Lancashire and South Cumbria Health and Care Partnership

Joint Protocol for the reception of patients under Section 140 of the Mental Health Act

July 2023

Contents

1. Purpose of the protocol

Reception of patients under Section 140 of the Mental Health Act 1983 (Amended 2007)

Protocol for Admission

1.1 The primary purpose of this protocol is to provide a safe experience for people who require care under a S140 in the case of special urgency and to meet the requirement for a joint local procedure for admission to hospital under Section 140 of the Mental Health Act 1983 (MHA). This will include working age adults, children and young people, people with a learning disability and older adults of which some presentations may be organic in nature (See Appendix 3 and 4).

1.2 Local Authorities, NHS commissioners, police forces and ambulance services should have a clear joint policy for the safe and appropriate admission of people in their area. Those carrying out functions for these parties should understand these policies and their purposes.

1.3 Following this review of the Mental Health Act, the Department of Health and Social Care recently published a white paper urging all local authorities to consider the Reforming the Mental Health Act white paper and respond as part of the consultation.

1.4 One of the recommendations of the review was to reflect on the importance of S140 MHA 1983. This is the responsibility of Integrated Care Board (ICBs) to identify to the Local Authority a hospital that may be used for the reception of people detained under the Mental Health Act in situations of 'special urgency'.

1.5 Section 140 is particularly important to local authorities due to their responsibility to approve and provide the Approved Mental Health Professional (AMHP) workforce. AMHP services have been under increasing pressure over recent years and a recent British Association of Social Workers (BASW) report has highlighted the impact of Covid 19 on this role. Good local arrangements around the implementation of S140 are vital in supporting AMHPS in their duties.

1.6 The MHA Code of Practice guidance specific to S140 can be found at paragraphs 14.77 to 14.86 and summarised as:

- ICBs should provide a list of hospitals and their specialisms to local authorities, which will help inform AMHPs as to where beds are available. [section 2]
- Local authorities, NHS commissioners, police forces and ambulance services should ensure they have a joint policy for the safe, appropriate admission of people in their area. [section 3]

- The joint policy should be agreed at board level or equivalent and each party should appoint a named senior lead. It is good practice for parties to the local policy to meet regularly to discuss any issues with the policy.
- Professionals should understand the roles and responsibilities of all agencies and individuals involved and receive the necessary training to carry out their functions under the policy.

2. Notifications of hospitals having arrangements for reception of urgent cases

Current legislation, Mental Health Act Code of Practice, National Guidance and current NHS Trust policies

1.1 It shall be the duty of every ICB of every local health board to give notice to every local Social Services Authority for an area wholly or partly comprised with the area of the ICB specifying the hospital or hospitals administered by (or otherwise available) to the ICB or Local Health Board in which arrangements are from time to time in force.

(a) For reception of patients in cases of ***special urgency***
(b) For the provision of accommodation or facilities designed so as to be specifically suitable for patients who have not attained the age of 18 years.

2.2 Paragraph 14.77 of the Code of Practice States:

If the doctors reach the opinion that the patient needs to be admitted to hospital, it is their responsibility to take necessary steps to secure a hospital bed: it is not the responsibility of the applicant.

2.3 Paragraph 14.78 of the Code of Practice States:

Clinical Commissioning Groups are responsible for commissioning mental health services to meet the needs of their areas. Under section 140 of the Act, CCGs have a duty to notify local authorities in their areas of the arrangements which are in force for the reception of patients in cases of special urgency or the provision of appropriate accommodation or facilities specifically designed for patients under the age of 18. CCGs should provide a list of hospitals and their specialisms to local authorities which help inform AMHPs as to where these hospitals are. This should in turn help inform AMHPs as to where beds are available in these circumstances if they are needed.

For the purposes of this protocol it is acknowledged that the Integrated Care Board will replace the Clinical Commissioning Group within any references to the Code of Practice.

2.4 Jones 2019 states:

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

2.5 ICBS are required to provide a list of hospitals and their specialisms to local authorities which will help inform AMHPs as to where these hospitals are. The ICBs across Lancashire and South Cumbria have identified the following hospitals as places where people can be admitted in cases of special urgency:

Site	Ward	Type	Bed Capacity
Furness General Hospital	Dova	Adult assessment and Treatment	20 mixed
The Cove	CAMHS	Children young People Assessment and Treatment	18 mixed
Pathfinders Drive Lancaster	Orchard	Adult assessment and Treatment	18 mixed
The Harbour Blackpool	Shakespeare	Adult assessment and Treatment	18 female
	Stevenson	Adult assessment and Treatment	18 female
	Churchill	Adult assessment and Treatment	18 Male
	Orwell	Adult assessment and Treatment	18 male
	Byron	PICU	8 female
	Keats	PICU	8 male
	Austen	Older Adult	18 female
	Dickens	Older Adult	18 Male
	Bronte	Older Adult	15 Female
	Wordsworth	Older Adult	15 Male
Royal Blackburn Hospital (Pendleview)	Ribble	Adult Assessment	14 Male
	Hyndburn	Adult assessment and Treatment	20 Female
	Darwen	Adult assessment and Treatment	19 Male
	Calder	PICU	6 Male
Royal Blackburn Hospital (Hillview)	Hurstwood	Older Adult	9 Male & 9 Female
	Edisford	Adult assessment and Treatment	15 Female
Ormskirk & district Hospital	Scarisbrick	Adult assessment and Treatment	10 Male & 10 Female
	Latham	PICU	4 Male
Royal Preston Hospital (Avondale Unit)	Skylark Centre	Older Adult assessment and Treatment	11 Female
Chorley and South Ribble District Hospital	Duxbury	Adult assessment and Treatment	15 Female

Site	Ward	Type	Bed Capacity
	Worden	Adult assessment and Treatment	15 Male
	Aveham	PICU	6 Female
	Ribblemere	Perinatal	8 Female
Guild Lodge Preston	Fairoak	Low secure inpatient	18 Male
	Fairsnape	Medium Secure Inpatient	8 Male
	Greenside	Medium Secure Inpatient	12 Male
	Calder	Medium Secure Inpatient	10 Male
	Bleasdale	Medium Secure ABI Inpatient	9 Male
	Whinfell	Medium Secure ABI Inpatient	9 Male
	Elmridge	Medium Secure Inpatient	9 Female
	Mallowdale	Medium Secure Inpatient	8 Male
	Marshaw	Medium Secure Inpatient	10 Male
	Dutton	Low Secure Inpatient	15 Male
	Langdon	Low Secure ABI inpatient	15 Male
	Fellside East	Low Secure Inpatient	8 Female
	Fellside West	Low Secure SD inpatient	15 Male

Out of Area Beds

Provider	Ward	Location	Contract Type	Number Contracted Beds
Priory	Rosemary	Preston	10 - Acute	16
Priory	Cottam	Preston	10 - Acute	12
Cygnet	Victoria House	Darlington	10 - Acute	8
Cygnet	Sanctuary Ward	Harrogate	10 - Acute	15
Cygnet	Haven Ward	Harrogate	10 - Acute	15
Cygnet	Fisher Ward	Hexham	10 - Acute	12
Cygnet	Phoenix Ward	Wyke	10 - Acute	19
Cygnet	Bennu Ward	Wyke	11 - PICU	6
Cygnet	Southampton Ward	Bury	12 - PICU	7
Cygnet	Compton Ward	Neild House	10 - Acute	9

3. Special urgency description

Criteria for Special Urgency[1]

3.1 Patients meeting the criteria for "special urgency" under Section 140 would fall within a category of patients requiring emergency admission (admission within 8 hours).

3.2 Special urgency will be defined as those in exceptional clinical need identified based on a current medical examination by a Section 12 approved doctor / other Doctor in consultation and agreement of a Consultant Psychiatrist (applicable to any person who may require hospital admission for their mental health, whether under MHA or informally) due to their severe mental disorder. The AMHP will always be consulted in cases of Mental Health Act assessments to determine urgency.

[1] Acknowledging details of agreed protocols shared by Cheshire and Merseyside, Birmingham and Solihull and Dorset ICS's

3.3 The AMHP and Doctor may also involve other professionals in determining whether to classify the case as special urgency. This may include involvement from the medics involved in the person's care, Police or Ambulance staff in attendance and Crisis/Home Treatment team.

3.4 The term "special urgency" is agreed as a situation where a mentally disordered person is so acutely unwell that failure to urgently admit the person to hospital under the Mental Health Act, or an excessive wait for a bed, could cause significant harm or potential death of the patient, those assessing the patient or other members of the public.

3.5 Special urgency is further endorsed by the fact that neither the AMHP or Doctor can safely leave the person unattended due to high risk, however there may be instances where professionals need to leave the person unattended due to risks or other circumstances. These situations will be fully risk assessed and may require a later visit or input from the wider community professionals.

3.6 ***The risk to self or others should be such that the person cannot be left unattended and thus harm to self or others is imminent or that there is high likelihood that such risks will occur imminently.***

3.7 ***The rationale for use of Section 140 must be clearly documented in the clinical record at the time a decision is made, this can be either the progress notes or within the AMHP Report.***

3.8 Cases that would not qualify automatically for Section 140/Category one:

> *Those cases who do not meet the clinical need threshold for Section 140 would not qualify for a Section 140 status based on being at a place of safety, A&E or in police custody, or based on recommendations for detention under the Mental Health Act alone.*

3.8 Children and Young People

3.9 Paragraph 19.98 of the code of practice (Children or Young People) states:

> "*In a small number of cases the child or young persons need to be accommodated in a safe environment could, in the short term, take precedence over the suitability of that environment for their age (referred to as an "emergency situation"). Such situations will arise where the child or young person needs to be admitted urgently to hospital and accordingly waiting for a bed to become available on a CAMHS unit is not considered to be an acceptable option. An "emergency situation" should be a rare and unusual case.*
>
> *Admissions and accordingly local policies should be in place to ensure that such admissions are to age appropriate environments*.

3.10 Paragraph 19.101 of the code of practice (Children or Young People) states:

> *"Where, whether owing to an emergency or because the admission is an "atypical" case, it is considered appropriate for the child or young person to be admitted to an adult ward, it will be necessary to ensure that appropriate steps have been taken to safeguard the young person.*
>
> *Discrete accommodation in an adult ward, with facilities, security and staffing appropriate to the needs of that young person, might provide the most satisfactory solution: for example, young female patients should be placed in single sex accommodation.*
> *Wherever possible all those involved in the care and treatment of children and young people should be CAMHS specialists. Anyone who looks after them must always have enhanced DBS, including a barred list check, and that clearance must be kept up to date".*

3.11 Where hospital admission is necessary, the child or young person should be placed as near to their home as reasonably practicable, recognising that placement further away from home increases the separation between the child or young person and their family, carers, friends, community and school.

3.12 The decision to admit a child or young person to hospital is inextricably linked to the decision to treat them once they have been admitted. They are, however, different decisions and need to be considered separately. In addition, the law about admission and treatment of young people aged 16 and 17 differs from that applicable to children under 16.

3.13 The following four concepts will be relevant to admission and treatment decisions of both children and young people:

- Consent.
- Assessing capacity (young people) or competence (children) to make decisions.

- The role of those with parental responsibility and the ‘scope of parental responsibility’.
- Deprivation of liberty (DoL).

3.14 A life-threatening emergency may arise when treatment needs to be given but it is not possible to rely on the consent of the child, young person or person with parental responsibility and there is no time to seek authorisation from the court or (where applicable) to detain and treat under the Act and apply the S140 process.

3.15 If the failure to treat the child or young person would be likely to lead to their death or to severe permanent injury, treatment may be given without their consent, even if this means overriding their refusal when they have the competence (children) or the capacity (young people and those with parental responsibility), to make this treatment decision.

4. General Admission Process (flow chart appendix 1)

Process for Hospital Admissions

4.1 The fundamental aspect of this whole process is to ensure that a **safe and effective bed management system** is in place and there are clear and agreed responsibilities and practices in line within the Mental Health Act Code of Practice (COP).

4.2 Process

- A request for a Mental Health Act assessment is received by the local authority who allocate an AMHP to co-ordinate the assessment.
- It is the AMHPs responsibility to organise the assessing team.The assessment is then carried out and a decision made regarding admission, if there is an admission required then the bed management process will commence.

4.3 Bed Management process (refer to process and escalation protocols 5.5)

4.4 Section 6 Jones 2019:

> "*Authority for the patient's detention in the hospital starts on their arrival at the suite or holding area.*
>
> *It is unlawful to convey a patient to hospital on the authority of an application which does not state the name of the potential admitting hospital. It is also unlawful to take the patient to a hospital that is not the named hospital on the application even though the hospital named on the application and the hospital to which the patient is being taken come under the control of the same hospital managers.*
>
> *Although the named hospital is not under a legal obligation to admit the patient, it should only refuse to admit the patient on reasonable grounds e.g. a suitable bed is not available or there are good clinical reasons to refuse admission. As the duly completed application does not provide authority to convey the patient to another hospital, it is essential for a recommending doctor to have confirmed to the applicant that a bed is available for the patient in the named hospital".*

4.5 *14.89* of the Code of Practice. Availability of beds:

Although CCGs and are required under section 140 MHA to make arrangements to provide beds for urgent situations, the concept of 'urgent' is not defined in the Act and only a small number of examples exist where local authorities and CCGs have effective arrangements under section 140.

4.6 Lancashire and South Cumbria ICS have, through a process of delegated responsibility, utilised Lancashire and South Cumbria Foundation Trust (LSCFT) bed management services to secure a bed.

4.7 For the puposes of this protocol the following steps are pertinent:

As per Code of Practice (14.77) the lead S12 Doctor[2] will secure a bed by contacting and refering to the relevant bed management hub or crisis team.

- The assessing doctor will telephone and provide the necessary clinical information to support the appropriate bed being secured. and the AMHP will support these conversations, as appropriate.
- It is good practice, upon completion of the assessment - and where an admission is the outcome; for the Dr to ensure the receiving hospital are in receipt of the most up to date clinical information via local processes including RIO if accessible.
- At this same stage it is the responsibility of the AMHP, as per the Code of Practice (14.93) to provide an outline report to the admitting hospital giving reasons for the application and any practical matters about the persons circumstances which the hospital should know.
- Once the bed is secured through the bed management processes, the application can be completed making the person liable to be detained. The person is then deemed to be in the legal custody of the AMHP (or others authorised to detain or convey the person under s.137 MHA) . The doctors responsibilities will have been completed at this stage and the AMHP will co-ordinate conveyance of the patient to hospital. It is expected that a discussion will have taken place between the doctor/s and AMHP to ensure risks are considered with respect of the AMHP and patient until conveyance is completed.
- The AMHP will liaise either with NWAS or with the Hub transport management team to arrange apprioate conveyance.The bed management team has the delegated responsibility to *authorise* transport through a secure transport provider. AMHPs have responsibility for coordinating the conveyance and therefore will need to liaise directly with ambulance providers but do not have the authority to approve transport (see Appendix 2)
- In situations where there may be a delay in securing a bed, the doctor and AMHP will jointly risk assess the immediate situation and decide whether it is safe to remain until the bed is secured.

[2] Lead Doctor will be determined by the assessing team

- The AMHP is still legally responsible for the admission and in this case of special urgency, they should still oversee the whole process of admission. The risk and 'special' nature of the case will warrant this continued oversight.
- If this delay crosses over with the AMHP ending their shift, the AMHP will notify the respective bed management service of the primary contact with the AMHP Team in the Local Authority.
- Where there is a delay in securing a bed, circumstances may require that interim arrangements must be made to ensure the patient is safely supported; this plan will be agreed between the AMHP and doctor and will involve discussion with the bed hub, home treatment team and any other team ionvolved in supporting the person.. It still remains the responsibility of the local health and social services authorities to provide the patient with the appropriate treatment and / or care until a bed is found.
- Each Local Authority will follow their own agreed process in respect of managing situations where no bed is available with reference 14.86 of the MHA code of practice.

4.8 The patient is then conveyed to hospital and the following documentation is sent to the admitting hospital (electronically or paper copy):

- Application of AMHP
- Medical recommendation/s
- AMHP report (or Outline Report initially with full AMHP report to follow)
-

Delegation of Authority to Convey form (as needed)4.9 Applications for detention must be addressed to the managers of the hospital where the patient is to be detained. An application must state a specific hospital. An application cannot, for example, be made to a multi-site provider without specifying which of the provider's sites the patient is to be admitted to.

4.10 Lancashire and South Cumbria Foundation Trust through ICB delegation should identify a bed manager or other single point of contact who will be responsible for finding a suitable bed as soon as possible and tell the applicant the name of the site at which it is situated.

4.11 Effective systems of bed management including discharge planning, possible alternative to admission and demand planning should be in place. The bed management team should work closely with commissioners to proactively identify local need; and with assessing doctors and AMHPs to secure a bed. AMHPs should be appropriately supported by their Local Authority in establishing working partnerships with other local agencies.

5. Identifying special urgency

Process for Admission under section 140

5.1 There are two scenarios where this would trigger the need for a bed under special urgency

1. Initial attendance of S12 Doctors / AMHPS who will carry out Mental health Act assessment and seek admission to hospital when they are satisfied that section 140 is engaged i.e. the patient has special urgency.

   Each local Authority will follow their own internal procedure for 140 escalation prior to raising with the bed management team. This will ordinarily involve AMHPs discussing the circumstances of the case with a senior manager and agreeing the criteria for escalation is met.

   Once a s.140 has been raised via the agreed protocol this will be considered a trusted position by all and the 140 protocol will continue.

   S140 is **not to be** applied solely on the basis that medical recommendations are to lapse as S140 will not be appropriate due to waiting times. It is based on clinical need and urgency as set out in Section 3 (above).

2. The presentation of a person, liable for detention under the Act and waiting for a bed, alters significantly and it is determined they have increased risks that now meet the requirements under special urgency.

   In this situation the s.140 escalation may be instigated by parties other than the assessing AMHP or doctors i.e. practitioners from the Home Treatment Team.

5.2 The Local Authority service manager and LSCFT senior bed manager will ensure the decision is verified before the bed management processes is mobilised.

5.3 A phone call is made to the Bed Hub and the following details are passed on:

Details of the individual
Location of the individual
Confirmation they meet S140 Criteria

Refer to section 4.7 of this protocol (call is made by assessing Doctor,)

5.4 It will be the responsibility of the notified senior bed manager to arrange for a suitable bed. It will also be necessary to inform the in hours or on call senior manager of the case and the nature of the urgency.

5.5 It will be the responsibility of the notified bed manager to notify the AMHP that S140 has been engaged after confirming with the in hours or on call senior manager, and following the escalation process set out in section 5.7.

5.6 Escalation Process of applying for Section 140 bed:

5.7 Should it become clear that it will not be possible to identify a suitable bed within 4 hours, the informed senior bed manager will notify the in-hours or on call senior manager.

5.8 It will be the responsibility of the notified senior manager to make all reasonable efforts to ensure a bed is available including securing any out of area bed as may be needed.

- It will be the responsibility of the notifying doctor to provide all necessary and available clinical and risk information.

5.10 Action to be taken for finding a section 140 bed

5.11 A category Section 140 case for bed allocation would:

1. Qualify for immediate allocation of a bed within the Lancashire and South Cumbria bed pool, if available.
2. If there is no bed available within Lancashire and South Cumbria there would be an automatic and immediate escalation to an alternative bed following the escalation protocol below (5.15)
3. Should there be no bed available within the regional bed pool, a bed should be immediately sought externally and anywhere in the country. Approval to be provided from the appropriate funding process.
4. Efforts to support the patient in the current location whilst efforts to find a bed continue until admission. This will include:
    - If the bed management team notifies the AMHP that no bed is immediately available, then the AMHP must give consideration to their own safety as well as to the safety of the patient, their carers, family members or other relevant people.
    - , the AMHP may decide that their presence is causing risks to escalate, or their own safety is compromised. In such situations the AMHP should leave and notify relevant agencies. If there is immediate risk to life of any individual, the AMHP must call 999 and request Police attendance
    - The AMHP should follow their local protocol on what to do in the event of no bed being available which may include the following options.

a) Request intervention from LSCFT Home Treatment Team (HTT) to provide additional support to the individual whilst waiting for the bed and the AMHP together with HTT will implement a risk management plan.

b) If the bed is unlikely to be available for over 8 hours then consideration will need to be given to continuing to look for alternative beds in the LSCFT footprint, and to consider additional support into a unit such as a hospital based place of safety, whilst following the appropriate legal framework.
c) AMHPs maintain contact with all agencies and update on progress and the bed management team will also inform the AMHP on changes to timescales. Both parties will ensure there is a direct telephone contact number available
d) Ensure Police and Ambulance are aware of the situation as a bed may become available quickly. Services will need to be able to respond quickly once the availability of a bed has been confirmed and follow the current transport policy
e) If the situation is beginning to escalate and the situation is becoming unsafe for either the patient, family or any other person, the AMHP should contact the police for assistance.
f) If the situation is likely to carry over into out of hours, the AMHP should advise the out of hour's duty team in the Local Authority of all the circumstances of the situation and where the statutory paperwork can be located. Similarly, if the situation is likely to carry over into the following day, ensure that the AMHP on duty is also aware of the circumstances of the case and where the statutory paperwork can be located.
g) When the admission is completed, ensure robust and full recording of actions and rational and refer the matter to safeguarding for further follow up by management across the appropriate Local Authority and LSCFT.

***NOTE**: The above actions apply not only to private addresses but to similar situations in A&E and Hospital Based Places of Safety. A&E staff need to be fully briefed over the above points, and there should be close contact with Psychiatric Liaison to ensure the appropriate level of support to the patient.*

5.12 72 hour Review and continuous improvement

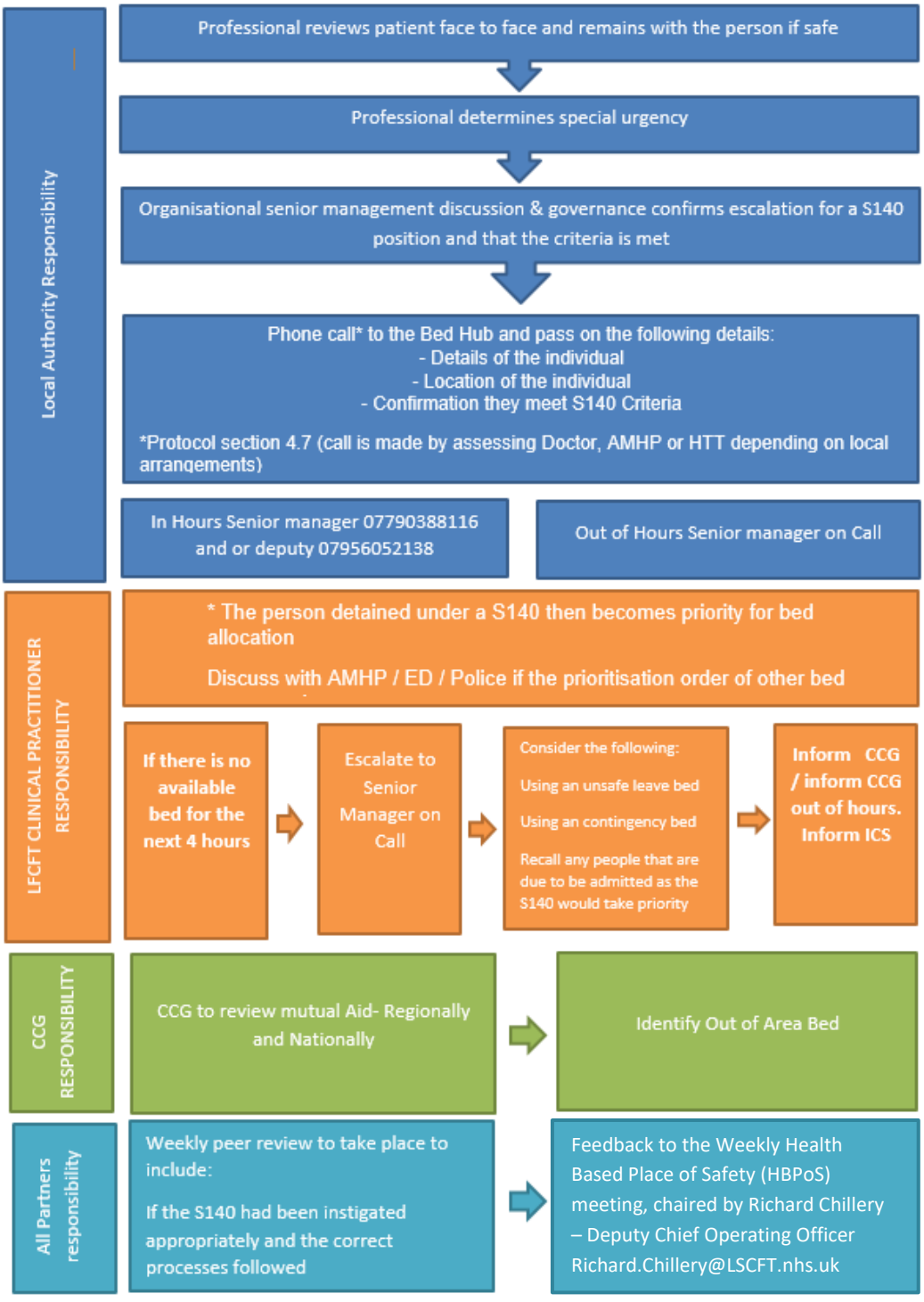
5.13 There is potential for disagreement in implementing protocols and the S140 process will not be without challenges. Due to the severe nature of the assessed presentation by two S12 Doctors and an AMHP it will be taken as a trusted assessment and any reviews will be conducted retrospectively. It is of primary importance that the process of escalation under special urgency is followed in the immediate term and not delayed by alternative clinical reviews.

5.14 Process for review:

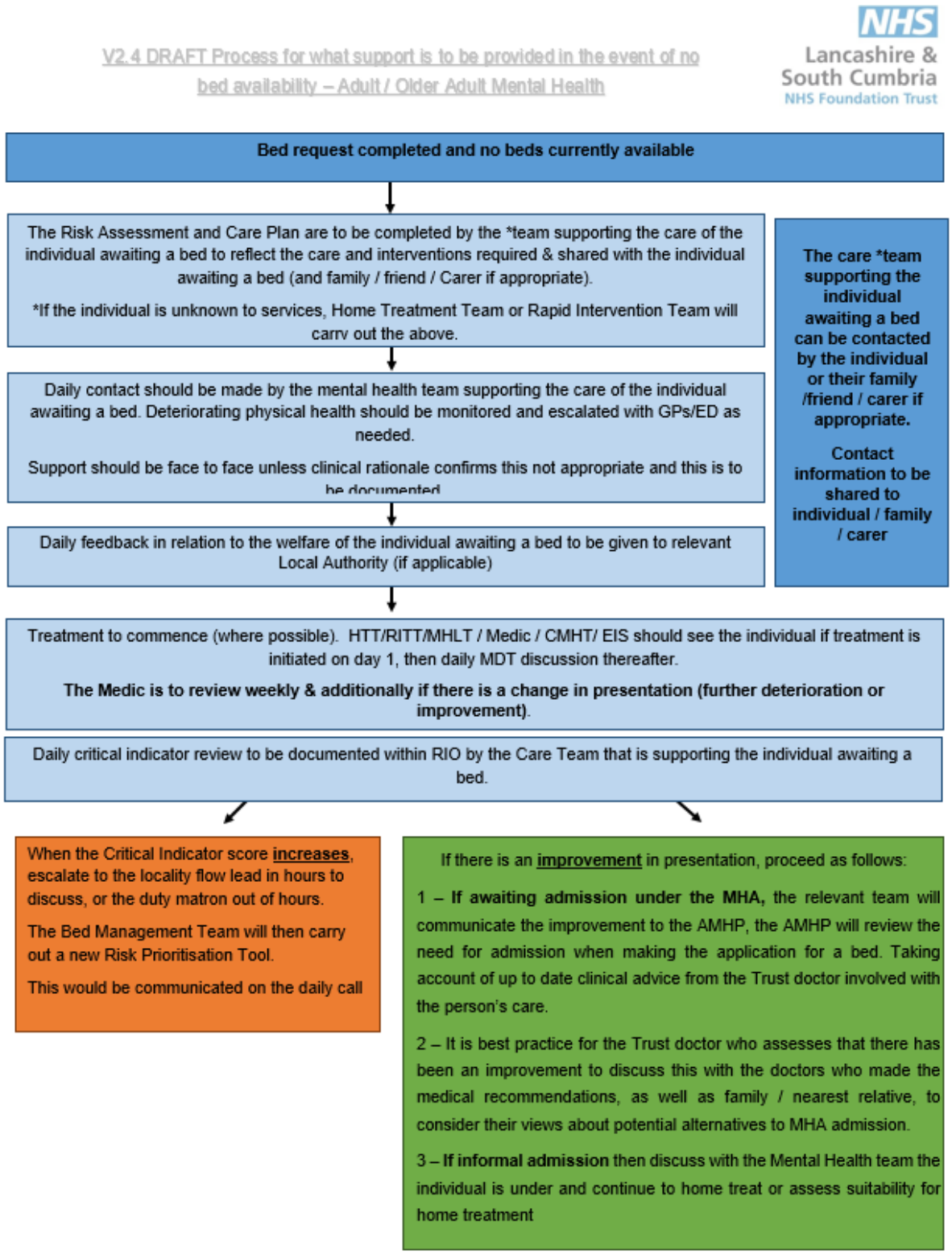
- There will be a multi-agency review process for each S140 which will be discussed at the established Health Based Place of Safety (HBPOS) meeting and will follow a continuous improvement methodology where lessons learned can be applied to future cases.

- It would add value to the discussion if the multi-agency team engage with a Consultant Psychiatrist to offer an objective view of the clinical aspects.
- The multi-agency team will determine the appropriateness of the rationale to enact the S140 and use improvement knowledge to inform future alterations to this protocol.

5.15 Section 140 escalation process



Appendix 1 General admissions process



Appendix 2: Secure Ambulance Transport Policy

Specialist beds

It has to be recognised that the requirement for specialist beds could add further risk to the situation where someone requires a bed under special urgency and the engagement of S140.

Appendix 3: Arrangements for People with Organic Presentations under s140

For adults who present with organic conditions and are assessed as requiring a bed under special urgency, the same principles will apply as outlined in this protocol.

Very often an assessment is undertaken for a patient who is already in a care home. In these circumstances contact must be made to the relevant commissioners (the ICB, or the LA or jointly) to secure extra resources such as 1:1 for the duration of the delay in the patient's admission.

If the patient is in the community, then a similar consideration can be given to commissioning extra support from a domiciliary care service.

In extreme circumstances, it may be necessary for the patient to be taken to an acute hospital trust whilst an appropriate bed is found.

The actual pattern of support to the patient under these circumstances will be determined by the availability of resources in that area.