NHS
Wirral
Clinical Commissioning Group

Cheshire and Merseyside S140 Protocol Approved October 2021

1.0 Introduction

1.1 Clinical Commissioning Groups (CCGs) are responsible for commissioning mental health services to meet the needs of their areas. Under s.140 of the Mental Health Act 1983 (2007) (MHA) CCGs have a duty to notify Local Social Services Authorities (LSSAs) in their areas of arrangements which are in force for the reception of patients in cases of special urgency or the provision of appropriate accommodation or facilities specifically designed for patients under the age of 18.

1.2 As Cheshire & Mersey STP (Sustainability & Transformation Plan) moves to become an Integrated Care System (ICS), the responsibility for notifying Local Social Services Authorities (LSSA's) will be transferred to the local leads within the 9 Integrated Care Partnerships, covering each individual local area "place". This will ensure that decision making will continue to safeguard a patient's right to be admitted to a hospital as close to their home area as possible.

1.3 This protocol under S140 applies to the Cheshire and Merseyside sub-region, in particular the areas covered by Cheshire and Wirral Partnership NHS Foundation Trust (CWP) and Mersey Care NHS Foundation Trust. For the purposes of this protocol both CWP and Mersey Care will be referred to as the secondary care mental health providers.

1.4. This protocol has been produced to inform staff of:

- The definition of special urgency;
- The procedure AMHPs should follow when they are dealing with a case which is of special urgency
- The role of the Crisis Resolution Home Treatment Team (CRHT) in supporting the patient during the assessment and sourcing a bed
- The role of the Bed Manager in sourcing a bed
- The mutual support provided to each other between CWP and Mersey Care

1.5 The protocol is relevant to all patient groups, adults and older people, patients with functional and or organic presentations, adults and children with a learning disability and children and young people. However, because the commissioning arrangements vary so considerably across all these groups, the operational body of this protocol applies to the following two groups:

- Adults of working age
- Older people (functional illness)

S140 arrangements for people with a learning disability and older people with an organic presentation are attached to this document in appendices covering their special needs, commission arrangements and circumstances.

See appendix D for older people with an organic presentation

See appendix E for adults with a learning disability

1.6 Further work is required to confirm in detail the s140 arrangements for children and young people but see para 3.4 below.

1.7 This protocol does not cover patients who are assessed as requiring admission under Part 3 of the MHA. Part 3 governs the arrangements for people who come into contact with the criminal justice system, including those who are subject to Secretary of State for Justice restrictions (but see exception in para 3.5 in respect of conditionally discharged patients).

1.8 Nothing in this protocol shall prevent local areas from developing practice and procedures which build on its principles and which reflect the particular needs of their localities.

2.0 Who needs to be aware of and comply with the guidance?

2.1Local authority staff undertaking the role of an AMHP

2.2 Responsible clinicians and on-call doctors for the secondary care mental health providers and other s.12 doctors who may be involved in examining patients under the MHA

2.3 Secondary care mental health provider staff with responsibility for bed management, sourcing beds and those trained to accept applications for admission under the MHA

2.4 Health and social care commissioners covering the Cheshire and Merseyside footprint.

3.0 When does this guidance apply?

3.1 This guidance will only apply where:

- an AMHP has been requested to undertake a MHA assessment in the community or custody suite/S136 suite, A&E, and;

- the AMHP in consultation with the assessing doctors and members of the CRHT believes that an admission of special urgency applies, and;
- there are no immediately available beds at the time the MHA assessment is requested or conducted

3.2 The term “special urgency” is locally 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 to:

- the patient
- the patient’s carers and/or family members and network of support
- those assessing the patient
- other members of the public.

3.3 In this context harm means a significant risk to the health and safety of the patient or the protection of other persons.

3.4 In respect of patients under the age of 18, any assessment under the MHA 1983 will be considered as meeting the definition of “special urgency”.

3.5 Examples of special urgency may include, but are not limited to the following scenarios:

- A patient, including patients under the age of 18 detained under S136, whether in custody (NB it is unlawful for a person under the age of 18 to be detained in police custody,) A&E or any other place of safety, who is assessed as requiring a bed under the MHA. The legal basis for detaining a patient under S136 expires after 24 hours but can be extended by up to a further 12 hours, but only in very limited circumstances. These are that, because of the person’s condition (physical or mental), it is not practicable to complete a Mental Health Act assessment within the 24-hour period. This might arise, for example, if the person is too mentally distressed, or is particularly intoxicated with alcohol or drugs. A delay in attendance by an Approved Mental Health Professional or medical practitioner is not a valid reason for extending detention. These circumstances do not include situations involving shortages of beds. The bed must be found within the legal timeframe.

- An episode of life-threatening self-harm together with physical illness, living alone, with lack of social supports and clearly identified severe mental illness signs and symptoms. (1 see footnote)

- Florid psychosis in a community setting, living alone with lack of engagement with home treatment team, non-concordance with treatment including medication combined with self-neglect and/or active agitation/thoughts of self-harm/harm to others/fear.

- Patient with features of mental illness with severe self-neglect showing features of dehydration or sustained food refusal over days.

- Conditionally discharged restricted patients, i.e. patients with a proven record of causing serious risk of significant harm to others when mentally unwell, currently

non-concordant with medication, disengaged from services and showing features of relapse of mental illness.

- Patient with such severe psychosis, mania or depression that they lack capacity to carry out activities of daily living including self-care, non-concordant with treatment in a community setting and disengaged from services.

4.0 Where can admissions occur to?

CCGS 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 CCG has identified the following hospitals as places where people can be admitted in cases of special urgency:

CWP

- Springview, Clatterbridge Health Park, Bebington
- Bowmere, Countess of Chester Health Park, Chester
- Mulberry Unit, Macclesfield

Merseycare

- Brooker Centre, Halton Hospital, Runcorn
- Hollins Park, Winwick, Warrington
- Knowsley Resource Centre, Whiston Hospital, Prescot
- Peasley Cross St Helens
- Clock View Hospital, Liverpool
- Broadoak Unit, Liverpool
- Hartley Hospital, Southport
- Thomas Leigh, Liverpool
- Windsor House, Liverpool

5.0 What is the procedure?

5.1 Prior to undertaking the Mental Health Act assessment, the AMHP should consider where there is high risk behaviour towards others, whether an application for a warrant under Section 135(1) should be applied for as the person is not under “proper control”. If granted by the Magistrates’ Court, this would allow the AMHP the ability to remove the person to a place of safety for assessment.

5.2 Good practice requires that AMHPs are supported by their local CRHT whenever they are conducting an assessment under the MHA. This is important for a number of reasons, including the requirement to consider all the available alternatives to admission and to consider the options for managing the risks if a bed is not immediately available. If the CRHT are unaware of a MHA assessment taking place, the AMHP should inform them as soon as possible that a special urgency bed may be required.

5.3 Where an AMHP has not requested a warrant under Section 135 and, upon going out to the assessment, the AMHP along with the CRHT agree that the circumstances meet the criteria of special urgency and that the presence of the police is required to assist them in managing the risks identified and or to prevent a breach of the peace occurring, then the police should be contacted as soon as practicable. Police support must be carefully considered and AMHPs should apply the RAVE framework prior to contacting the police.

R = Resistance
A = Aggression
V = Violence
E = Escape

5.4 The CRHT will prioritise any agreed bed searches for special urgency cases and these cases will be allocated the first available, appropriate bed. The CRHT will inform the Bed Manager accordingly of the clinical priority for admission.

5.5 If CRHT/Bed manager 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. In exceptional circumstances, 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 i.e. police, NWAS etc. The AMHP should follow their local protocol on what to do in the event of no bed being available (Appendix A covers an example of a protocol for AMHPS when no bed is available. Local areas are encouraged to design their own protocols to support AMHPs in their area.)

5.6 If there is immediate risk to life and limb of any individual, the AMHP must call 999 and request police attendance.

5.7 AMHPs must notify the CRHT if, following assessment, that the special urgency case has been assessed as not requiring a bed in order that the Bed Manager can cease any searches for a bed. This must be done immediately.

5.8 If a bed cannot be identified at an hospital within the footprint of one of the two secondary care providers, then the relevant bed manager/CHRT should contact the bed manager/CRHT in the other secondary care mental health provider to search for a bed. For example, patient x has been assessed for admission under special urgency who lives in Chester. No bed is available within CWP. The CWP bed manager/CHRT will contact the bed manager in Mersey Care for a possible bed.

5.9 If the Bed Manager/CRHT cannot locate a bed in either secondary care mental health provider, then the Bed Manager/CRHT will widen their search to out of area, including beds in the private and independent sector, if required to do so.

5.10 The S12 doctors, when completing an examination under S3, will need to know the hospital or hospitals which are available to them for the purpose of confirming the availability of appropriate treatment.

5.11 Should a patient leave a property during assessment, the AMHP may, if deemed appropriate, contact the Police and inform them, along with any details of risks. The Police

will then make a decision regarding the appropriateness of looking for the person and considering whether the use of S.136 is appropriate.

5.12 In the event that an application for detention is made to a specific hospital pending a bed becoming available for admission, but a bed becomes available at another hospital (inside or outside of Cheshire and Merseyside), the AMHP will need to complete a fresh application for detention naming the hospital with the available bed. The application can be scanned and emailed to the receiving ward to allow the papers to be accepted remotely. For the purposes of an application under S3, the s12 doctor may need to amend their medical recommendation so that they can confirm the availability of appropriate treatment.

5.13 In the event of no bed being available within a reasonable timeframe (3 hours) and the AMHP having gone off duty before a bed becomes available, a fresh assessment by an AMHP would be required to make an application for detention. See appendix A as to what to do in the event of no bed being available.

5.14 Where action under paragraphs 5.12 and or 5.13 have been undertaken then this should be reported to senior management within secondary care mental health provider trust, the CCG and the Local Authority (see sections 9 and 10 in respect of escalation, monitoring and review).

6.0 CWP and Mersey Care responsibility in relation to identifying a bed in cases of special urgency

6.1 Once it has been agreed that an admission under the MHA under the special urgency is required the CRHT/Bed Manager will begin the process of searching for and confirming a bed.

6.2 If there are no beds available in the relevant secondary care mental health provider and there is little likelihood that such a bed is to be made available then the bed manager/CRHT will contact the partner mental health provider for support. This situation will be escalated to the appropriate senior duty on call manager for the relevant secondary care mental health provider

6.3 The AMHP and CRHT will remain in contact with each other until the admission has been accomplished.

6.4 The Bed Manager /CRHT will make continued attempts to identify a bed until one is located.

6.5 In the event that a bed is likely to become available, the Bed Manager/CRHT must make it clear the expected time scales for this. The AMHP will liaise with NWAS (and the police if required) to confirm the arrangements for conveyance under S6 of the MHA (see appendix B). If the bed is unlikely to be available for over 3 hours then consideration will need to be given to continuing to look for alternative beds in the partner secondary care mental health provider, or further afield if this is likely to provide a bed more quickly. Alternatively, the AMHP together with CRHT may consider implementing a risk management plan as outlined

in the example in appendix A. The AMHP and CRHT, together with the S12 doctor(s) will agree on the most appropriate way forward under these circumstances.

7.0 Receiving the patient at the hospital

7.1 Where it has been agreed that a patient can be brought to the specified hospital pending a bed becoming available, the AMHP will make an application for detention to allow the conveyance of the patient to hospital. The bed manager/CRHT must make it clear to the AMHP that the bed is in fact available as there are no facilities for patients to be supported in the identified hospital for the holding of a patient.

7.2 Upon arrival, the patient will be taken to identified ward within the hospital and the admission process will then proceed.

7.3 When a patient is admitted to a partner secondary care provider, that is, not their local hospital, then consideration should always be borne in mind for the possibility of a transfer back to the local secondary care provider, once a bed is free and the clinical circumstances of the patient support such a transfer. This will have the benefit of enabling easier access for family and carers to then visit the patient as well as for local services to plan more effectively for the discharge of the patient

8.0 Out of Area Patients

8.1 When a patient is assessed for admission to hospital under the MHA in an area covered by this protocol, but is registered with a GP in another CCG, then the services local to the area within which the patient is present, will take responsibility for organising his/her assessment under the MHA. As soon as this situation becomes known, the Bed Manager for the area in which the patient is present will immediately contact the home secondary care mental health provider with a view to exploring the possibility of an admission directly to one of their hospitals.

8.2 If a bed is available, then the AMHP can make an application to that hospital and will be supported by NWAS to convey the patient. There may be a number of reasons why this is not possible and where admission to the nearest hospital is required, and include but is not limited to the following:

- No bed is immediately available within the secondary care mental health provider for the area within which the patient is registered.
- The clinical presentation of the patient is so urgent that he/she requires admission to a hospital within which the patient is present
- The distance involved may make conveyance impractical

8.3. If such a patient is admitted to a hospital within the area within which the patient presents, then liaison between that hospital and the home hospital of the patient should take place at the earliest opportunity, with a view to arranging a transfer of the patient under S19.

8.4 The guiding principle is that no patient should be delayed from admission to hospital on the grounds that they are registered with a GP from another CCG area alone. This principle applies to both patients from within Cheshire and Merseyside who present in another CCG area within this footprint, as well as to patients who are from outside Cheshire and Merseyside.

8.5 See appendix C for Guidance for North West Councils: Mental Health Act assessments for residents who are not in their home area at the time of the assessment. This guidance provides advice to AMHP services on how to respond to such circumstances.

9.0 Escalation

9.1 In the event that the duty Bed Manager/CRHT cannot locate a bed either locally, sub-regionally or beyond, then the Bed Manager/CRHT and or AMHP should escalate the issue to their senior line managers in accordance with their own local escalation procedures

9.2 AMHP Leads and the Out of Hours Service Manager must ensure arrangements are in place within their Local Authority area/service for contact to be made with a senior manager from within the local authority and communicate this to their AMHPs.

9.3 The assessing doctors and where involved, the GP, together with the AMHP and the CRHT must ensure a risk management plan is in place (see appendix A for an example).

9.5 Any incident forms completed will be reviewed according to local procedures to ensure the system is working as effectively as possible.

10.0 Monitoring and Review

10.1 Incidents of special urgency and those where no bed is available for more than 3 hours, will be recorded on a locally agreed incident form and brought to the attention of senior managers within the secondary care mental health provider, the local authority, NWAS and if involved, the police. Trust wide S140 monitoring will be the responsibility of a locally agreed body (this function can be undertaken by a pre-existing body) and reported up the Cheshire and Merseyside Mental Health Oversight Group on a quarterly basis.

Local incidents should be collated and depending on local arrangements, should be reported to the relevant adult/children safeguarding board.

(1) The 5 examples of special urgency are taken from the 140 agreement of Birmingham and Solihull MH Foundation Trust

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Wirral
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Appendix A Advice to AMHPs: What to do when no bed is available – a proposed model

Local authorities should agree with their respective secondary care mental health providers a protocol similar to the one established in Cheshire East as to what to do in the event of no bed being available. The protocol would reflect local arrangements and resources and can be added to this appendix once completed.

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Appendix B NW regional guidance for transporting mental health patients (under review)

NW%20Regional%20
Mental%20Health%2(

Appendix C: Good Practice Guidance for North West Councils: Mental Health Act assessments for residents who are not in their home area at the time of the assessment

FINAL%20Cross%20
border%20agreement

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Appendix D: 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 section 3 of this protocol.

Service design is different for this group of patients and this is reflected in this appendix to the protocol

In hours, Monday- Friday, 8am- 8pm and 8am-4pm at weekends AMHP's should contact the bed management team within the relevant secondary care mental health trust to inform them that a MHA assessment will be taking place and also the outcome of that assessment.

If a bed is required, the bed manager will co-ordinate this and follow the process as outlined in section 6

If an assessment has taken place out of the hours the AMHP should contact the relevant CRHT who will undertake the co-ordination of locating a bed.

NB CRHT are not commissioned to attend assessments for this group of patients.

Currently, outside of the CMHT working hours 9am- 5pm, Monday- Friday there is no commissioned service which can assist with the management of the patient if no bed can be located. AMHPs following the protocol outlined in appendix A will therefore need to take this into account when considering a risk management plan for a patient under these circumstances.

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 CCG, 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 within Cheshire and Merseyside.

Appendix E: Arrangements for Adults with a Learning Disability under s140

- Assessment and Treatment Units for CWP and Mersey Care are as follows:

  CWP

  - Greenways, Macclesfield
  - Eastways, Chester

  Mersey Care

  - Byron House, Warrington

- As soon as it is known that a MHA assessment is needed, an admission avoidance meeting should be convened. In practice, such meetings will often have already taken place as the changes in the patient's behaviour should already have required specialist intensive support services to become involved.

- Such meetings may be called Blue Light or Community Care and Treatment Reviews, Admission Avoidance meeting or a LEAP. Their primary purpose is to consider all alternatives to admission to hospital and to ensure services are in place to support this objective.

- If intensive support services feel the admission is appropriate and urgent, the bed manager for the appropriate secondary care mental health provider will then begin the process to identify an appropriate bed. Where appropriate, partnership agreement to be sent and returned prior to admission.

- Following a MHA assessment and where admission is required the request for a bed should be made through either:

  - the local Community Team or through Bronze On-call outside of office hours (Mersey Care)
  - the local Community LD team or 2nd tier on-call outside of office hours (CWP.) It is noted that CWP do not take any out of area patients outside of office hours).
  - If there is no local suitable bed available, the request should be escalated through the Bronze 2nd Tier On-call to:

    - liaise with the relevant CCG to commission a bed
    - consider beds within generic wards if appropriate
    - liaise with provider services (such as Intensive Support Teams) to manage risks in the interim

- The process for sourcing an out of area bed is as follows:

  - Referral to be sent out
  - On receipt of referral and associated documents, information to be reviewed by MDT

  - If appropriate, gatekeeping to be arranged within 5 working days wherever possible.
  - Minimum of two lead clinicians to complete gatekeeping assessment
  - Initial verbal response given within 24 hours
  - Gatekeeping presented at following MDT meeting
  - If not appropriate, the reasons will be given verbally and the report sent out within 7 working days with recommendations.
  - If appropriate, admission aims confirmed and partnership agreement sent. Bed offered or individual placed on waiting list. Gatekeeping report to be completed and sent within 7 working days.
  - Admission planned when contract received

- Regular multi-agency meetings should be held whilst a bed is identified for information sharing and risk management planning.

- For people with a learning disability who are under 18; the children's / CAMHS pathway should be followed.

Appendix F: CCGs, LA's and Police Authorities covered by this Protocol

CCG's

Cheshire
Halton
Knowsley
Liverpool
South Sefton
Southport & Formby
St Helens
Warrington
Wirral

LA's

Cheshire East
Cheshire West and Chester
Halton
Knowsley
Liverpool City
Sefton
St Helens
Warrington
Wirral

Police Authorities

Cheshire Constabulary
Merseyside Police

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Appendix G: Members of the S140 Task & Finish Group

Keith Evans Cheshire East Council; Chair

Margi Butler Warrington CCG; Group Co-ordinator

David McCluskey NHS England; Group Co-ordinator

Jane Alexander Mersey Care

Sally Ali-Bachari Alderhey

Sean Boyle CWP

Gavin Butler Cheshire West and Chester

Cheryl Cooper Cheshire CCG

Lisa Cooper Alderhey

Jimmy Cousineau Mersey Care

Alex Crisp Cheshire Police

John Edwards Knowsley CCG

Tom Fairclough Liverpool CCG

Joy Fenna CWP

Sue Henderson St Helens BC

Dave Jones CWP

Mike Kenny Mersey Care

Andrew Kevern Alderhey

Shaun Lockett Knowsley BC

Anjan Mandara CWP

Lisa Nolan Liverpool CCG

Ester Rebay Cheshire West and Chester BC

Steve Roper Sefton BC

Hayley Sherwin Mersyside Police

Lindsay Smith Halton BC

Liam Stowell Mersey Care

Carla Strudwick Warrington BC

Alison Toolan Liverpool CC

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