Camden and Islington NHS
NHS Foundation Trust

HEALTH BASED PLACE OF SAFETY (HBPOS) OPERATIONAL POLICY

AUGUST 2019

Policy title	Mental Health
Policy reference	CL
Policy category	Operations
Relevant to	All Trust Staff and stakeholders
Date published	
Implementation date	
Date last reviewed	
Next review date	
Policy lead	Michael Dunning (Service Manager)
Contact details	michael.dunning@candi.nhs.uk
Accountable director	Adele McKay, Associate Director
Approved by	**Local Operational Management Meeting**
Ratified by	**Trust Operational Management Meeting**

Document history

Date	Version	Summary of amendments
Aug 2019	1.0	New Procedures

Membership of the policy development/ review team	Michael Dunning (Service Manager); Debbie May (Senior Service Manager) Adele McKay (Associate Director); Sharon Fox (Head of Nursing)
Consultation	**Metropolitan Police Sergeant Matt Coad** **Head of Social Work in Mental Health London Borough of Camden Cath Millen** **Head of Islington Social work Mental Health Anna Grainger** **C&I Head of Nursing and Governance Acute Services Sharon Fox**

DO NOT AMEND THIS DOCUMENT

Further copies of this document can be found on the Camden and Islington NHS Foundation Trust intranet.

DRAFT

DRAFT

1. Introduction

1.1.1. The Hospital Based Place of Safety (HBPoS)Operational Policy describes the systems, processes and procedures by which care will be delivered to patients, their families and carers within this service. .

1.1.2. Its purpose is to provide guidance on issues relating to the Trust's provision for the care of persons detained under Section 136 of the Mental Health Act 1983, who are found to be in need of care and containment anywhere other than in a private dwelling, and where it is required that they be taken to a place of safety. Specifically this refers to those persons:

- Detained under s136 by the Metropolitan Police or British Transport Police in the locality of Camden or Islington regardless of their address, found anywhere other than in a private dwelling in Camden or Islington or those who are of no fixed abode, in a public place in need of care and containment.
- Detained in another London Borough outside Camden or Islington but where their nearest place of safety is at capacity

1.1.3. The HBPoS Operational Policy is specifically underpinned by the principles and processes outlined in the following guidance:

- Department of Health (2017) Guidance for the Implementation of Changes to Police Powers and Places of Safety - Act 1983: Code of Practice
- Royal College of Psychiatrists (2011) Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales).
- Department Of Health (2014) Positive and Proactive Care: reducing the need for restrictive interventions
- Department of Health (2014) Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis
- Health London Partnership (Pending) Health Based Place of Safety Specification
- Relevant NICE Guidance.
- Relevant Camden and Islington NHS Foundation Trust Local Policies.

2. C&I Model:

2.1.1. The Place of Safety service is the single point of admission in the trust for all adults requiring care in a hospital based place of safety. It will operate from a specially designed unit situated at the Highgate Mental Health Centre providing a 24 hour, 7 days a week service and be staffed by a dedicated multidisciplinary team.

2.1.2. Clinical leadership for the service will be provided by the Team Manager, Service Manager and designated Consultant Psychiatrist.

2.1.3. The nursing team will comprise of clinical charge nurses (Band 6), staff nurses (Band 5) and assistant practitioners (Band 4). The nursing team will work using a shift pattern that facilitates the provision of continuous high quality care.

DRAFT

2.1.4. Core medical cover will be provided by a Specialty Doctor and a Consultant Psychiatrist (See Section 4.6 for out-of-hours medical provision).

2.2. The designated place of safety for this policy is:

The Place of Safety, Highgate Mental Health Centre, Dartmouth Park Hill, London. N19 5NX. Tel 0203 317 7077

3. Purpose and scope of the policy

3.1. This policy sets out clear guidelines for the safe admission, care, assessment and discharge or transfer of adults admitted to the Place of Safety.

3.2. This policy should be read in conjunction with other relevant Camden and Islington NHS Foundation Trust Policies.

4. Roles and responsibilities

4.1.1. The **Divisional Director** and **Clinical Director** are responsible for the implementation of this policy within their division and through liaison with other Divisions and external agencies.

4.1.2. The **Clinical Team Manager**, **Service Manager** and **Lead Clinicians** are responsible for the implementation of practice and training processes and standards, which may include liaison with internal and external services for e.g. Police. In addition, they are responsible for ensuring that the Place of Safety standards are met by all staff and highlight any issues which impact / reduce the implementation of the policy with senior service managers. .

4.1.3. All clinical staff working in the service are responsible for being familiar with this policy and associated policies and ensuring the policy standards are met. .

4.1.4. Data Collection

The **Service Manager** will have overall responsibility for producing narrative for Performance/Evaluation Reports

The **Clinical Team manager** will have overall responsibility for data collection

Assistant Practitioners – will ensure that the Section 136 CareNotes Form is completed in full for each patient, including the response times for AMHP's

Administrators - will ensure that all the data is captured and checked for accuracy. They will also collate data for reporting purposes and will run reports from CareNotes

Charge Nurses – will be responsible each shift for ensuring that the information captured by the assistant practitioners is up to date and fully complete

DRAFT

5. Role of the police

5.1.1. **<u>The Mental Health Act (1983) States</u>:**

- If a constable finds a person who appears to him/her to be suffering from mental disorder and to be in immediate need of care or control, anywhere other than in a private dwelling, the constable may if s/he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety.
- Police officers are required to consult specified healthcare professionals, where practical to do so, before deciding whether or not to keep a person at, or remove a person to, a place of safety under section 136(1).
- A person removed to a place of safety under this section may be detained there for a period not exceeding 24 hours for the purposes of enabling him/her to be examined by a registered medical practitioner and to be interviewed by an Approved Mental Health Professional and of making any necessary arrangements for his/her treatment or care.

5.1.2. Officers should be aware that they do not necessarily have to witness erratic or unusual behaviour by the person in order to detain under a section 136 of the MHA. This information can come from a third part or from careful questioning of the identified person. Sometimes the individual may appear calm and quiet; however, this taken in conjunction with other factors, might still indicate mental disorder and require detaining under Section 136 the Mental Health Act .

5.1.3. When considering the use of Section 136 powers, there is an expectation that police officers will contact the place of safety suite for a brief consultation with nursing staff before detaining someone under the Act's provisions. The purpose of this consultation is for the police officer, who is considering using their powers under section 136, to obtain timely and relevant mental health information and advice that will support them to decide a course of action that is in the best interests of the person concerned. There will be occasions where it is not suitable to contact MH Professionals before they detain someone under S136 i.e. to prevent harm/injury/risk. Refer to CAT section (9.1)

5.2. Section 136 versus an Arrest for an Offence

5.2.1. The ongoing knowledge of a person's forensic history is critical for risk management in the community. Where a criminal offence is committed, in general, consideration maybe given to the person being detained for the criminal matter, using powers to arrest, and a mental health assessment requested as part of the Police & Criminal Evidence Act 1984 (PACE) investigation whilst the person is in police detention. It is important to remember that the person's medical and mental health takes precedence over arrest **and all decisions** made will be on a case by case basis.

5.2.2. If the persons mental state is such that immediate treatment is required powers under section 136 MHA can be used alongside the Police and Criminal evidence

DRAFT

Act 1984. The person may be bailed to a police station for a criminal investigation to be completed after appropriate treatment.

5.2.3. S136 powers can be exercised anywhere other than in a private dwelling.

5.2.4. If a police officer finds a person to whom Section 136 is applicable, they will attempt to obtain their name, address and date of birth. Checks will be conducted to establish if they are reported missing from a specific establishment or have not returned from authorised section 17 leave.

5.2.5. If they are missing/not returned from section 17 leave, they are to be taken (or arrangement made for them to be taken) back to that place. Such cases must be treated in a pragmatic and flexible way that considers the resources available, travel time and the experience and wellbeing of the patient. There may be cases where the most sensible solution is for the police and LAS to return the patient directly to the ward that they are absent from. Where there is a significant distance involved or this proves to be too much of a demand on the available resources the person can be conveyed to the nearest Place of Safety and onwards conveyance arranged by the healthcare team as per the Code of Practice.

5.2.6. On the very rare occasions where a police station is used, the MHA code places two clear responsibilities upon health and social care agencies

- Place of Safety staff should work to locally agreed targets times to transfer the person. (These target times will be set in the service specification and in line with NHSE 136 Pathway document)
- Place of safety staff should work with the police to arrange transfer to a more suitable place of safety.

5.2.7. If a Custody Officer has authorised a person's detention and Section 136 applies, an SPR will be contacted and asked to attend the Police Station as soon as practicable.

5.2.8. The person will be placed in a cell and a risk assessment completed by the Custody sergeant in conjunction with the SPR to determine the level of care and observation required whilst in custody. This will be reviewed in light of any changes to the person's presentation.

5.2.9. Under the MHA 1983 (as amended by MHA 2007) it is now legally permissible to transfer a person.

5.2.10. Throughout the person's detention, the Custody Officer and local Place of Safety Coordinator will liaise with each other. If a place becomes available, the person can be transferred. Every effort should be made to secure an ambulance and the use of police transport avoided. Even when police transport has to be used due to the risks posed by violent behaviour, a member of the ambulance crew should be asked to be present in the police vehicle and the ambulance requested to follow behind. In any case, a police officer will always accompany the detained person to the Place of Safety suite.

5.2.11. Section 32 of the Police and Criminal Evidence Act 1984 (powers to search persons arrested other than at a police station) must be used, i.e. if there are grounds to suspect that the person may present a danger to him/herself or others. Police may seize and retain anything found if there are reasonable grounds

DRAFT

for believing that the person searched may use the article to cause physical injury to him/her or others. PoS staff will conduct another search of the patient themselves on arrival at the PoS this search will be conducted in then presence of the police. This is to ensure that all items that may be of concern to the PoS staff are held in safekeeping

5.2.12. After contacting the unit, the LAS (in the company of the police) should convey the person directly to the Place of Safety suite.

5.2.13. On arrival the police officer must provide all the information about the case to the Place of Safety Coordinator which must include whether the person was searched. Once the patient has been accepted into the PoS another search of the patient must be conducted by Police officers in the presence of PoS staff.

5.2.14. The person should remain in the vehicle used for conveyance whilst the handover discussion takes place.

5.2.15. The police officer will also complete MPS Form 434. It is the officer's personal responsibility to be in possession of this form; however the Place of Safety suite will also have a stock of forms for the officers to complete fully on arrival.

5.2.16. If agreed with the Place of Safety Coordinator, the detained person can be taken into the suite.

5.2.17. It is recognised that in very exceptional circumstances the need to ensure the safety of the person may take priority over the completion of the form prior to entering the Place of Safety suite.

5.2.18. If the police are restraining the person, they should continue to do so until the Place of Safety Coordinator is confident that nursing staff are sufficient and available to take over the restraint.

5.2.19. In cases where police officers are dealing with a violent or potentially violent individual, the use of force employed in any restraint will be no more than necessary. Police officers are to remain with the patient until it is agreed in consultation with the Place of Safety Coordinator that it is safe to leave.

5.2.20. Police units should be released at the earliest opportunity and this will be reviewed after the first 15 minutes.

5.2.21. On receiving a call relating to a Section 136 from the police, the place of safety staff will request the following basic information about the person detained:

- Name and date of birth
- Location where person found
- Behaviour which led to detention
- Confirmation of whether there is an available space at the PoS and if not, what arrangements will be made to find the next (i.e. local ED, Chase Farm etc.)
- Details of relative/friend contacted
- Name and shoulder number of police officer

DRAFT

- Estimated time of arrival

Officers will be asked further questions about the person detained that will determine whether they need to be taken straight to the nearest Emergency Dept.:

- Is the person having any difficulty breathing or appearing physically unwell
- Is the person intoxicated? and if so are they able to walk independently

  Is there any suspicion of an overdose, head injury or loss of consciousness? Is the person obviously pregnant or elderly? (Over 65)

6. Place of safety team

6.1.1. The Place of Safety is responsible for offering police officers advice in conjunction with the police constable on whether the use of Section 136 of the Mental Health Act 1983 and admission to a Place of Safety is necessary and in the person's best interests. The Nurse will also offer alternative outcomes. The PoS team can be contacted on **0203 317 7077**

6.1.2. The Service Manager and Team Manager are responsible for the safe and effective running of the unit. The Service Manager will have a lead role in monitoring and evaluating the service. The lead will represent the unit in meetings with both internal and external partners.

6.1.3. The Place of Safety Clinical Team Manager holds overall management responsibility for the delivery of care within the Place of Safety. They will ensure that practices are in accordance with the guidance and procedures outlined in this policy.

6.2. The Place of Safety team is responsible for:

- Coordinating Section 136 activity for the local area, Camden and Islington. Part of this coordination will involve working closely with neighbouring designated Places of Safety (Chase Farm, Homerton, The Gordon Hospital and other local (non-designated) Places of Safety that are Emergency Departments (EDs) at The Whittington, UCLH, and Royal Free.
- When the Highgate PoS is full it will be the responsibility of the Nurse in Charge to co-ordinate with other HBPoS to identify a suitable place where the patient can be taken. If that PoS is a local Emergency Department, the PoS Coordinator must contact the Nurse in Charge of the nominated ED and advise them of the situation and negotiate a plan that will involve the ED accepting the patient. the PoS team will also include assurance about what arrangements can be made to return the patient to the C&I PoS once it is safe to do so.

DRAFT

- Providing care to persons admitted to the Place of Safety in accordance with the HBPoS Operational Policy
- Facilitating Mental Health Act assessments within a specified time frame.
- Formulating a discharge or transfer plan that provides the appropriate level of on-going care.
- Ensuring the safety and wellbeing of all users of the service.

7. Centralised Single Point Of Access (C-SPA)

7.1.1. A Police officer should consult with a Mental Health Professional before placing a person under S136. Police will be able to call the PoS directly to facilitate this discussion. In the event that a S136 is not felt to be necessary, C-SPA will take an active role in offering an alternative option to the use of Section 136 by offering alternative solutions, such as home treatment alternatives where appropriate for C&I residents.

8. Approved mental health professionals (AMHPS)

8.1.1. **<u>In office hours: 9am to 5pm, Monday to Friday</u>**

8.1.1.1. If the person is seen by a doctor and is deemed to have a mental disorder requiring an assessment by an AMHP, the agreement is that the AMHP duty service of the borough in which the person is resident, will deploy a duty AMHP to attend the Place of Safety to complete the assessment under section 136. The borough in which the person is resident will take precedence over the borough in which the police made the detention.

8.1.1.2. If a patient is known to Mental Health services in Barnet, Enfield and Haringey NHS Trust. The AMHP duty service of the relevant borough will be contacted and asked to attend to complete the assessment. In the event these boroughs are unable to provide an AMHP responsibility will fall to Camden under Section 13 (1) MHA

8.1.2. **<u>AMHP Service out of office hours: Monday to Friday, 5pm to 9am and Saturday and Sunday, 24 hours</u>**

8.1.2.1. Outside of office hours, the Emergency Duty teams for Camden and Islington will follow the same protocol as the day time AMHP duty services.

8.1.3. **<u>AMHP assessments for homeless people and/or people with no recourse to public funds</u>**

8.1.3.1. If the person who has been detained by the police is homeless and has a local connection to one of the London boroughs of Camden and Islington, then the AMHP duty service in that borough will deploy an AMHP to do the assessment. If the person has no connection to either borough responsibility will fall to Camden under Section 13 (1) MHA

8.1.3.2. For the purposes of establishing which AMHP service should respond, a 'local connection' will be defined as the borough where the person has an

DRAFT

address or GP, is receiving mental health services, or is still open to a mental health service.

8.1.3.3. If the person has no local connection, then the person will be assessed by a Camden AMHP as part of their duty under Section 13 (1) MHA

.

9. Housing duties

9.1.1. Under part 7 of the Housing Act 1996, local authorities have a duty towards homeless people if certain criteria are met. For the purposes of this agreement, homeless people who are being discharged from the Place of Safety will be signposted for housing assistance to the local authority in which they have a 'local connection' using the definition of that within Part 7 of the Housing Act 1996, that the person must: "live, or have lived, in the area for at least six months in the last year or three of the last five years."

9.1.2. If the person appears to have no 'local connection', then they will be directed to present to the borough in which the person was detained by the police and accepted for assessment there.

9.2. People with no recourse to public funds (NRPF)

9.2.1. NRPF applies to people who, subject to exceptions, are 'subject to immigration control' and, as a result, may have no entitlement to certain benefits, local authority housing and homelessness assistance. However, they may be entitled to social services care and support under the Care Act 2014 and require an assessment of their eligibility for care and support. In such cases, the person will be signposted to present to the local authority in which they have a 'local connection' using the definition above, or the local authority in which they were detained by the police. If there is reason to believe that they are NRPF but it is not known whether the relevant local authority or government agency has made such a determination, they should be advised that they are entitled to present at the relevant agency for a determination.

10. Children and young people

10.1.1. The Mental Health Act 1983, applies equally to children and young people and to adults and children, and young people can be detained under section 136 of the Mental Health Act 1983. The C&I HBPoS is commissioned to provide services for adults only. The environment, staffing model and operational policy is designed specifically for adults.

10.1.2. If Police officers approach HBPoS, with a young person under 18, clinical staff will direct officers to the most appropriate local Emergency Department

11. Dispute resolution

11.1.1. In the event of operational disputes between the AMHP services - either in or out of hours - over which duty service should undertake an assessment; the

DRAFT

immediate safety and best interests of the service user and their carers/family should be paramount. Any operational disputes should be negotiated between the AMHP practitioners on duty in order to facilitate the timely completion of the assessment in the best interest of the service user. However, if this fails or is not possible, and the dispute is going to cause an unreasonable delay in assessment, then the duty AMHP for Camden should complete the assessment. If such disputes occur more than once, this will need to be escalated to the Heads of Social Care in the respective boroughs. This will be considered a breach of this protocol and the individual cases formally reviewed and appropriate direction given to the practitioners involved.

12. Medical

12.1.1. **Roles for Medical staff**

12.1.2. Medical cover arrangements for the PoS are a vital component of the Place of Safety operations.

12.1.3. The Lead Clinician for the PoS is also the Consultant Psychiatrist for the unit and they will provide the clinical leadership to the multi-professional team and to partner agencies.

12.1.4. They will also take a lead on ensuring that there are consistently high standards of personal and professional clinical practice in the delivery of services within the PoS and contribute to the development of the skills of the multi-professional team

12.1.5. They will work with the PoS Team Manager to contribute to the general management and clinical performance of the service by leading on and taking responsibility for:

a) Assuring quality of clinical care

b) Patient safety

c) Clinical governance

d) Service delivery within the available resources

e) Evidence-based practice and effective clinical systems being in place.

The Lead Clinical/Consultant Psychiatrist:

12.1.6. Will work closely with the clinical director, operational director, service manager and team manager to provide strategic clinical leadership to the multi-professional group and contribute to strategic direction of the unit and development of this care pathway.

12.1.7. Will also provide consultant expertise to staff to support directly and indirectly those service users who present to the PoS in crisis with mental disorders and/or emotional and behavioural problems; and ensure that mental health difficulties are correctly identified, assessed and appropriate interventions are provided.

12.1.8. - will take the lead in Research, audit and training with the unit staff.

DRAFT

12.1.9. Will assure the quality of clinical care through interpreting and introducing new clinical systems to meet current challenges and to constantly improve patient care within the available resources.

Medical Cover

12.1.10. Medical cover is provided 24 hours a day and 7 days a week. Three tiers of medical cover will operate during office and out of office hours (including Bank Holidays) to fulfill the key roles and responsibilities of the medical team, including Junior Trainee, Higher Trainee and Consultant.

12.1.11. Medical input to the PoS also includes a speciality doctor working Mon-Fri 9am-5pm. Their role will include carrying out assessments under the Mental Health Act and supporting the team in all aspects of care and can provide specific support around prescribing and physical health matters

12.1.12. If needed a recommendation for detention under the Mental Health Act (MHA) will be completed by a member of the PoS medical team. Mon-Fri 9am to 5pm, where no PoS doctor is available, the Section 12 rota doctor will be asked to attend to assess whether detention under the MHA is appropriate. Out of hours the Higher Trainee will complete this first assessment.

Medicines management

- The PoS will keep a small stock of medications in a locked cupboard containing commonly used antipsychotics, medicines for rapid tranquilisation, common anxiolytics that can be used on a PRN basis and a few basic physical health medications for patients with complex physical health issues that may deteriorate without immediate treatment.
- These medications will be accessible to medical, nursing and pharmacy staff.
- A weekly medicines audit will be conducted by the nursing or medical staff / team leader to ensure effective ordering, appropriate clinical use and accounting for stock medications in line with the Trust's Medication Management policy.
- There will be an allocated pharmacist providing input into the PoS; overseeing and supporting the PoS with the effective use and management of medicines.
- Out of hours, the PoS can access the on-call pharmacist as required in line with the Trust's local Medicine's Management policy.

DRAFT

13. Transport provider

13.1.1. The private secure ambulance company contracted with the Trust is responsible for facilitating the safe, dignified and timely transport of persons who have been assessed in the place of safety and require admission.

13.1.2. All PoS transfers will be considered to be emergency/urgent transfers.

13.1.3. For persons who are to be admitted to a service outside of this area the place of safety team will request that the receiving Trust covers costs for secure transport and escort. If this is not possible this will be booked via the usual telephone booking system.

14. Emergency Departments (ED's) within C&I boroughs

14.1.1. There are three circumstances whereby section 136 of the MHA is relevant to the Emergency Department:

- When a patient detained on section 136 requires transfer from the HBPoS to the ED for an urgent medical review.
- When a patient detained on section 136 requires urgent medical assessment +/- treatment before transfer on to an HBPoS.
- When an ED is designated as the PoS for a patient on section 136.

An ED should only be used as designated PoS as a **last resort**, if there is no capacity in the C&I HBPoS and efforts to identify an alternative HBPoS have been exhausted.

14.1.2. When a patient requires transfer from the C&I HBPoS to the ED for an urgent medical review, a C&I HBPoS Doctor should closely liaise with ED clinicians and the Mental Health Liaison team (MHLT) to meet the needs of the patient.

14.1.3. There must be a written handover or discharge summary completed before transfer of patients from the C&I HBPoS to ED, with collaborative formulation of a clear care plan and estimated timescale for care.

14.1.4. If the medical review is required there should be discussion between the HBPoS and the MHLT. It may be appropriate for the MHLT to review and take the lead in the patient's psychiatric care until transfer back to the C&I HBPoS. This may require proceeding with a Mental Health Act assessment. In all cases, the MHLT and HBPoS staff should liaise closely to focus on the needs of the patient.

DRAFT

14.1.5. Medical fitness for transfer to an HBPoS must be documented by the MHLT onto CareNotes, and written as a hard copy accompanying the patient if the HBPoS is outside C&I. This should include:

- Patient able to eat and drink
- IV medications not needed
- Any discussions with the HBPoS about physical disability issues which might affect safety on the HBPoS
- Physical health observations and any outstanding actions required
- Blood tests/investigations documented as negative OR declared unnecessary as documented by the acute trust medical team OR positive BUT have been reviewed and documented by the acute trust medical team not to need current acute trust management
- A plan for any acute trust follow up if required.

15. Mental Health And Learning Disability Services (MHLD)

15.1.1. If during the assessment process the person detained under a Section 136 is established to have a Learning Disability the same assessment and care pathway arrangements outlined in this policy will apply.

15.1.2. For persons who are known to LD services their locality team should be contacted to establish if there is a role for LD services in the assessment, discharge planning or current care of the person.

15.1.3. Where a person is unknown to LD services but for which the POS team require guidance or assistance the LD service for where the person is resident may be contacted.

15.1.4. Out of hours (Monday to Friday, Weekends and Bank Holidays), a LD SPR should be contactable via switchboard.

15.1.5. The assessment process and care decisions for persons with a Learning Disability should be underpinned by the principle of inclusion; people with a learning disability should be supported to access generic or ‘mainstream’ services.

DRAFT

16. Admitting a patient to the place of safety

16.1.1. The purpose of removing a person to a place of safety is only to enable the person to be examined by a doctor and interviewed by an AMHP, so that the necessary arrangements can be made for the person's care and treatment (Mental Health Act 1983 Code of Practice).

16.2. Physical health concerns

16.2.1. If a person appears to be in need of care and treatment for physical reasons (i.e. injury), the person is to be conveyed by ambulance (police transport is only to be used in exceptional circumstances) to the nearest Accident and Emergency Department (ED). The patient will go through the normal triage system. If they are likely to be discharged from ED within one hour, the police are to remain with the patient. If it is expected that treatment will take more than one hour, the ED consultant/registrar and the mental health team will liaise with a supervising police officer to formulate an action plan and discuss how long the police need to remain. The Police should not leave unless local security and/or hospital staff are willing to accept the risks and management of the patient.

16.2.2. The Police officer will also liaise with the London Ambulance Service to provide conveyance, unless the person is so disturbed that conveyance in a police vehicle is deemed more suitable. An ambulance should be the preferred vehicle of choice. Police should be prepared to assist with conveyance in an ambulance if necessary.

16.2.3. Any physical healthcare that is provided after arrival at an ED is done either with the patient's consent, or if they are refusing treatment and lack capacity to make that decision, under the Mental Capacity Act. The medical needs of the person detained under Section 136 are a separate issue from his/her detention under the Mental Health Act. For those patients where there will be a prolonged need for physical health care, the emergency department should accept section136 paperwork and take legal responsibility for custody of the individual for the purpose of the mental health assessment being carried out. Once the person is discharged from ED he/she will be conveyed to a place of safety to be assessed.

16.2.4. Under the MHA 2007, it is now possible to move someone on a Section 136 from one place of safety to another. This means that a patient being seen at an ED for physical health problems can be subsequently conveyed on the Section 136 to the designated Place of Safety and similarly, for someone detained in a police station. This power should not be abused to move people from place to place, but should be appropriately invoked to facilitate onward movement if someone has been held temporarily in one of the above-mentioned sites. If such a power is utilised, staff must clearly identify reasons for such a move.

16.2.5. Where a person has been taken directly to an ED it is the responsibility of the acute trust to arrange transport and onward conveyance to a Place of Safety once discharged from the ED. If a person has been admitted to the Place of Safety and then transferred to an ED for medical care the responsibility for conveyance back from the ED to the Place of Safety remains with the Place of Safety.

DRAFT

17. Intoxication

17.1.1. If the person is intoxicated with drugs or alcohol one of the following will happen:

- Where a police officer exercises a Section 136 power of arrest and the person is under the influence of alcohol or illicit drugs, medical advice should be sought as soon as practicable, this can be sought from LAS or from PoS staff over the phone. This is due to the heightened risk that the person presents to themselves and potentially others.
- Unless there are exceptional circumstances, the police officer should request the LAS. The ambulance crew will decide if medical treatment is required at ED.
- If the person is not adversely affected by alcohol or illicit drugs e.g. able to bear own weight, they should be conveyed to the Place of Safety as normal, then follow guidance on the Assessment and Management of Drug and Alcohol Misuse.
- Detention under Section 136 is up to 24 hours for the purpose of carrying out a Mental Health Act assessment. Should assessment not be able to proceed due to intoxication the time of detention can be extended by 12 hours – to a maximum of 36 hours. This might arise, for example, if the person is too mentally distressed, or is particularly intoxicated with alcohol or drugs and cannot co-operate with the assessment process.
- A delay in attendance by an Approved Mental Health Professional or medical practitioner is not a valid reason for extending detention.
- The Place of Safety will not admit someone who is unable to carry his or her own body weight. This must be brought to the attention of a supervising police officer.
- If the person is not accepted into the PoS, they must be conveyed to an ED. A police custody suite is not to be used. Once at ED it is for the police officers to negotiate with the ED staff with regard to on-going observation/ support.

18. Legal status

18.1. Section 17 Leave (AWOL) - Officers finding a person in a place to which the public have access, requiring immediate care and control, will conduct checks to establish if the person is a detained patient missing without authorised section 17 leave. (Refer to AWOL policy if this situation becomes relevant).

18.2. Missing persons - If the person is missing without authorised section 17 leave, the police will contact that venue to arrange the person's return.

18.3. **Not Subject to the MHA -** A person cannot be admitted to the Place of Safety as an informal patient. That is to say there must be an appropriate and valid legal framework in place which permits a person to be removed from the community to a place of safety and detained for a period of time. For the purposes of this policy the only recognised legal frameworks which permit admission to the Place of Safety are Sections 135 and 136 of the Mental Health Act (1983, 2007).

DRAFT

18.4. **Currently Admitted Elsewhere** – A person who is already admitted to another acute mental health service elsewhere as either an informal or detained patient cannot be admitted to the Place of Safety. This includes for the purposes of temporarily secluding the patient. The Trust Seclusion of Service User 18 years and Over January 2017 (Appendix 5) contains guidance on the procedures that must be followed where seclusion is required in emergency circumstances.

18.5. Incapacitant Sprays (e.g. CS Spray)

18.5.1. If an incapacitant spray is used on a person detained under Section 136, the responsibility for immediate steps to decontaminate the person remains with the police. This will require where possible the person being exposed to fresh air for a period of time for the air to remove any crystals of spray from the person's body and clothing.

18.5.2. The person will require a medical examination on the scene from the LAS crew, if the person requires medical intervention they should be transferred to the local ED. The Team must be informed of the need to decontaminate the person further and for a change of clothing or a pair of pyjamas prior to entering the department. The individual must be physically deemed fit for transfer prior to being then taken to the place of safety.

18.5.3. If the person is deemed fit for transfer to a Place of Safety by the LAS crew. The person must be transported in the most suitable transport as agreed by LAS and Police to the Place of Safety. On arrival at the Place of Safety the person will be taken to a secure open area for further exposure to the air and for the person to be given a change of clothing to avoid any further exposure to the incapacitant spray. The person can then be transferred to the Place of Safety unit.

18.6. Use of Taser

18.6.1. If a Taser is deployed on a person detained under section 136, the responsibility will remain with the police to covey that person via LAS, or in exceptional circumstances in police transport, to an ED. On arrival at ED the person will be assessed by a doctor. The police will stay with the person in ED until the assessment has taken place and will obtain a written report to verify the person is fit.

18.6.2. After the person is deemed fit in ED they will be transferred to a Place of Safety by police and LAS. The escorting police will hand over the written report from ED to the Place of Safety Team. The Place of Safety team should assist the police by prompting for this report.

19. Referral sources

19.1. The following is a list of recognised referral sources:

- The Police
- Approved Mental Health Professions (135 admissions)

- Community Mental Health Teams (135 admissions, planned Mental Health Act assessments where the person has requested that the assessment does not take place at their home).

20. Referral process for persons subject to Section 136

20.1. The trust has a dedicated telephone number 0203 317 7077 which is the single point of referral for Section 136 admissions. Police Officer's will be re-directed to the PoS by calling the pan London phone number 0300 200 0169 this number to gain advice before placing someone on section136.

20.2. A police officer, upon attending to an incident in which they assess there to be a mental health care need, will contact the Central Communications Command (CCC) to create a CAD message. The CAD message will include the recipient's name, preferred contact number and as much information about the person as possible. For example: name, gender, age, ethnic origin and address, and an indication of whether person presenting is communicative, hostile/aggressive. This will help facilitate internal checks made by C&I staff and the Police.

20.3. Upon receiving a call from the referring Police officer, the Place of Safety staff will request the following basic information:

- Name and address of person
- Location where person found
- Behaviour which led to detention
- Normal borough of residence
- Details of relative/friend contacted
- Name and shoulder number of police officer
- CAD Number
- Confirm LAS have attended and completed an assessment
- Is emergency medical treatment required i.e. does patient need to go to A&E – see section 7.2 and appendix 1.
- Is person intoxicated - see section 7.3
- Estimated time of arrival

21. Referral process for persons subject to Section 135

21.1. Planned Section 135 admissions will be accepted in exceptional circumstances and should be arranged with bed managers who will inform the Place of Safety team of all relevant details in advance.

21.2. Further clinical information should be sought directly from the AMHP by the Place of Safety team.

21.3. Emergency Section 135 admissions to the Place of Safety must be agreed by bed managers/site coordinators.

DRAFT

22. Conveyance to the Place Of Safety

22.1. When a place of safety has been allocated, the CCC will contact the LAS to arrange transport.

22.2. Only in exceptional circumstances may police transport be used to convey a person to the Place of Safety, for example:

- If the ambulance control indicates a significant delay.
- Where there are urgent reasons for the removal of the person by the police AND the risks caused by the delay are greater than using police transport.

22.3. In all cases a collaborative decision-making process between the police and the LAS must be followed which considers each person's presentation and risk on an individual basis.

22.4. If the LAS have been in attendance there is an expectation that in all cases they will accompany the person to the place of safety in order to facilitate a handover of the person's physical state.

23. Admission process

23.1. A designated nurse will oversee the admission process from point of referral through to admission in to the unit.

23.2. Upon receiving notification of a pending admission the Coordinator should start making preparations to receive the patient. Based on the information provided by the Police the Coordinator will make a risk assessment and allocate an appropriate assessment room in the Place of Safety.

23.3. The person due to be admitted will be allocated a nurse prior to arrival and will work collaboratively with the coordinator during the admission. The Coordinator is responsible for sourcing the other staffing resources required to facilitate the admission. This should firstly be sourced locally from the Place of Safety team. On occasion it may also be necessary to utilise the site response team. The Coordinator will also inform the POS Doctor or Duty Doctor of the pending admission. Any issues in terms of forming a team to receive the patient should be acknowledged and addressed prior to the arrival of the patient.

23.4. As a minimum there should be a team of 3 nurses present to facilitate the admission and transfer into the Place of Safety. During the hours of 09:00-17:00hrs the Place of Safety Specialist Doctor should be present during all admissions from the point of arrival. Outside of these times the Place of Safety Duty Doctor should be present.

23.5. The Duty Nurse should prioritise Place of Safety Admissions over all non-emergency site issues.

23.6. When the police arrive on site they must notify the Place of Safety team. The Place of Safety admitting team will then meet with the escorting police and ambulance personnel. The patient will remain in the vehicle used for conveyance

DRAFT

at this time. The admitting team and attending doctor in conjunction with the police and LAS must make an initial assessment to establish:

- If there a physical health need that requires assessment and treatment at an ED.
- The risks associated with transferring the patient into the Place of Safety unit.

23.7. Where there are no immediate concerns with regard to the person's physical well-being, the Coordinator will liaise with the Police and Ambulance crew to formulate a plan to transfer the patient from the Ambulance or Police Vehicle in to the Place of Safety. Where it is safe to do so, the Place of Safety team should lead on the transfer of the patient. Where it is risk assessed that the Police will need to transfer the patient for safety reasons the attending Doctor or an RMN must remain involved taking responsibility for the monitoring of the patient's physical state.

23.8. If the person is held in handcuffs (or other mechanical restraints) they should remain so until they are in the Place of Safety and the admitting team are confident that it is safe to remove them.

23.9. Once inside the Place of Safety the admitting team should ask the Police to search the person and provide guidance about what items must be removed for safe storage during the admission (Police officers have powers under Section 32 PACE 1984 concerning the searching of prisoners).

23.10. The attending doctor must then complete an initial physical assessment. If it has not been possible for a doctor to attend, the allocated nurse and Duty Nurse should make a joint assessment of physical health utilizing NEWS assessment scoring. If there are any concerns a doctor must be contacted immediately.

23.11. If there are no concerns the Place of Safety Coordinator can continue with the process of formally taking responsibility for the care of the patient – taking a handover and accepting and signing the Form 434.

24. Handover of care

24.1. A multidisciplinary team should be present during the handover from the police and ambulance service. A charge nurse from the PoS must be present. The doctor may be called in the event where the patient may appear physically unwell and it is unclear if it is safe to accept into the PoS.

DRAFT

25. Police

25.1. The Coordinator must ensure that they receive the Form 434 from the police before the person to be detained is taken into the assessment area.

25.2. It is recognized that in very exceptional circumstances the need to ensure the safety of the person may take priority over the completion of the form prior to entering the Place of Safety suite.

25.3. A stock of forms should be available in the Place of Safety for use by police who have come directly to the Place of Safety suite

25.4. Police officers should not normally expect to remain at the Place of Safety for any longer than 30 minutes.

25.5. There may be exceptions to this, particularly in the case of a severely disturbed patient, where staffs feel they are at risk of harm. In these cases, the Place of Safety Coordinator may request the police to stay longer than normal. A supervising police officer will be contacted to negotiate with the Place of Safety Coordinator. This process will include consideration of the use of additional staff and security.

25.6. In cases where police officers are dealing with a violent or potentially violent individual, the use of force employed in any restraint, will be no more than necessary. Police officers are to remain with the patient until it is agreed in consultation with the Place of Safety Coordinator that it is safe to leave.

25.7. Any dispute over length of time police are required to stay will be resolved by a supervising police officer and the Place of Safety Coordinator.

26. London Ambulance Service

26.1. A clinical hand over of the patient should be given to the Health Care Professional taking responsibility for that patient, using the LAS patient report form (pink sheet) to provide structure and clarity of the information provided.

26.2. The handover will focus on any physical examination that has taken place and any information that the person has conveyed to the LAS staff regarding their current situation.

26.3. LAS staff should also be given an opportunity to discuss any issues around the presenting circumstances and staff should acknowledged LAS staff's experiences offering support and debrief if needed.

26.4. It will not always be possible to conduct a complete physical examination of the person.

26.5. In cases where this has not been possible, in conjunction with the place of safety team a decision will be made regarding any need for further medical investigation.

26.6. LAS staff should be encouraged to complete an audit form as part of the handover process.

DRAFT

27. Place Of Safety Care Pathway

27.1. A Care Pathway is a description of what a patient can expect to happen at different points in the assessment and treatment of their condition. The condition will be a mental or mental & physical health disorder. The aim is to ensure that every patient receives the best possible care and support so that they are able to reach their optimum level of recovery. Appendix 18 outlines the Place of Safety Care Pathway.

27.2. All Care Pathways and the associated Operational Policies are underpinned by the Care Quality Commission's (CQC) Essential Standards of Quality and Safety (March 2010). The CQC is the organization responsible for regulating and monitoring health and adult social care. The Essential Standards of Quality and Safety focus on the regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

28. Assessment process

28.1. The Place of Safety Care pathway is underpinned by the best practice guidance for Place of Safety/ Section 136 assessments.

28.2. The Mental Health Act 1983 Code of Practice specifies that 'the same care should be taken in examining and interviewing people in places of safety as in any other assessment. No assumptions should be made about them simply because the police have been involved, nor should they be assumed to be in any less need of support and assistance during the assessment'.

28.3. The code of practice dictates that an 'assessment by the doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety. In cases where there are no clinical grounds to delay assessment, it is good practice for the doctor and AMHP to attend within three hours; this is in accordance with best practice recommendations made by the Royal College of Psychiatrists. Where possible, the assessment should be undertaken jointly by the doctor and the AMHP.

28.4. In addition to the formal Mental Health Act assessments a comprehensive nursing assessment will be conducted by a nurse allocated to that person. The nursing assessment will focus on:

- The immediate needs of the person including but not limited to: hydration; nutrition; personal care; hygiene; contact and relationships with family, friends and/or carers.
- The person's view of their situation and understanding their individual story and needs.
- The person's experience being brought to the Place of Safety.
- The person's rights and understanding of why they have been brought to the Place of Safety

DRAFT

- Coping strategies and providing opportunities to access therapeutic materials available in unit to enable the person to occupy themselves and self-calm or soothe.

28.5. The allocated nurse must also provide an observational summary of the person's behaviour, mental state, interactions with others and any contact with family/ carers/ professionals.

28.6. Place of Safety staff must inform and include Carers or significant others in the assessment process to gain further understanding of the patient's history and presenting needs.

29. Persons subject to a Community Treatment Order (CTO)

29.1. If during the assessment process it is established that the person is already subject to a CTO – and it is felt they need a period of in-patient assessment the priority is to use the CTO recall procedures and to end the detention under s2, s3, s4 or s136. Note that – because these sections have been used in 'good faith' - the actions of the doctors, AMHP's and police officers in using MHA powers are not unlawful. See Community Treatment Orders (Reviewed Policy) 2015 for further guidance.

30. Transgender patients

30.1. In addition to the standard care and treatment contained in the care pathways, transgender patients will be supported in line with the Trust's guidance on supporting trans patients. Transgender policy.

31. Patients who are pregnant

31.1. In addition to the standard care and treatment contained in the care pathways, women who are pregnant will be supported in line with the Specialist perinatal mental health services operational policy. In the first instance, women who are identified as being pregnant will be diverted to an Emergency Dept. as a more appropriate environment for their assessment. Only once they have had a specialist review by the obstetric team, with a detailed discussion/handover with the Junior trainee or Higher Trainee, will they be accepted for transfer back to the Place of Safety.

DRAFT

32. Treatment under Sections 135 and 136

32.1. Sections 135 and 136 are EXCLUDED from Part IV of the Mental Health Act 1983 (Consent to Treatment) and, therefore, treatment can only be given either with the consent of the patient or under the Mental Capacity Act if the patient is assessed as lacking capacity. If the patient requires emergency treatment and it has not been possible to determine the patient's mental capacity, urgent treatment can be given in the patient's best interests under the Mental Capacity Act provided that staff have reason to doubt the patient's capacity.

33. Transfers between Places Of Safety

33.1. The transfer of patients detained under Section 136 can occur from one Place of Safety to another during the duration of this section.

33.2. All other transfers will require a separate section of the Mental Health Act.

33.3. If transfer does occur between places of safety the following must take place: -

- In all circumstances a record needs to be made of the person's time of arrival at the Place of Safety suite to which they are first admitted. This must be captured on the Pro-forma on care notes. Essential to this recording is to ensure that the police officer who has used Section 136 powers has completed the necessary paperwork (Form 434)
- If transfer does occur within the total duration of the detention then a very clear record needs to be made by all parties of the time of the original detention and the time that the transfer takes place. A clear rationale should be recorded for the decision to move places of safety.
- Information (including medical and risk assessments) should be shared between the transferring and receiving place of safety.
- Any transfer between one Place of Safety and another should not take place unless it has been confirmed that the new Place of Safety is willing and able to accept the person. Unless it is an emergency, a person should not be transferred without the agreement of an AMHP, a Doctor or another healthcare professional competent to assess whether the transfer would put the person's health or safety (or that of other people) at risk. Code of Practice 16.57.

34. Discharges from the Place Of Safety

34.1.1. Once the assessment is completed the assessing professionals must agree upon one of the following:

- The person is found to not be suffering from a mental disorder.
- The person is found to be suffering from a mental disorder but not of a degree or nature to warrant compulsory admission.
- The person is found to be suffering from a mental disorder of a degree and/ or nature that warrants compulsory admission.

DRAFT

34.1.2. This decision will inform discharge planning and follow-up arrangements.

34.1.3. Where it is likely that the person will require an inpatient admission (on an informal or formal basis) the relevant trust bed management team should be notified at the earliest opportunity.

34.1.4. The section 136 confers holding powers until the assessment (by the AMHP and by the doctor) has taken place and an outcome been reached. If the outcome is that a Section 2 application is made, that application will confer holding powers (as the patient will be regarded as liable to be detained) until conveyed to the hospital the application is made out to. Once conveyed to that hospital and once the application has been received and accepted by the hospital, the person becomes detained under the MHA under section and confers holding powers.

35. Discharge planning and follow up

35.1.1. The authority to detain a person under section 135(1) or 136 ends as soon as the assessment has been completed and suitable arrangements have been made. If a doctor assesses the person and concludes that the person is not suffering from a mental disorder then the person must be discharged, even if not seen by an AMHP (MHA 1983, Code of Practice 16.50). This decision should be communicated to the AMHP.

35.1.2. In such cases formal follow up arrangements may not be necessary. However, as a minimum for all persons admitted to the Place of Safety, regardless of the outcome of the assessment, the following discharge standards apply:

- The person has a means of accessing safe accommodation (e.g. house keys, someone at home to let them in, friend to stay with, directions /appointment with the Homeless Persons Unit).
- The person has the means to access funds.
- Appropriate transport arrangements have been put in place to convey them to their place of residence.
- With the consent of the person a relative/ friend/ carer will be informed of the discharge and follow up plans
- The person's GP and their local CMHT (if known) is notified of the admission within 24 hours via a written discharge summary.
- The person has a means of accessing an appropriate level of on-going support (e.g. GP appointment, family, friends, carers, appointment with Care Coordinator, information about drop in centre for substance misuse, peer support group, HTT, CRT)
- The person has information about accessing their local crisis services.
- The person is provided with a written crisis plan.
- If on Opiate Substitution Therapy (e.g. Methadone or Buprenorphine/ Subutex) all arrangements are made for the prescription to continue in the community. ****Never prescribe take home Opiate Substitution Therapy**.

DRAFT

35.1.3. If the doctor sees the person first and concludes that there is evidence of a mental disorder and that compulsory admission to hospital is not necessary, but that they may still need treatment or care (whether in or out of hospital), the person should still be seen by an AMHP. The AMHP should consult the doctor about any arrangements that might need to be made for the person's treatments and care (MHA 1983, Code of Practice, 16.51).

35.1.4. If admission following assessment is not required, the referring police station is to be informed of the outcome by the nurse coordinating the admission.

36. Persons with No Fixed Abode

36.1.1. Persons discharged who are of no fixed abode should be sign posted to the relevant services in the borough where they have a local connection.

36.1.2. Each Local Authority has specific criteria by which they assess whether a person has a local connection to that borough.

36.1.3. Access criteria for accommodation provided by charitable organisations should be sought directly from the provider.

37. Follow-up care

37.1.1. Follow up care must be arranged for people in their area of residence when they are not admitted to hospital following a mental health assessment unless they have no mental disorder or care and support needs of any kind. This might include a referral to a community-based team or for an assessment under the Care Act 2014. This should also include prompt and adequate communication with the individual's GP.

37.1.2. Staff should be aware of alternative community services to support the individual's mental health and social needs. This includes peer support and talking therapies that are on offer for the individual.

37.1.3. If it has been decided not to admit under the Mental Health Act, responsibility for any further engagement reverts to community services where the person lives. Where the individual does not reside in the local area, the place of safety coordinator is responsible for making any necessary referral to the appropriate local service, obtaining advice if the person's place of residence is not clear.

38. Repeat and frequent attenders

38.1.1. Repeat attenders to the place of safety are defined as having had more than one presentation to the service within a three-month period.

38.1.2. Persons classified as repeat attenders will have a comprehensive multidisciplinary review of their crisis plan and on-going care arrangements as part of the discharge process.

38.1.3. The place of safety team will hold a weekly meeting focused on repeat attenders. This meeting will utilise a formulation based approach to identify precipitating, perpetuating and protective factors with the aim to reduce the number of repeat attenders. The minutes of this meeting will be sent to the persons care coordinator/ community team.

DRAFT

39. Serenity Integrated Mentoring.

39.1.1. SIM supports the small number of service users in every community struggling with complex mental health disorders who often request emergency services whilst making limited clinical progress. There is a high incidence of these patients coming to the attention of Police and may be frequently detained under Section 136 and brought to the Place of Safety. Patients who are identified as being of part of the SIM project will be managed accordingly. Staff will access and utilise the Crisis Response Plan that has been created for each individual. During office hours the SIM Clinical Nurse Specialist and named Police officer will be alerted to the presence of any SIM patient in the Place of Safety. Where possible a joint review will be conducted between Place of Safety staff and the SIM team.

40. Transfers to inpatient services

40.1.1. Where the decision is made that it is in the best interests of the person to be admitted to inpatient services for on-going assessment and treatment consideration should always be made as to the least restrictive option.

41. Informal admission

41.1.1. If the person is agreeable to an informal admission, the bed management team should be notified and a bed identified according to the trust's bed management policy.

42. Admission under the Mental Health Act

42.1.1. All patients detained under the Mental Health Act, will be allocated a bed if there is a Camden or Islington local connection. The bed management team should be informed of the decision to admit and requested to identify a bed, according to the trust's bed management policy. The PoS Team will liaise with other Mental Health Trusts for their patient transfer.

43. Admission to a Psychiatric Intensive Care Unit

43.1.1. Psychiatric Intensive Care Units are specialised in the care of those who are in an acutely disturbed phase of a serious mental disorder. There is associated loss of capacity for self-control with a corresponding increase in risk which dos not enable their safe management and treatment in a less acute and/ or less secure inpatient setting.

43.1.2. Where it is the opinion of the Place of Safety team and/ or the Mental Health Act assessment team that a person may require admission to a PICU they must follow the established PICU referral process. See the Trust Operational Policy for Psychiatric Intensive Care Unit.

43.1.3. Place of Safety team members should make referrals to the PICU wards for screening for C&I patients and follow procedures for other Mental Health Trusts for out of area patients.

43.1.4. Admission to a PICU must always be under the framework of the Mental Health Act 1983 (2007).

44. Where it has not been possible to complete an assessment within the time frame of the Section 136

DRAFT

44.1.1. Section 136 allows a person to be detained for a maximum of 24hours (+discretionary 12 if extra time needed) for the purpose of assessment and the making of any necessary arrangements for treatment or care. In the event that it has not been possible to complete the assessment and transfer the person to an appropriate setting the person should be allowed to leave the Place of Safety immediately. However, where there are on-going concerns for the person's health and wellbeing this must be escalated to the Team Manager and the Service Manager for the place of safety.

44.1.2. Where a decision is made to restrict a patient's liberty in their best interest outside of a legal framework. A datix incident report should be completed to recognise potential breaches in mental health law. This should include details of: the patient, the concerns raised, the clinical discussion formulating the rationale to restrict the patient's liberties; as well as any plans for ongoing resolution of the concerns identified with details of agencies who will be involved in this plan.

44.1.3. This data will be shared routinely with the Trust's Mental Health Law Committee and regular feedback will be provided for learning and continued evolvement of the service.

44.1.4. Section 136 of the MHA 1983 sits under the umbrella term of Emergency Sections. Broadly speaking these are sections that can be rapidly applied usually by one health professional which provide a period of time to make other assessment and care arrangements. Their function is to allow a Mental Health Act Assessment to take place whilst effectively managing a scenario where there are significant risks. Other commonly used emergency sections would include Section 5(2) and 5(4).

44.1.5. Emergency sections should not be applied back-to-back. That is to say it is not appropriate to continue the detainment of a person subject to Section 136 by utilising section 5(2).

45. Conveyance from the Place Of Safety

45.1.1. The Place of Safety team must facilitate the onward conveyance of all persons who have been detained or those who will be admitted informally or to a Crisis House.

45.1.2. When considering transport options, the preference should always be for a method which is most likely to preserve the person's dignity and privacy consistent with managing any risk to their health and safety or to other people (MHA1983, Code of Practice, 17.3).

DRAFT

46. Discharges to the community

46.1.1. Where a person is to be discharged to their place of residence transport arrangements should be made on an individual basis and be guided by the person's preferences. A comprehensive multi-professional risk assessment must be conducted and documented to inform this decision-making process.

46.1.2. It is preferable that, with the person's consent, consideration should be given as to whether a family member or carer can assist by collecting the person from the department.

46.1.3. Out of Area Patients - For persons who do not normally reside in the London Boroughs of Camden and Islington, practical measures will be implemented to convey them back to their normal place of residence. Where possible and where consent is granted, family or carers should be contacted to see whether they can assist with this process. Where this is not possible the various transport options will be considered and weighted against person's preferences and risk assessment. Provision will be made for the purchasing of train or bus tickets where this is deemed an appropriate method of conveyance.

46.1.4. Persons with No Fixed Abode - For persons of no fixed abode efforts should be made to ensure they are conveyed to a location where safe accommodation is available as per 16.1.2. Where this is not achievable as a minimum the person should be conveyed to the borough in which they normally reside.

47. Admission to inpatient services

47.1.1. Where a person is to be admitted to hospital the AMHP holds the professional responsibility for ensuring all necessary arrangements are made for the patient to be transported to hospital. All relevant agencies should co-operate with the AMHP to ensure safe transport to hospital (MHA 1983, Code of Practice 17.9).

47.1.2. Patients should be informed as soon as possible of the reasons for any planned transfers and their views taken into consideration. They should also be supported, where appropriate, to discuss the planned transfer with carers (who should usually be informed if the patient has a learning disability, autistic spectrum disorder or dementia). A record of these discussions should be made in the patient's notes (MHA 1983, Code of Practice, 17.3).

47.1.3. If an AMHP wishes to delegate the responsibility for transferring the patient to a member of the Place of Safety Nursing team the Nurse in-charge of the unit will make an assessment, in conjunction with the second RMN or the charge nurse, as to whether they are able to accept this responsibility given the present demands on the service.

47.1.4. In some circumstances it may be appropriate or necessary for the person to be transferred by the private transport provider. In such circumstances the AMHP must ensure that it will be safe to do so and that a medical escort other than the driver will be available. (MHA 1983, Code of Practice, 17.17).

DRAFT

48. Prevention and Management of Violence & Aggression

48.1.1. The admission criteria to the Place of Safety means that patients will at times present with behavioural challenges. All Place of Safety must review the PMVA Policy as well as Chapter 26 of the Mental Health Act Code of Practice.

48.1.2. Seclusion

48.1.3. Seclusion refers to the supervised confinement and isolation of the patient, away from other patients, in an area from which the patient is prevented from leaving, where it is an immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others (see Chapter 26 of Mental Health Act 1983 Code of Practice). It has a place to play in the spectrum of interventions available to support the management of violence and aggression. Seclusion policy

48.1.4. Hyperlinks
Rapid Tranquillisation Guidance
PMVA policy

49. Management of visitors to the Place of Safety

49.1.1. Where practicable visits and involvement in the assessment process by family members, carers and/ or friends to persons admitted to the Place of Safety are encouraged. However, this must be balanced against the need to offer the service user a fair assessment.

49.1.2. The process of facilitating a visit should be carefully considered and risk assessed by the Place of Safety team before proceeding. Safeguarding issues must have been considered prior to the facilitation of a visit and the consent of the service user must have been obtained.

49.1.3. A member of the Place of Safety team should meet with the visitor prior to the facilitation of the visit to explain the current situation and any health and safety guidance that is relevant such as what to do if the emergency alarms are activated. The team's plan for how the visit will be facilitated must also be discussed with the visitor and direction given to why (e.g. on safety grounds) and how a visit would be terminated if necessary.

49.1.4. Carer's information leaflets will be available in the unit for information purposes.

DRAFT

50. Place Of Safety standards

50.1.1. All patients will be treated with respect and dignity receiving equality of care without prejudice to gender, sexuality, disability, religious beliefs or ethnicity.

50.1.2. All patients will receive the necessary physical investigations and physical health care treatment in situ where this is within the scope of the Place of Safety service or via an onward referral and liaison process.

50.1.3. Patients and carers will be provided with verbal and written information on all aspects of the unit including their rights under s136, unit routines and procedures, the assessment process, available care and treatments.

50.1.4. Patients to have access to interpreting services if required.

50.1.5. Health promotion information including diet and exercise, substance misuse and smoking cessation, Safeguarding Adults Leaflets and signposting information on domestic abuse for both victims and perpetrators will be available.

50.1.6. The physical environment will provide a therapeutic space which maximises safety, privacy, dignity and the overall service user experience.

50.1.7. The multidisciplinary team will work collaboratively with patients to conduct a comprehensive assessment of health (physical and mental) and social circumstances.

51. Governance / Performance

51.1.1. Key to the smooth operations of the POS is the

- robust capturing of activity data
- incidents
- the reporting back of activity and incidents
- associated learning from all the above measures

51.1.2. Key information contained in the HBPoS Form in CareNotes will be completed for all persons admitted to the Place of Safety:

51.1.3. This data will be collated and monitored within the Community Acute Performance Meeting and C&I Trust Performance Meetings.

52. Data Submission

52.1.1. MONITORING COMPLIANCE

52.1.2. An annual audit of the Trust Place of Safety will be conducted in order to monitor compliance with this policy.

DRAFT

REFERENCES

- Department for Health (2015) Mental Health Act 1983: Code of Practice
- Lees, L., Ferreday, J. (2003). The role of a patient-flow coordinator in an emergency assessment unit. Nursing Times; 99: 32, 32–34.
- National institute for Clinical excellence (2004) Clinical Practice Guidelines for The Short-term Management of Disturbed/Violent Behaviour in Adult Psychiatric In-service user Settings and Accident and emergency Settings. Draft for 2nd Stage Consultation Period. NICE, LONDON
- Royal College of Psychiatrists (2011) Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales).

FREEDOM OF INFORMATION ACT 2000

All Trust policies are public documents. They will be listed on the Trusts FOI document schedule and may be requested by any member of the public under the Freedom of Information Act (2000).

DRAFT