS or escalate the matter as per the Trust's protocol.	the HBPoS site or alternative. If the police have been informed that the HBPoS has capacity to accommodate the individual, actions should be taken to preserve this capacity. If, in exceptional circumstances, the HBPoS becomes unable to accept the individual, the police / LAS should be informed and an alternative identified by HBPoS staff. Ensure all relevant information is received from the police / LAS about the individual's situation. Notify the AMHP service for the area of the individual's arrival.	member of HBPoS staff should travel with the individual and take responsibility for their management. A person should never be transferred unless it has been confirmed that the new place of safety is willing to accept them. **LAS** LAS are able to leave the site once the individual has been accepted. **Police** Police should stay to complete handover with HBPoS staff, normally 30 minutes. If requested by staff, police should remain at the site for up to one hour; a longer time period should be mutually agreed between the police and HBPoS staff.	is agreed, **the person should be discharged or transferred to hospital as soon as possible.** **AMHP service** The AMHP has overall responsibility for coordinating the assessment unless otherwise agreed locally. This includes arranging the s12 doctor(s). **The legal duty to assess falls on the AMHP service for the person's location at the time the assessment is needed.** **S12 doctor(s)** If admission is likely, one of the s12 doctors should be employed by the Trust responsible for care in the geographical area where the patient is being assessed. The second doctor should have previous acquaintance with the person or be a s12 doctor.	delegated to the bed manager (or equivalent) of the receiving Trust supported by the AMHP. **Admission should be treated as an emergency**, with decisions based on clinical judgement and what is in the individual's best interests. This may mean admitting the patient temporarily at the site where the HBPoS is located, even if they are usually resident in a geographical area served by a different Trust. No treatment should be refused or delayed due to ambiguity as to which ICB is responsible for funding the care. The receiving Trust should be aware that detention under s136 cannot be extended beyond 24 hours because of a bed shortage. HBoPS should transfer patient records to the receiving Trust.

Proposed admissions from a community setting

Pathway	Individual within the community	MHA assessment	Waiting for access to inpatient care	Conveyance	Admission to ward
Key actions	Individual in the community appears in need of immediate mental health care (e.g. individual is at home or their GP surgery, or a call is made to '111'). The local crisis team should be contacted about the individual's situation. Local arrangements may be a 24/7 mental health triage / crisis line service and/or the CR&HT team. All known information should be provided to the operator to facilitate appropriate triage. **Local crisis team** Call to the crisis team will be triaged, and, where appropriate, the team will attend the community site. If the team are to attend, the operator should provide a timeframe for arrival. Where appropriate, local teams should respond within one hour of referral. On arrival, the crisis team should undertake an initial mental and physical state assessment within 4 hours of referral. This may conclude that the individual can be treated safely and beneficially in the community, or that admission for inpatient care is best for the patient If admission is deemed necessary and voluntary admission refused, the team should contact the AMHP service to arrange a	**AMHP / s12 doctors** A formal assessment under the Mental Health Act decides whether formal detainment and admission to a hospital under s2/s3/s4 of the MHA is necessary. The assessment should be by a doctor approved under section 12(2) of the MHA and an AMHP. Assessment from a second doctor is also required for a formal detention and admission under s2/s3. **It is good practice for the AMHP and s12 doctors to arrive within 3 hours of being contacted** unless there are clinical grounds for delay or in situations where a warrant under section 135(1) of the MHA is required. An assessment should not be delayed due to uncertainty around bed availability. **AMHP service** The AMHP has overall responsibility for coordinating the assessment unless otherwise agreed locally. This includes arranging the s12 doctor(s). **The legal duty to assess falls on the AMHP service for the person's location when the assessment is needed.**	**Local crisis team / AMHP** **If the outcome of the assessment is that admission is required, the person should be transferred to hospital as soon as possible.** The crisis team / AMHP should make contact with the receiving Trust to confirm capacity for the individual. The receiving Trust will usually be the Trust responsible for care in the location where the person is usually resident. Finding a bed is formally the responsibility of the doctors concerned, but usually this is delegated to the bed manager (or equivalent) of the receiving Trust, with support from the AMHP. Both the doctors and AMHP making the assessment should provide a full risk assessment to the receiving Trust as part of their overall assessment. The crisis team / AMHP should maintain regular liaison with the receiving Trust, including alerting them if the person's condition deteriorates. The crisis team / AMHP have a duty to take reasonable care for a person's health and safety until the patient is admitted to the receiving Trust.	**AMHP service** If the individual is to be admitted formally, the AMHP is responsible for arranging conveyance from the community site to the receiving hospital, with the support of the crisis team, as needed. Transport should be chosen in consultation with other professionals involved and following a risk assessment. Before the individual is transferred, the AMHP should ensure that the receiving Trust is expecting the patient and has been told the probable arrival time. If possible, the name of the person receiving the patient and their admission documents should also be obtained in advance. If admission is voluntary, arranging transportation is the responsibility of the crisis team / sending Trust. **Local crisis team** Remain in attendance while the individual is conveyed to the place identified for inpatient treatment. Complete formal handover with receiving Trust staff.	**AMHP service** If the individual is to be admitted formally, the AMHP should provide an outline report for the receiving Trust when the patient is first admitted, giving reasons for the application to detain and any practical matters about the person's circumstances which the hospital should know. **Receiving Trust** Ensure all relevant information is received about the patient, including any history of restraint whilst in the community.

Pathway	Individual within the community	MHA assessment	Waiting for access to inpatient care	Conveyance	Admission to ward
	formal assessment under the MHA. In situations that require a warrant under section 135(1) of the MHA to access an individual believed to be suffering from mental disorder, contact should be made with the AMHP service to apply for a warrant and coordinate a formal assessment. **Police / AMHP service / s12 doctor** On execution of a warrant under section 135(1), and following entry by police, the accompanying AMHP and doctor may convene a mental health assessment in the person's home, if it is safe and appropriate to do so and the person consents to this. This decision should consider who else is present, particularly if the person is distressed by the assessment taking place in these circumstances. Such decisions by an AMHP and doctor should also be made in consultation with the police. If the AMHP and doctor decide that it is inappropriate to assess the person at home, the AMHP should phone ahead and make arrangements to convey the individual to the closest HBPoS for assessment. **HBPoS** If the closest HBPoS does not	**S12 doctor(s)** If admission is likely, one of the s12 doctors should be employed by the Trust responsible for care in the geographical area where the patient is being assessed. The second doctor should have previous acquaintance with the person or be a s12 doctor. **Local crisis team** The crisis team continue to remain onsite to provide reasonable care to the individual's health and safety. One of the team doctors may also participate in the assessment itself, as one of the s12 doctors.	**Receiving Trust** Inform the crisis team / the AMHP that they are the responsible Trust for the individual and provide a timeframe for admission. Admissions should be prioritised on the basis of clinical need. Treatment should not be refused or delayed due to ambiguity as to which ICB is responsible for funding an individual's healthcare. Ensure full risk assessment for the individual has been provided. This should cover whether the individual requires constant supervision, and whether the individual is subject to restraint or on-going restraint by police officers. (On- going restraint + mental illness = medical emergency) Maintain liaison with crisis team / AMHP, undertaking continuous reassessment and re-prioritisation of admission based on full clinical risk assessment, including any deterioration of the individual as a result of delay in receiving treatment. Delays in accessing an inpatient bed should be escalated per the Trust's protocol.		

Pathway	Individual within the community	MHA assessment	Waiting for access to inpatient care	Conveyance	Admission to ward
	have capacity to receive the individual, the facility coordinator at the site should advise of an alternative HBPoS or escalate the matter as per the Trust's protocol.				

Proposed admissions from police custody

Pathway	Individual is in police custody	MHA assessment	Waiting for access to inpatient care	Conveyance	Admission to ward
Key actions	Individual who has been arrested and is being held in police custody on suspicion of committing an offence appears in immediate need of mental health care. **Police** Police should contact Liaison and Diversion service. Police provide reasonable care to the individual's health and safety, and otherwise act in accordance with their duties under the Police and Criminal Evidence (PACE) Act. **Forensic Medical Examiners (FMEs) and Liaison & Diversion (L&D) service** FME and L&D team should attend within one hour of being contacted by police. On arrival, the FME and L&D team should undertake an initial mental and physical state assessment within 4 hours of	**AMHP / s12 doctors** A formal assessment under the Mental Health Act decides whether formal detainment and admission to a hospital under s2/s3/s4 of the MHA is necessary. The assessment should be by a doctor approved under section 12(2) of the MHA and an AMHP. Assessment from a second doctor is also required for a formal detention and admission under s2/s3. **It is good practice for the AMHP and s12 doctors to arrive within 3 hours of being contacted** unless there are clinical grounds for delay. An assessment should not be delayed due to uncertainty around bed availability. Occasionally the AMHP may decide they need to return to re-interview the person to decide on an appropriate course of action. **AMHP service**	**AMHP / s12 doctors** **If the outcome of the assessment is that admission is required, the person should be transferred to hospital as soon as possible.** As soon as it is known that admission is likely, the AMHP should make contact with the receiving Trust to confirm capacity for the individual. The receiving Trust will usually be the Trust responsible for care in the location where the person is usually resident. Finding a bed is formally the responsibility of the doctors concerned, but this is usually delegated to the bed manager (or equivalent) of the receiving Trust with support from the AMHP. Both the doctors and AMHP making the assessment should provide a full risk assessment to the receiving Trust as part of their overall assessment. The doctor / AMHP may need to	**AMHP service** If the individual is to be admitted formally, the AMHP is responsible for arranging conveyance from police custody to the receiving hospital, with the support of the police as needed. Transport should be chosen in consultation with other professionals involved and following a risk assessment. Before the individual is transferred, the AMHP should ensure that the receiving Trust is expecting the patient and has been told the probable time of arrival. If possible, the name of the person receiving the patient and their admission documents should also be obtained in advance. If admission is voluntary, arranging transportation is the responsibility of the police / L&D team. **Police** Provide reasonable care to the individual's health and safety.	**AMHP service** If the individual is to be admitted formally, the AMHP should provide an outline report for the receiving Trust at the time the patient is first admitted, giving reasons for the application to detain and any practical matters about the person's circumstances which the hospital should know. **Receiving Trust** Ensure all relevant information is received about the patient, including any history of restraint whilst in police custody.

Pathway	Individual is in police custody	MHA assessment	Waiting for access to inpatient care	Conveyance	Admission to ward
	referral. This may lead to a referral to primary or secondary mental health care services in the community, a referral to the local crisis team (e.g. home treatment team), or a decision that admission for inpatient care and treatment is needed. If admission is deemed necessary, and voluntary admission is refused, the team (or police) should contact the AMHP service to arrange a formal assessment under the Mental Health Act. L&D team provide support to custody staff and person's family.	The AMHP has overall responsibility for coordinating the assessment unless agreed otherwise locally. This includes arranging the s12 doctor(s). **The legal duty to assess falls on the AMHP service for the person's location when the assessment is needed.** **S12 doctor(s)** If admission is likely, one of the s12 doctors should be employed by the Trust responsible for care in the geographical area where the patient is being assessed. The second doctor should have previous acquaintance with the person or be a s12 doctor. **L&D service / Police** Neither the L&D service nor the police are formally involved in the assessment itself, but continue to provide reasonable care to the individual's health and safety.	arrange a forensic psychiatrist to give an opinion on the appropriate care pathway and level of security for admission for individuals suspected of a high gravity offence. **L&D services / Police** Duty to take reasonable care for person's health and safety. On-going liaison with the receiving Trust, including notification if the person's condition deteriorates. Following a decision to admit, in relation to the original suspected offence, the police will need to decide whether to take no further action or to bail to a specified address / the hospital where the individual is to be admitted. **Receiving Trust** Inform the AMHP and police custody sergeant that they are the responsible Trust for the individual and provide a timeframe for admission. Admissions should be prioritised on the basis of clinical need. Ensure full risk assessment for the individual has been provided. This should cover whether the individual requires constant supervision, and whether the individual is subject to restraint or on-going restraint by police officers. (On-going restraint + mental illness =		

Pathway	Individual is in police custody	MHA assessment	Waiting for access to inpatient care	Conveyance	Admission to ward
			medical emergency) Trust should maintain liaison with the custody sergeant, undertaking continuous reassessment and re-prioritisation of admission, based on full clinical risk assessment, including any deterioration as a result of delay in receiving treatment. Delays in accessing an inpatient bed should be escalated per Trust's protocol.		

Appendix 2: Examples to help clarify boundaries of responsibility between Mental Health Trusts for accepting adult inpatient admissions

Section 4.2.3 establishes a set of principles to clarify responsibilities between Mental Health Trusts for admitting adult patients in need of mental health inpatient care. This appendix contains examples in an effort to illustrate how those principles should be applied in practice, particularly in complex situations where two or more geographical areas and Trusts are involved. The examples listed are not exhaustive but where possible set out principles that can be applied more widely.

In terms of commissioners' responsibility for funding, the principles contained in the *Who Pays? Guidance* continues to apply. However, in situations where the responsible ICB does not align with the area of the admitting Trust, recharging arrangements should be put in place between ICBs so that funding follows the patient.

The place of GP registration and residence are in different areas

	Scenario	**Trust responsible for accepting the admission**
1	Anna presents in crisis in London within area A and requires admission. She says she is resident in area A, having moved 3 months ago to the area to be near family. She was previously resident in area B, and is still registered with a GP in that area. Anna has not been under the care of a mental health provider previously, and says she wants to receive care close to her new home and her family.	Anna should be admitted by the Mental Health Trust in area A. This is where Anna says she is resident. It is also closest to her family, and where she says she wants to receive care.
2	June presents in crisis in London within area C and requires inpatient admission. She says she is resident in area C, having moved to the area almost 6 weeks ago to be near her daughter and grandchildren. She is registered with a GP in another area out of London on the South Coast (area D). June was previously under the care of a mental health provider in area D, but says she would prefer to stay close to home and receive care close to her daughter.	June should be admitted by the Mental Health Trust in area C. This is where June says she is resident. It is also closest to her family, where she says she wants to receive care. As June intends to reside and receive care in area C, the Mental Health Trust in area D will also need to facilitate adequate handover of care.
3	James presents in crisis in London within area A, and requires inpatient	Arrangements should be made for James's transfer to the Trust in

	Scenario	Trust responsible for accepting the admission
	admission. Five years previously he stayed with a friend in area A and is still registered with a GP practice there, but he says he is now resident out of London (in area B). He has never been under the care of the Mental Health Trust in area A. He has been admitted twice, under section 2, to the Mental Health Trust in area B. James says he would prefer to return home to area B for treatment, rather than being admitted in area A.	area B once it is safe to do so. This may mean admitting to area A temporarily, considering the distance and his mental state.
4	A student, Kylie, who is attending university and is registered with the local GP there for these purposes, becomes unwell and requires inpatient admission. She is admitted to the inpatient service attached to that GP where she is studying. Her family, however, live far away and ask that she be transferred to their local services in area A where she grew up and which Kylie feels will be best for her and her recovery.	Arrangements should be made for Kylie's transfer to the Trust in area A once it is safe to do so. This is where she is usually resident, and is closest to her family and where Kylie feels will be best for her and her recovery. Given the distance between the areas, transfer should only be done once it is safe for Kylie to travel.
5	John, who lives with his sister in Borough A, becomes unwell and for more support goes to live with his brother who lives in Borough B some distance away. John unfortunately deteriorates further and now needs an inpatient admission. Inpatient beds are available in Borough B. There are no beds in Borough A where his sister lives and where he is registered with a GP. However, the Trust attached to Borough A knows that a private bed is available in Borough C, located miles away from both his siblings. John wants to stay close to his family.	Arrangements should be made for John to be admitted closest to his family, including his brother, within Borough B.

The individual is not registered with a GP

	Scenario	Trust responsible for accepting the admission
6	Ivan is a Slovenian national working in the UK. He has been resident in area A in London for 6 months, but has yet to register with a GP. His mother has visited recently and is extremely concerned about his mental health. She takes him to the emergency department in area B, where he is seen by Liaison Psychiatry and a Mental Health Act assessment is requested. Medical recommendations are provided for s2 and the AMHP is minded to make a s2 application.	Ivan should be admitted by the Trust in area A. This is where he says he is resident.
7	Graham and his family relocated to area A from Cumbria three weeks ago. He has yet to register with a local GP. He is taken to area B's Health-Based Place of Safety under section 136. He is assessed under the Mental Health Act and agrees to an informal admission. The assessing doctors and AMHP are in agreement with this plan.	Graham should be admitted by the Trust in area A. This is where he says he is resident.
8	Nadra is unwell and her mother takes her to the closest emergency department, in area B. She is assessed under the Mental Health Act and an application made for a s2 detention under the Mental Health Act. Nadra is not registered with a GP practice and is unable to give a place of residence. Her mother says she is resident in area A of London, where she has a strong support network of friends and family.	Nadra should be admitted by the Trust in area A. Another person (e.g. a parent or carer) may give an address on her behalf.

The individual is in temporary housing

	Scenario	Trust responsible for accepting the admission
9	Ben presents at an emergency department in area A, requiring mental health care. He is seen by Liaison Psychiatry and a Mental Health Act assessment is requested. Medical recommendations are provided for s2 and the AMHP is minded to make a s2 application. Ben says he is living in a hostel in area B. He is registered with a GP in area B. He is not known to mental health services in London.	Ben should be admitted by the Trust in area B. This is where Ben says he is resident. He is also known to primary care in that area.
10	Anya is taken to area A's Health-Based Place of Safety under section 136. She is assessed under the Mental Health Act and agrees to an informal admission. The assessing doctors and AMHP are in agreement with this plan. Anya says she is living in temporary accommodation within a hostel in area B, and is known to mental health services in that area. She is not registered with a GP.	Anya should be admitted by the Trust in area B. This is where Anya says she is resident. She is also known to the mental health team in that area.
11	Charlie has been living, and receiving mental health care, within area A of London, where she has family and has lived since she was a teenager. Due to the complexity of her needs, her care team place her in temporary supported accommodation within area B, which is in London but some distant from area A. She registers with a local GP in area B. After being in the new accommodation for approximately 3 weeks, she becomes unwell and is referred to the home treatment team. The team recommends an inpatient admission, and Charlie is admitted by the Trust in area B. After a second admission in area B, the supported accommodation	At this point, arrangements should be made to transfer Charlie to the inpatient services of the Trust responsible for care in area A while she recovers, and ideally, a more suitable accommodation placement is found closer to her support network.

	Scenario	Trust responsible for accepting the admission
	suggests that the placement has failed. Charlie's care coordinator has remained involved but due to the distance has not been able to provide sufficient support. Charlie is far from her family and support networks.	

The individual is resident outside of England

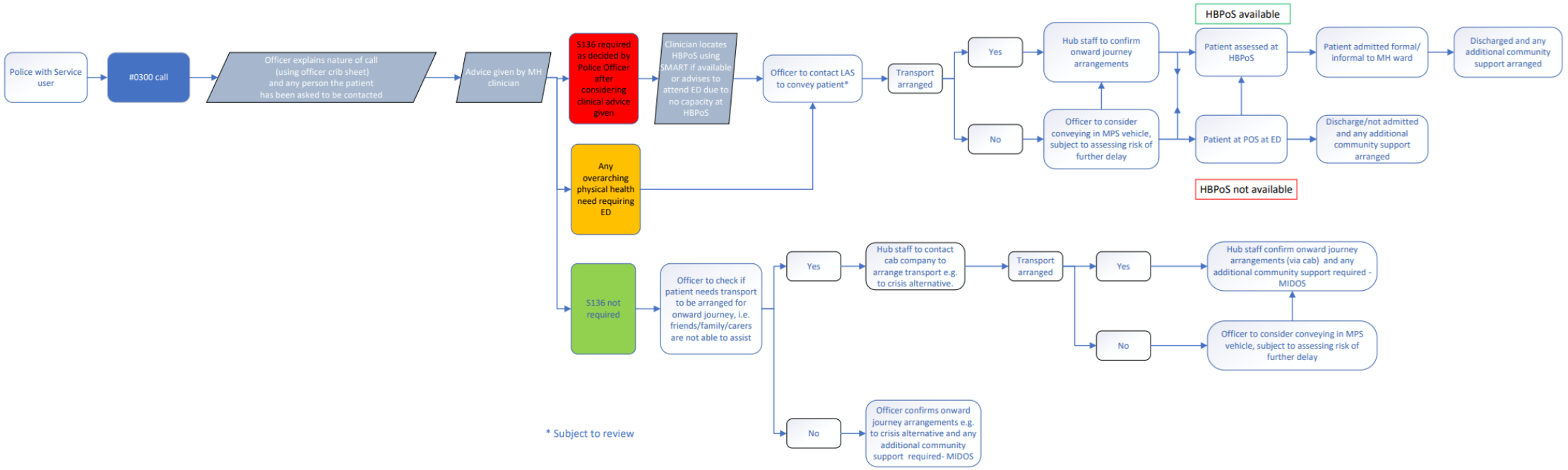
	Scenario	Trust responsible for accepting the admission
12	Jill lives in Edinburgh. Whilst visiting London she is arrested for shoplifting and taken to the local Police Custody Suite in area A. She is seen by the Liaison & Diversion team who request a Mental Health Act assessment. The AMHP and s12 doctors are all of the view that it is necessary for Jill to be admitted into hospital for further assessment, and this can only take place if she is detained under s2 of the Act.	Jill should be admitted by the Mental Health Trust responsible for care in area A, where the assessment has taken place.[43] Once it is safe to do so, arrangements could be made to transfer Jill to a Scottish hospital, if this is in her best interests.
13	Antoinette is a French national. She is two weeks into a 6 week stay with an old school friend, Simone, who lives in area A. Simone, concerned about Antoinette's mental health, takes her to her local emergency department in area B. She is seen by Liaison Psychiatry and accepts their offer of an informal admission to hospital.	Antoinette and Simone's preferences for the location of inpatient care should be sought before Antoinette is admitted. If the two agree it would be best for Antoinette and her recovery to be admitted close to Simone, Antoinette should be admitted by the Trust in area A - closest to Simone's residence - as she has no other support.

[43] There is no provision in English or Scottish Law for an AMHP in England to make an application to a Scottish Hospital.

The individual has 'no fixed abode'

	Scenario	Trust responsible for accepting the admission
14	Joe is arrested on suspicion of a low gravity offence in London within area A. He is then taken into police custody in area B where it is decided that a Mental Health Act assessment is required. The outcome of the assessment is that Joe requires an admission to receive mental health inpatient care. Joe has no fixed abode and does not provide a residential address. He is not registered with a GP practice.	Joe should be admitted by the Trust in area B. This is the area where he is being held in police custody and where the Mental Health Act assessment has taken place.
15	Ellen is arrested for shop lifting in London within area A. She is then taken into police custody in area B where it is decided that a Mental Health Act assessment is required. The outcome of the assessment is that Ellen requires an admission to receive mental health inpatient care. Ellen has no fixed abode and is not registered with a GP, but was previously known to social services in area C. Within the last 6 months, she has also had an admission, under section 2, to the Mental Health Trust in area C.	Ellen should be admitted by the Trust in area C. She is known to services in that area.
16	Ekene presents in need of mental health care at an emergency department in area A. He is seen by Liaison Psychiatry and a Mental Health Act assessment is requested. Medical recommendations are provided for s2, and the AMHP is minded to make a s2 application. Ekene does not provide a residential address and is not registered with a GP practice. He does not provide any further details.	Ekene should be admitted by the Mental Health Trust responsible for care in area A. This is the area where the Mental Health Act assessment has taken place.

Appendix 3: MHCAL Pathway Flow Chart

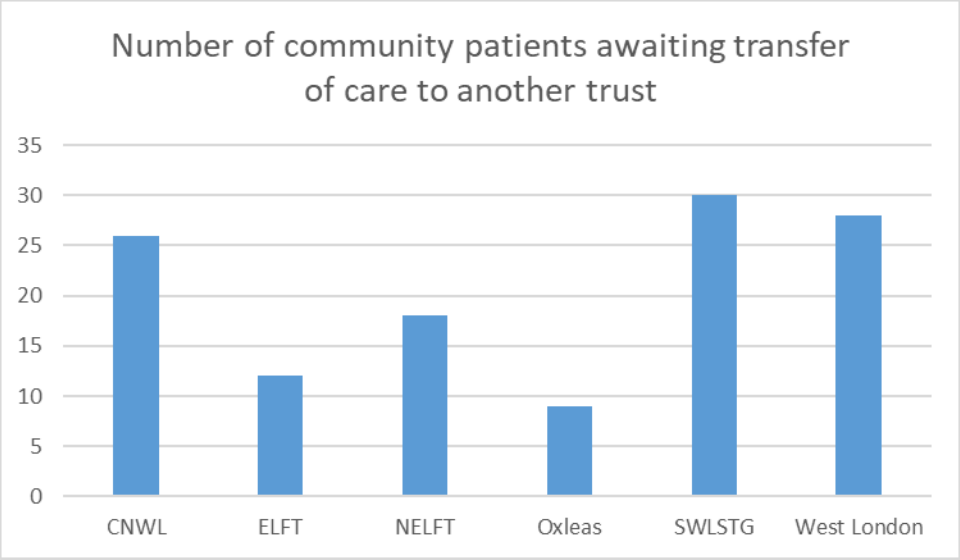


Appendix 4: London Transfer of Mental Health Community Care Agreement

Introduction

Transfers and changes in continuity of care are more likely to lead to relapses so transferring a patient with a well-developed relapse prevention care plan with advance directives developed in coproduction with a trusted team is best practice. Within the health economy it can be frequent for people using Mental Health services to move location and live in different areas. For the NHS and Social Care this often requires careful planning to ensure that service users needs can be met wherever they reside. In population health, MHTs are ideally placed to feed into annual public health JSNAs' i.e. local authority strategic needs assessment process. This would enable us over time to report how many people have had to be placed out of borough/ICB area so that future Housing and Care provision could be more tailored to predicted demand. Transfers are unsettling and time consuming. London frequently experience people presenting or being placed in a neighbouring borough, which can then often lead to challenges for local health and social care providers. The primary driver of patient safety and quality of care and treatment required, should follow the person when moving from one mental health trust to another.

Graph 1 below provides a snapshot at a moment in time of community patients awaiting transfer of care to another trust. It should be noted that this does not cover all London mental health trusts and therefore the total number is expected to be larger.



Graph 1 – Number of community patients awaiting transfer of care to another trust

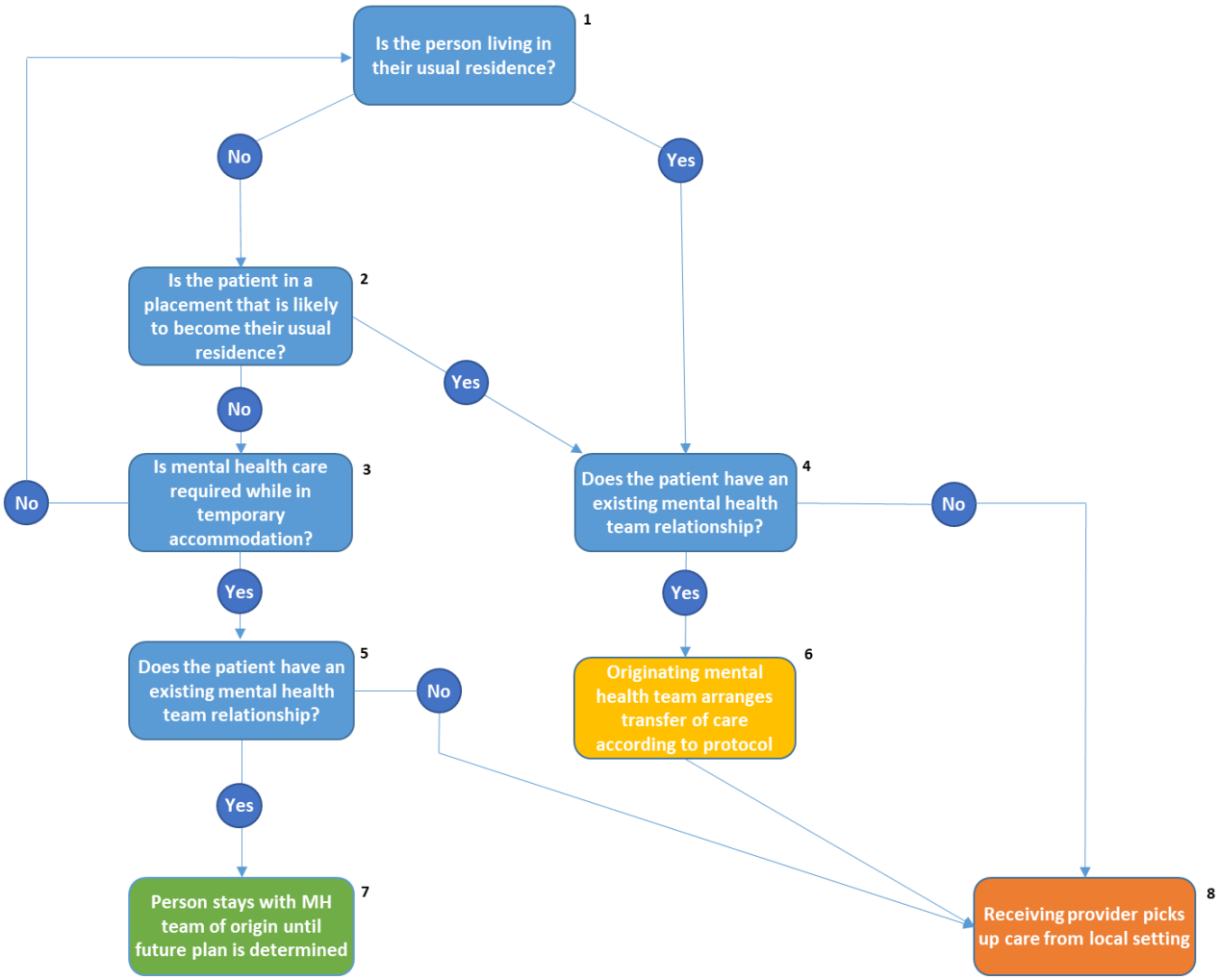
There have been a number of key papers written to highlight the importance of safe and effective transfers of care which are outlined in section 9.

Key Principles for Transfer of Care

- Safe and continuous access to care for the patient.
- Care to be provided wherever possible locally to the patient's usual residence.
- Efficient usage of existing resources within the local area.
- Flexible system that responds to on-going care needs.
- Safe and timely transfer of all relevant clinical information including risk history and management.
- Good communication between referring and receiving team.
- Transfer of care should be prompt and within an agreed timescale

Provision of Health Care Local to the Individual

- The local health care team provides for the patient living in that area.
- A clear distinction between *payment* and *provision of care* is agreed.
- The distinction is crucial to provide safe, effective and responsive care as set out within *The London Compact (2019).*
- Funding arrangements should not block or delay the safe and efficient transfer of care, as this is a clear risk - *Who Pays Guidance (2020)*.



Graph 2 - Decision Tree

MH team of origin = referring team/service in original area of residence
Receiving provider = receiving team/service in new area of residence, usually a different MH trust in a new Borough

Example of Good Practice Transfer of Care

James is a 45 yr. old male with a history of schizophrenia, dating back for 20 years and has been under the care of the Lewisham North Recovery Team since 2010, which is part of SLAM MH trust. Following a recent admission to hospital under Section 3 of the Mental Health Act, James has been accepted for a higher level of floating support in a low intensity resource in the London Borough of Wandsworth, which is under the care of SWLSTG MH trust.
A discharge CPA meeting was held on the ward at the Ladywell Unit, Lewisham Hospital, and the plan was outlined and recorded with James's CC and CMHT. The plan was recorded in detail in the clinical notes and updates were sent to all

including James, his carer, his GP, the CC and CMHT.
The CC referred James to Central Wandsworth CMHT, the team responsible for provision of mental health care in the area where James will now have usual residence.
The receiving team of Central Wandsworth CMHT acknowledged the referral, and this was recorded and entered onto their electronic patient record system (EPJS) as waiting.
The Lewisham CMHT ensured a comprehensive and professional sending of all relevant information including diagnosis, treatment, risk, care plan, recovery goals, physical health, social needs and any other relevant issues were sent to Central Wandsworth CMHT.
A transfer of care meeting was arranged by Lewisham CMHT to Central Wandsworth CMHT – this is best done in person where possible, or virtually due to Covid restrictions.
James was transferred to his new team Central Wandsworth CMHT, following the meeting and this was completed within the timescale as agreed of 6 weeks from point of referral by Lewisham. James was registered with a GP local to his new address, and usual residence in Wandsworth.
Lewisham CCG continue to pay as the responsible CCG and the local provision of mental health care is now provided by Wandsworth. James is now discharged from SLAM services to the care of SWLSTG.

Common Situations Where This Can Occur

- Patient is admitted under the MHA with no collateral or known history to the area and requires S117 aftercare on discharge.
- Patient is placed out of borough into temporary accommodation by another borough e.g. Wandsworth place a patient in Croydon due to unavailability of any housing stock within their own borough.
- Patients are place out of borough for recovery and rehabilitation purposes e.g. complex care and require on-going follow up.
- Patients are placed within a borough e.g. for rehabilitation and require both RC and local health care such as CMHT provision.
- Patients move to a different borough through personal choice for supportive network reasons e.g. family in a different borough so patient moves from South West London to East London and requires on-going support.
- Some boroughs may be *Importers of Care* as a result of structural and environmental factors such as more available stock for temporary accommodation, plus having a central resource that has to manage high volume of demand for people and space to live. Croydon is a clear example of this with the location of Lunar House, and the borough having access to wide availability of social housing which is often temporary accommodation.

Process of Transfer

The transfer process must both underpin and execute the action to ensure all relevant parties are informed, updated, engaged and involved in key discussions from the point of referral at the beginning, to the safe handover of care on completion, at the end. The process must include the following:

- An agreed timescale of 6 weeks from point of referral to the local team involved taking over the persons care inclusive of RC and CMHT responsibility where this applies and is required.
- A complete safe sharing and transporting of all clinical information including diagnosis, treatment, risk history, care plan, crisis and contingency plan, substance misuse, engagement, recovery plan, carers, involved others/support, physical health care and any other relevant information which impacts upon the patient's mental health and will be required for on-going follow up.
- A planning meeting must take place to safely and effectively hand over the person's care. This can be done face to face or virtually to meet the Covid pandemic restrictions. This meeting works best when the handing over team attend the site where the person's care will go to e.g. a Care Coordinator from a Wandsworth CMHT attending the receiving team base in Lewisham CMHT. Prior to the meeting all the necessary information as highlighted previously must have been sent, and an acknowledgment of this by the receiving team recorded clearly in the patient's notes or system on both sides.

Solutions to Common Transfer Issues

ISSUE	CHALLENGE	SOLUTION
Person moves borough by personal choice.	Local team decline referral leaving gap for care provision.	Current assessment and agreement of MH needs. Progress according to need which may include transfer of care to new local team. Use escalation process to resolve dispute if required.
Person released from prison and placed in Approved Premises (AP)* in different borough to previous care provided.	Local team decline referral leaving gap for care provision.	Borough of origin before prison to engage with borough where AP is to determine and formulate a plan to provide care going forward. AP* will be temporary accommodation, (TA)

		usually 8 weeks, so will need to follow next issue/example.
Person placed in temporary accommodation (TA) in different borough due to lack of stock in own area. *Some boroughs may have frequent challenge in receiving as they may be an *importer borough* due to level of available housing stock e.g. Croydon.	Local team decline referral leaving gap for care provision. Determining the type of TA e.g. emergency may be very short term e.g. days or weeks. If non-emergency this may be a longer period e.g. months, years and thus become usual residence.	Determine the type of TA. Refer to local team if required e.g. TA likely to be usual residence for period longer than 12 weeks. Arrange transfer of care as required within agreed timeframe.
Person moved into borough due to placement location and requires on-going MH follow up and after care.	RC required. Local Consultant reluctant to accept as has no known history or contact with the person moved into the area. Local team decline referral leaving gap for care provision.	Originating team continue to support the patient and escalate the need to transfer using the escalation protocol.
Person resides in borough but is registered with GP in different area. *We know many MH users do not engage or attend GP, and often have outdated, inactive registration or out of area e.g. person lives in Richmond but has GP record of Birmingham.	Local team decline referral leaving gap for care provision.	Refer to and comply with The London Compact (2019). If area is outside of London, local provider to ensure MH need is met according to residence of person. Referring team to complete a comprehensive and inclusive transfer of care to next MH provider local to residence of person.
Person is placed out of borough for safeguarding reasons e.g. domestic violence, offending, cuckooing etc.	Local team decline referral leaving gap for care provision. Placements tend to be a TA arrangement and determination of duration of stay is difficult due to	The placing agent (local authority) will need to align with equivalent in other borough, and agree a plan for going forward depending on likely timeframe. This must

	circumstances of individual e.g. can be victim or perpetrator.	involve the team of origin and any new local MH provider service who may need to be involved on a medium to long term basis.
CAMHS transition of care to adult when person moves to another borough.	Local team decline referral leaving gap for care provision. This may be due to different arrangements in local area.	Referring team to refer at earliest point of 6 months prior to leaving CAMHS. Clarification sought as this point about support and provision for future needs to determine who is required to do this e.g. may not require secondary services.
Person is placed out of borough when they are on a Community Treatment Order (CTO)	It is important that the rights based review processes under the MH Act and DHSC Code of Practice are observed e.g. person is on a CTO but the best supported accommodation for their needs is in another borough.	Any consideration of reviewing the CTO is logged between MHA offices of transferring providers.

This is not an exhaustive list of issues but has been included to provide examples of common issues.

Escalation

MH trusts must have their own escalation protocols in place, to enable timely access for individuals being transferred in need of care. These protocols should include a clear timeline with responsibilities and expected actions, setting out at what stage senior managers will be made aware, including Leads, Directors and Chief Operating Officers.

It is crucial that all parties involved in this transfer process carry out their roles and responsibilities in accordance with a pan London wide agreement. The patient and their care must be the primary objective and any disputes must be resolved at the earliest point. This is crucial to patient safety and quality of the care experience and should not be derailed as a result of different opinions from the referring and receiving team. There is a strong evidence base of serious incidents including homicides taking place, where communication within transfers has been poor, and has highlighted gaps within the wider system.

Issue	Escalation actions
Resolving uncertainties over MH trust accepting transfer of care.	Appropriate escalation at MH trusts level as per required to resolve quickly.
Dispute and delay in transfer of care.	Health and Social Care providers should escalate matters between them to avoid delays.

Please refer to item 1 below for the Mental Health Compact Escalation Framework.

Appendix 5 - References

The Health and Social Care Act. Department of Health (2012)
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Good Practice in the Transfer of Service User Care & Support between Trusts and Local Authority Areas. Care Coordination Association (2014)
http://www.cpaa.org.uk/uploads/1/2/1/3/12136843/transfer_protocol_between_mh__districts_final_12_dec_14.pdf

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/252864/OR_Guidance_2013-10-01_Revised__with_new_contact_details_New_DH_template.pdf

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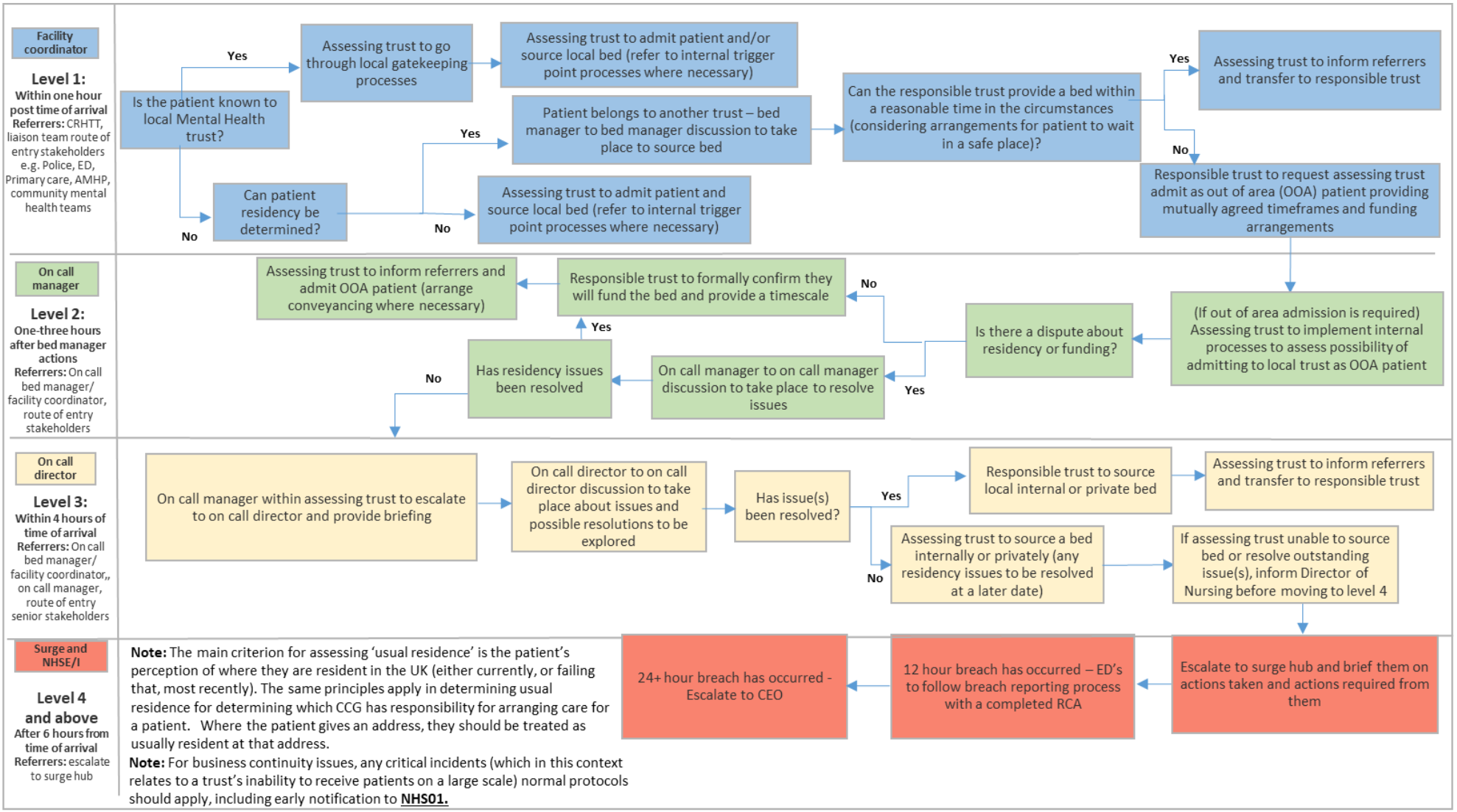
1. Mental Health Compact Escalation Framework



Appendix 6: Surrounding Counties Memorandum of Understanding

Surrounding Counties and London Compact
Access and Flow Escalation Protocol

Memorandum of Understanding

The organisations that are signatories to this Memorandum of Understanding have made a commitment to work together so that people in mental health crisis have timely access to mental health inpatient care and treatment when they need it.

Author:
Heather Caudle, Chief Nursing Officer, SABP and London Mental Health Compact Clinical Lead

Signatories:

NHSE London
NHSE Southeast
NHSE East of England
Oxleas NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
Southwest London and St Georges NHS Trust
East London NHS Foundation Trust (including Bedfordshire & Luton)
Northeast London NHS Foundation Trust
Barnet, Enfield, and Haringey MH Trust
Camden & Islington NHS Foundation Trust
Central and Northwest London NHS Foundation Trust (including Milton Keynes)
Essex Partnership University NHS Foundation Trust
West London Mental Health Trust
Hertfordshire Partnership NHS Foundation Trust
Berkshire Healthcare NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation
Kent and Medway NHS and Social Care Partnership Trust
Oxford Health NHS Foundation Trust
Cambridge and Peterborough NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
Southern Health Foundation Trust
Solent NHS Trust
Isle of Wight NHS Trust
Sussex Partnership Foundation Trust

Introduction:

The London Compact Agreement (LCA) is a publication which focuses on access to Mental Health (MH) inpatient services in London. The LCA is between London's Mental Health and Acute Trusts, Local Authorities, CCGs, NHS England/NHS Improvement, London Ambulance Service and Police services and has been active since June 2019.

Geographically, London is surrounded by a number of Mental Health Trusts, which share borders with London Trusts. All trusts have experienced a number of patients who present in a neighbouring catchment area rather than their home catchment area. This can provide some challenges logistically due to the different teams involved and processes used.

Despite the LCA being founded with the intention of establishing a common understanding of what is expected from each part of the health and care system, in providing access to MH inpatient facilities in London, including Health-Based Places of Safety, for patients in MH crisis whose places of residence and or GP Practices straddle the border between London and its surrounding counties this did not always happen. It was decided therefore to develop a Memorandum of Understanding to help achieve this. with all surrounding counties becoming party to and adhering to the principles set out within the London Compact agreement – which will now be known as **"The Compact"**.

The surrounding regions and organisations who **have agreed to be party to, and implement the principles of, the "Compact**" are:

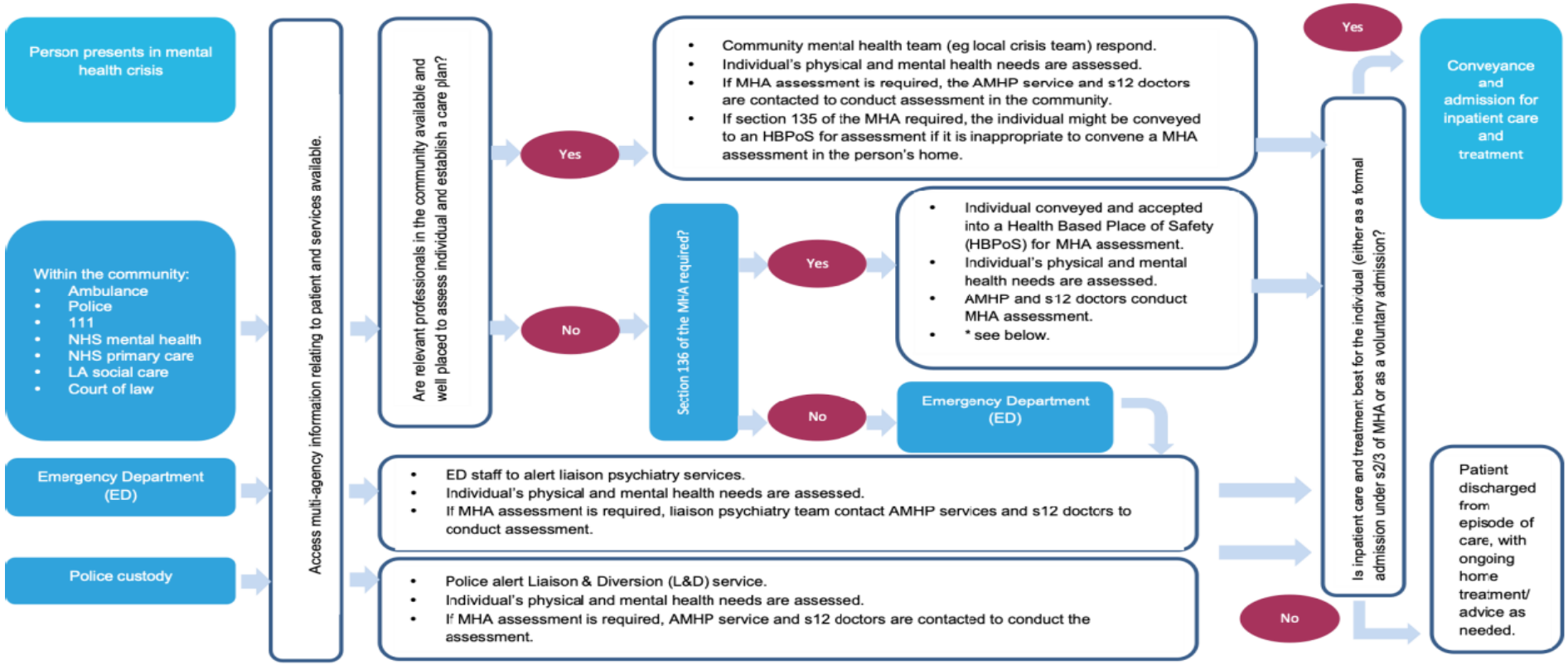
NHSE/I London
NHSE/I Southeast
NHSE/East of England
Oxleas NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
Southwest London and St Georges NHS Trust
East London NHS Foundation Trust (including Bedfordshire & Luton)
Northeast London NHS Foundation Trust
Barnet, Enfield, and Haringey MH Trust
Camden & Islington NHS Foundation Trust
Central and Northwest London NHS Foundation Trust (including Milton Keynes)
Essex Partnership University NHS Foundation Trust
West London Mental Health Trust
Hertfordshire Partnership NHS Foundation Trust
Berkshire Healthcare NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation
Kent and Medway NHS and Social Care Partnership Trust
Oxford Health NHS Foundation Trust
Cambridge and Peterborough NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
Southern Health Foundation Trust
Solent NHS Trust
Isle of Wight NHS Trust
Sussex Partnership Foundation Trust

Purpose:
The purpose of this MOU is to provide a clear and concise escalation protocol to manage requests safely, effectively and efficiently between mental health trusts in surrounding counties and London, which will lead to:

- Patients no longer staying in A and E for non-clinical reasons.
- A standardised process for identifying responsible provider as set out within the Compact - which will lead to fewer disputes and ultimately reduce delays for patients within A&E, police custody or in community waiting for an admission
- A joined-up protocol which sets out the discharges/transfer timelines for the host and receiving trust

Scope

The Compact covers services for all ages – children and young people (CYP), adults and older adults – who present in MH crisis. It does not currently explicitly cover pathways for patients who meet the Transforming Care criteria, i.e. people with learning difficulties and autism, who display behaviour that challenges, including those with a MH condition. The Compact does not apply to access to services or facilities available in the community without the need for inpatient assessment or potential need for assessment. The diagram below demonstrates an overview of the pathway into Inpatient care, for those in MH crisis:



In cases where a S136 is applied the individual could still go to ED if there were emergency physical health needs or if there is no HBPoS capacity

Boundaries of responsibility between Trusts for accepting adult inpatient admissions

An adult patient should be accepted for admission by the Mental Health Trust responsible for care where the person is usually resident.

If a service user considers themselves to be resident at an address (e.g. at a hostel or other temporary residence), then this should be accepted as the individual's usual residence. Acceptance for admission should not be subject to proof of address (e.g., a tenancy agreement or utility bill). If the person's place of residence is unknown or they cannot provide an address, then the Mental Health Trust closest to where the person has been assessed should accept the admission. Prisons are not a place of residence. Any treatment provided by a Mental Health Trust to a prisoner must be discounted when considering which Trust is responsible for ongoing mental health care and treatment. This means that upon release the prisoner would be deemed to be a resident in accordance with their assigned/chosen residency upon release.

There are two possible exceptions to the principles outlined above. The first is when a person presents a long way from home. If it is not in the person's best interests at the time to convey them to the receiving Trust, the Trust closest to where the person has been assessed should admit them temporarily.

The second exception is in situations where a person has received inpatient care within the past six months or is receiving S117 after-care or is on the caseload of a community team for treatment (not merely assessment). In such cases, if a transfer of care under the London Transfer Agreement has not been initiated by the referring trust, and the patient has expressed a preference to be cared for by the trust providing ongoing care, then they should be admitted by that trust. In all other cases the default arrangement in the paragraphs above will apply.

Admission

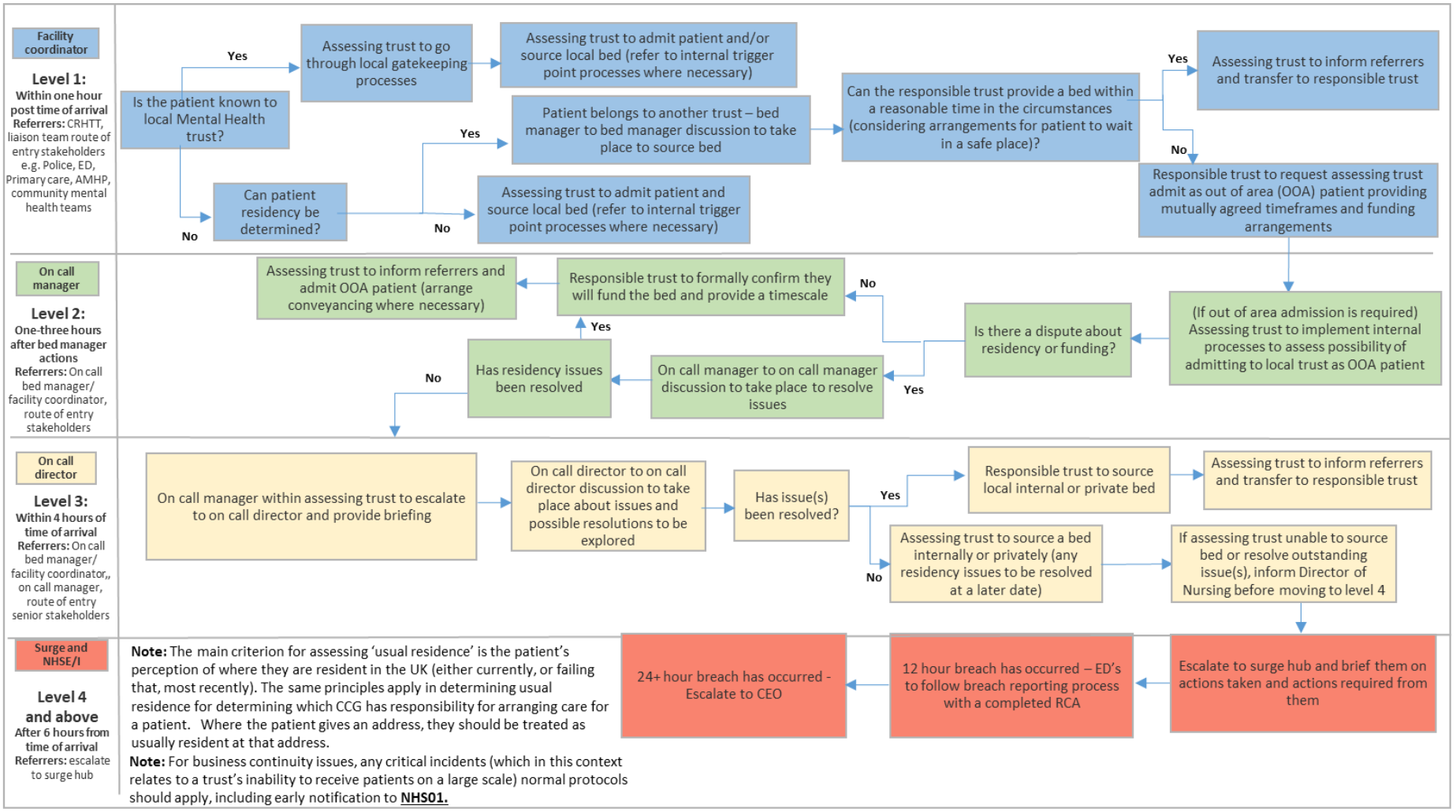
I. The referring organisation will conduct the assessment and contact the host organisation with the outcome of the assessment, then a clinician-to-clinician conversation will take place to decide on the appropriate outcome for the patient, without the need for any further assessments, and honouring the initial assessment. All parties will adopt the Trusted Assessment Framework (appendix 1).

II. **Level 1 escalation:** If after 2 hours there is no progress on the request then the referring organisation will escalate to their respective manager (Service Manager or equivalent) who will then discuss directly with their counterpart in the receiving organisation. It is expected that a clinically driven conversation is held which expands further on the operational demands not being able to progress the request.

III. **Level 2 escalation:** If after 4 hours escalation, there is no progress on the bed request, then the referring organisation will escalate to their Silver

command and (for London Trusts) the respective Surge Management Team. The relevant team will then discuss directly with their counterpart in the receiving organisation to avoid a 12 hrs A&E trolley breaches. It is expected a structured discussion that covers the clinical and operational discussions should be held with a focus on clear and concise actions to resolve the request in the shortest time practical.

See the escalation process map overleaf for decision-making and escalation.



Each Mental health provider is required, under the terms of the **NHS Standard Contract**, to accept emergency referrals or presentations where it can safely do so.

- It is important to note that not all stages of escalation need to occur. If, for example, assurances can be given in writing at stage 2 that requests are progressing to the desired outcome however some additional time is needed, this should be agreed between the two organisations and no further escalation is required.
- When escalating, the respective individuals who are being escalated to, shall check that the previous steps have been followed before engaging further. If the protocol has not been adhered to, the individual will request that the protocol is followed.

Disputes on responsibility

It is acknowledged that there are likely to be patients who move between borders without the prior knowledge of any involved mental health services. For clarity, all trusts and commissioners should determine funding responsibility by following the Who Pays Guidance, diagram below. Trusts should note that the Who Pays Guidance should be uncoupled from provision of treatment, with the latter taking priority led by clinical need (e.g. not moving the patient a long distance if they require urgent treatment), and thereafter being determined by usual residence or patient preference where expressed as per the Compact.

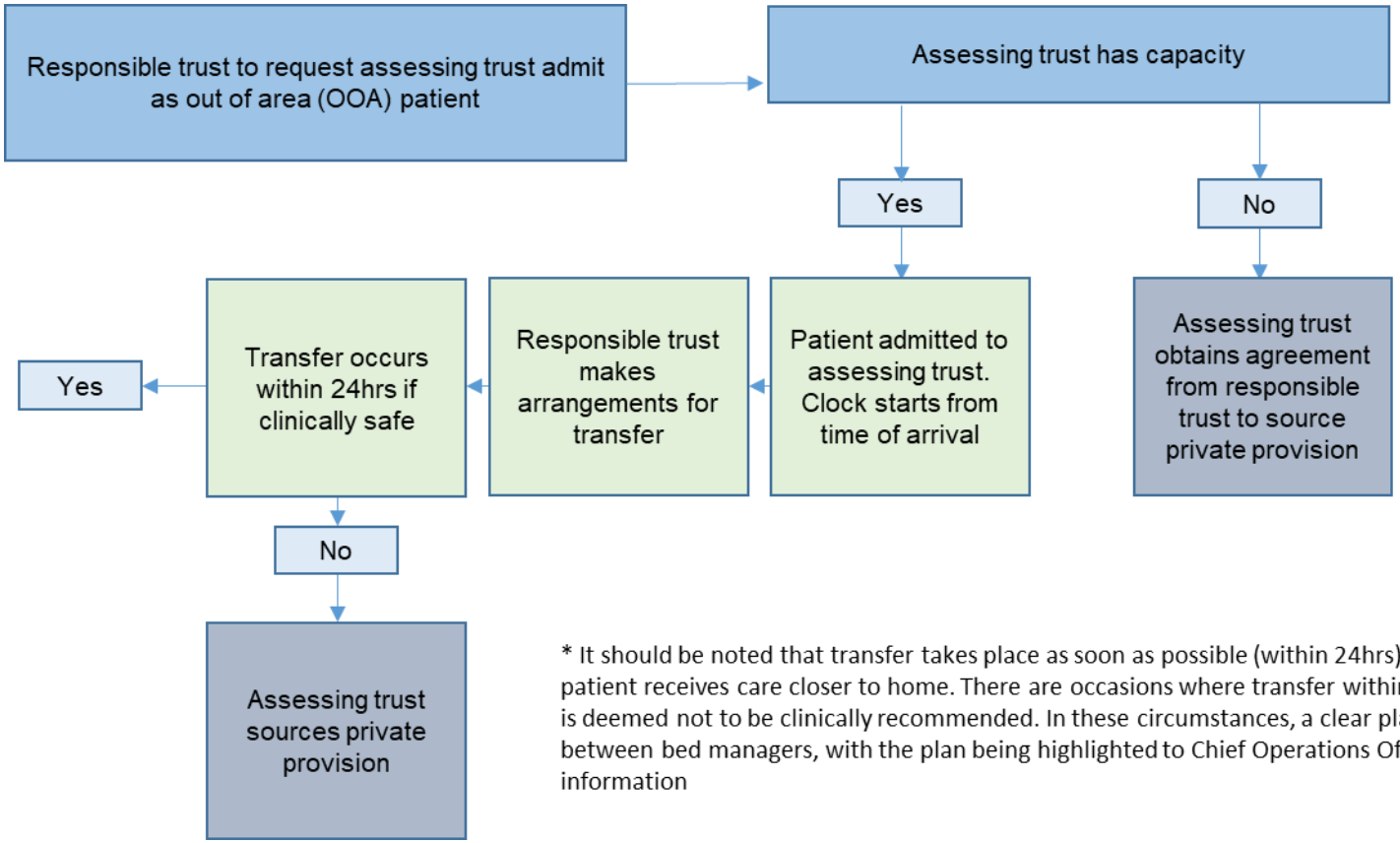
Who Pays Guide

The Who Pays guidance sets out responsible commissioner **not responsible provider**
A provider that holds a written NHS Standard Contract for certain services with one commissioner must, under Service Condition 6, accept certain referrals to those services from any commissioner, even one with which it holds no written contract. **This applies to any referral or presentation for emergency treatment** (where the provider can safely accept the referral)
All trusts need to follow this guidance to avoid lengthy delays to admission. The rules for determining the responsible Commissioner are:

Ref.	Description
1.	GP first
2.	Where no GP then apply the usual resident test (this applies to homeless people also)
3.	The 'usually resident' test must only be used to establish the responsible commissioner when this cannot be established based on the patient's GP practice registration;
4.	'Usually resident' is different from 'ordinarily resident'. If a person is not ordinarily resident in the UK and not covered by an exemption in regulations then they are liable for NHS hospital treatment costs themselves. The 'usually resident' test may still be needed to establish the responsible commissioner for non-hospital services;
5.	The main criterion for assessing 'usual residence' is the patient's perception of where they are resident in the UK (either currently, or failing that, most recently). The same principles apply in determining usual residence for determining which ICB has responsibility for arranging care for a patient.
6.	Where the patient gives an address, they should be treated as usually resident at that address.
7.	Certain groups of patients may be reluctant to provide an address. It is sufficient for the purpose of establishing usual residence that a patient is resident in a location (or postal district) within the ICB geographical area, without needing a precise address. Where there is any uncertainty, the provider should ask the patient where they usually live. Individuals remain free to give their perception of where they consider themselves resident. Holiday or second homes should not be considered as "usual" residences.
8.	If patients consider themselves to be resident at an address, which is, for example, a hostel, then this should be accepted. If they are unable to give an address at which they consider themselves resident, but can give their most recent address, they should be treated as usually resident at that address.
9.	Another person (for example, a parent or carer) may give an address on a patient's behalf.
10.	Where a patient cannot, or chooses not to, give either a current or recent address, and an address cannot be established by other means, they should be treated as usually resident in the place where they are present.

Transfer

In the event of a bed being found ahead of responsibility being established or the place where the person has local ties has been identified, then there should be a commitment to transfer within 24 hours, where it is clinically safe to do so. The benefit of this time would be to have measurable parameter within which to work and would have the added benefit of providing information that can be used to guide improvement efforts to improve quality. Please see the diagram below.



* It should be noted that transfer takes place as soon as possible (within 24hrs) to ensure the patient receives care closer to home. There are occasions where transfer within this timeline is deemed not to be clinically recommended. In these circumstances, a clear plan is agreed between bed managers, with the plan being highlighted to Chief Operations Officers for information

Governance and Evaluation

It is expected that all Parties subject to this Memorandum of Understanding will commit to 6-weekly meeting schedules, with representation at Executive Bord Director level (COO) or representative to enable swift decision making and good partnership working.

Monitoring and Compliance

The following metrics will be completed daily and submitted weekly to respective NHSE/I Regions:

1. number of local patients who are placed in another region's / organisation's bed.
2. number of patients from another region / organisation placed in host bed.
3. number of responsible provider disputes (will need to get a baseline with which to show a reduction in disputes).
4. number of transfers which exceed the agreed timeframe.

It is expected that any concerns in performance, conduct or otherwise that require immediate attention will be discussed as such between the respective organisations rather than waiting for the above-mentioned meeting.

Appendix 1: Who Pays Guidance

https://www.england.nhs.uk/wp-content/uploads/2022/06/B1578_i_who-pays-framework-final.pdf

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