Kent County Council and Medway Council 136 Joint Operational Guidance

Version	Date	Changed by	Summary of change
1.0	10.06.2021	Helen Burns	Implementation of version control

Kent County Council (KCC) AMHP Service is a 24/7/365 provision responsible for all s136 Assessments within Kent.

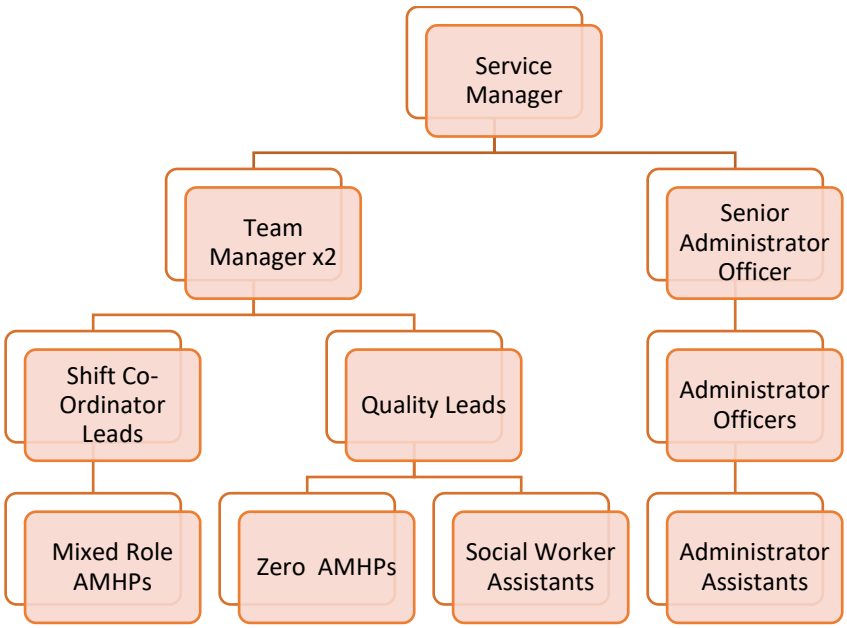
Kent AMHP Service has a memorandum of understanding with Medway Council (MC) and provides urgent Mental Health Act assessments for Medway residents that originate out of hours and that cannot wait until the next working day.

Referrals received by Medway before 17.00 and work that has already been started remains the responsibility of MC AMHP Service.

This out of hours service is provided Monday to Thursday 17.00 – 09.00 and Friday to Monday between 17.00 and 09.00. Kent AMHP service also provide urgent cover to Medway over Bank Holidays.

KENT AMHP SERVICE STRUCTURE AND STAFFING

Kent AMHP Service Structure



Kent AMHP Service operates a 24-hour rota with a mixture of shifts including:

07.45 – 20.15 (Day Shift)
19.45 – 08.15 (Night Shift)
12.00 – 20.00 (Late Shift)
14.00 – 02.00 (Twilight Shift)

There are several variations to these shifts to accommodate flexible working requests.

The service aims to rota a minimum number of staff on each shift.

Weekday Shift
1 x Shift Coordinator
5.5 x AMHPs

Saturday Day Shift
1 x Shift Coordinator
4 x AMHPs

Sunday Day Shift
1 x Shift Coordinator
3.5 x AMHPs

Bank Holiday Day Shift
1 x Shift Coordinator
3.5 x AMHPs

Night Shift
1 x Shift Coordinator
1 x AMHP

Numbers of AMHPs on shift often exceed the minimum and additionally the service can flex when there is a surge in referrals by offering cold call payments to staff when they are off duty.

There is a handover between Medway and Kent AMHP Services twice daily. After 17.00 Medway AMHPs call work through via the central AMHP number. At 08.30 the Kent AMHP Service email Medway with information about assessments outstanding.

Section s136 assessments are given a high priority and the aim is to allocate cases based on agreed standards. However, both KCC and MC undertake a variety of Mental Health Act work so in addition to timeframes the overriding determinate is risk. This means that other assessments may need to be prioritised over 136 assessments.

KENT AMHP SERVICE MORNING MEETING

Each morning at 08.30 there is a virtual meeting and all those working in the Kent AMHP Service are expected to join.

Colleagues from other organisations also join the meeting including a representative from North East London Foundation Trust (NELFT) (if there is a CAMHS assessment), KMPT Patient Flow Team and the 836-phone coordinator.

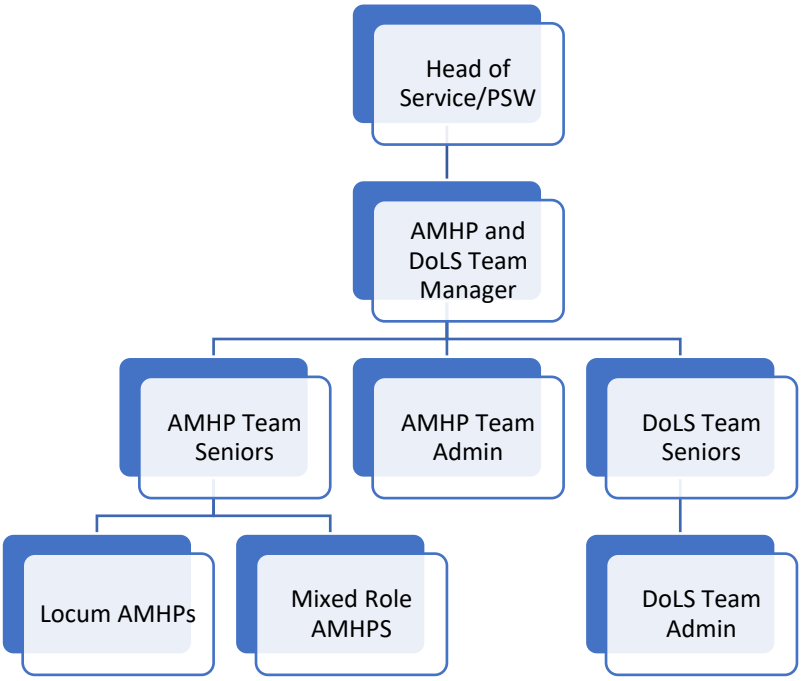
The meeting is held remotely via MS Teams and Chaired by the person coordinating the service that day.

The purpose of the meeting is to provide an opportunity for staff to come together at the start of each shift, allocation of work, updates from management, administration team and KMPT.

Outside of the morning meeting work is allocated throughout the day as AMHPs become available.

Medway Council AMHP and DoLS Team Structure and Staffing

Medway Council AMHP and DoLS Team Structure



The Medway Council AMHP and DoLS team operates Monday to Friday 9am to 5pm, excluding bank holidays.

The rota is covered each day by one AMHP senior and 2 AMHPs, these could be either a Locum or mixed role AMHP.

Medway AMHP's receive a daily handover email from KCC AMHP service between 8.30 and 9am. Each referral is input onto our client database by admin staff whilst the senior undertakes the necessary triage.

KCC RECEIVING REFERRALS, PRIORITIING AND ALLOCATING WORK

Referrals to the Kent AMHP Service are received by telephone in hours on the central AMHP number and out of hours (OOH) via Agilisys (this is a message taking service).

Central AMHP Number: 03000 422 480
Agilisys (OOH) 03000 419 191

In hours

- Referrer contacts AMHP Service via the central number.
- Initial information is taken by a Social Work Assistant (SWA) or administrator.
- This is passed to the coordinator, who screens the information and if necessary, will contact the referrer for further exploration of the case.
- The case is then prioritised (Red, Amber or Green) and listed on the AMHP Shift Report.

Out of Hours

It is important to note that out of hours Agilisys provide a message taking service and calls to this number do not constitute a referral.

Messages are passed to the duty AMHP and they will call back to discuss the enquiry. The duty AMHP also undertakes assessments so may not be able to call back immediately if they are driving or in an assessment.

Once a referral has been accepted the same risk rating will be applied.

- Red – Fit for interview case awaiting allocation.
- Amber – unclear picture of needs/not fit for interview and awaiting information.
- Green – case is allocated to an AMHP and assessment process has begun.

MEDWAY COUNCIL RECEIVING REFERRALS, PRIORITISING AND ALLOCATING WORK

Referrals to the Medway AMHP and DoLS team are received by telephone:

Medway Central AMHP Number: 01634 331888.

- The referrer contacts the Medway AMHP team via the main phone number.
- Initial information is taken by an admin worker, who will check the client's home address against: https://www.gov.uk/find-local-council as parts of Medway's borders come within KCC boundaries.
- If the client is in supported or residential accommodation, they will check social care records to determine if Medway Council fund the placement.
- The information is passed to the AMHP Senior, who will triage the referral, contact the referrer, and gather further information if necessary.
- The referral is then actioned accordingly on the team spreadsheet and if the person requires an assessment, allocated as soon as possible.

THE ASSESSMENT (Approved Mental Health Professional)

MHA Section 13 describes the process the AMHP will need to go through prior to satisfying themselves that an application ought to be made. MHA S13 (1A) (b) states they should have 'regard to any wishes expressed by relatives of the patient or any other relevant circumstances' while MHA S13 (2) states that before making an application for admission an AMHP should be satisfied that 'detention in hospital is in all the circumstances of the case the most appropriate way of providing the care and medical treatment of which the patient stands in need'; see also MHA COP 14.50. The Reference guide MHA 8.32 explains what is included within 'all the circumstances of the case'.

To comply with these directives some considerable degree of preparation needs to be undertaken by the AMHP by way of gathering and analysing information prior to the interview with the patient taking place (poor preparation for the MHA assessment was cited as a failing in the TW domestic homicide).

Use of the Mental Health Act is not to be taken lightly as this is a deployment of the full authority of the State. The consequences can result in individuals having their liberty and right to make certain decisions removed. When an AMHP is considering a case, they also need to strike a fair balance reached by the application of the proportionality principle. On this basis they will consider whether someone may need to rest before an assessment can take place so that the individual if able to fully engage in the process.

Consideration of available records/documentation

The MHA COP further describes sources of information which should be included in terms of considering 'relevant circumstances' and 'all the circumstances of the case' when an AMHP is deciding whether it is necessary to make an application for detention.

MHA COP 14.52 states that AMHPs 'must exercise their own judgement, based on social and medical evidence, when deciding whether to apply for a patient to be detained under the Act.' MHA COP 14.56 refers to 'information that the AMHP can obtain from reliable sources.' MHA COP 14.6 says that when deciding if the criteria for detention are met 'The criteria require consideration of both the nature and degree of a patient's mental disorder.' Further to this it describes 'nature' in terms of mental disorder as referring to 'the particular mental disorder from which the patient is suffering, its chronicity, its prognosis and the patient's previous response to receiving treatment of the disorder.' Degree refers to 'the current manifestation of the patient's disorder.' (see also Reference guide MHA 8.3) MHA COP 14.8 states that 'In all cases consideration should be given to …the patients cultural background, the patient's social and family circumstances. Further to this MHA COP describes factors to consider in relation to the health or safety of the patient (MHA COP 14.9) and the protection of others (MHA COP 14.10); within this specific mention is made to 'what is known of the history of the patient's mental disorder' (MHA COP 14.9) and 'any relevant details of the patient's clinical history and past behaviour, such as contact with other agencies and (where relevant) criminal convictions and cautions.' (MHA COP 14.10); see also Reference guide MHA 8.32.

In terms of any person who has had previous/current contact with mental health services a vitally important source of evidence in the above respects is likely to be their electronic records: RIO, MOSAIC and PADS; if the person is known to services outside of KMPT requesting relevant records from the services in that area (or from within that service e.g. CAMHs and KCC CFE) will also be invaluable in relation to accessing relevant information.

Useful information related to the person's mental health history may also be available via their GP surgery i.e. by requesting an encounter report. Trust doctors are also able to contribute information from GP records by accessing MIG.

The TW domestic homicide review stated in its conclusions: 'The failure not to read all the available relevant information by staff carrying out the MHA Assessments influenced the decision making as all of the available information was not considered.'[1] Additionally within the body of the report they stated 'the staff involved did not have a thorough understanding of all the long and complex history of Brian and his family. The history in this case contained vital information that should have been considered as a key part of the MHA assessment.'[2]

[1] Domestic Homicide Review Alan/2011: **6.13**
http://www.kent.gov.uk/about-the-council/partnerships/kent-community-safety-partnership/domestic-homicide-reviews
[2] Domestic Homicide Review Alan/2011: **4.78**

- **Consultation with others**

In addition to accessing records the MHA and MHA COP specifies that consultation should take place with a variety of people as a means of informing the AMHPs consideration of the circumstances of a person's case.

MHA S11 states that the AMHP should, where possible, communicate with the patients nearest relative in relation to an application for MHA S2 (MHA S11 (3) MHA COP 14.58) and must where 'reasonably practicable' communicate with them for an application for MHA S3 (MHA S11 (4)(a) (b) MHA COP 14.59).

As such the AMHP will need to identify who the nearest relative is (MHA COP 14.57). The hierarchy for identification is listed in MHA S26 (1) and MHA S26 goes on to give further guidance as to possible variations to this general order of priority (see also MHA COP 5.2). Jones (*Mental Health Act manual* (19th Ed) 1-410-420) provides extensive notes on these scenarios and clarification of definitions arising from case law; an area which Jones considers and which can often have relevance when identifying the nearest relative relates to S26 (4): notes on ORDINARILY RESIDES and CARED FOR (1-417). Reference guide MHA Chapter 2 also gives extensive guidance on issues related to the nearest relative. The MHA COP 5.2 states that if the nearest relative is not the carer then the carer (if there is one) should also be contacted particularly as they may be in possession of the most relevant information regarding the persons care and interests. There are additional considerations for children MHA COP 5.3 and MHA COP 19.6-13.

There are exceptional circumstances where the duty to communicate with the nearest relative can be disregarded MHA S11 (4) (b), MHA COP 14.60, 14.61, Reference guide MHA 8.26 and it is very likely that decisions related to this issue are going to be informed by corroborating evidence which may well come to light via scrutiny of existing records.

Although neither the MHA nor MHA COP explicitly state that communication with the nearest relative must take place prior to the assessment interview (Reference guide MHA 8.28 says that the medical recommendations may be obtained before consultation with the nearest relative takes place) taking place it would seem productive (and to be supported by inferences from within the MHA and MHA COP) to do this wherever possible. Dialogue with the nearest relative could provide valuable information which could later help contextualise and guide the interview with the person being assessed.

MHA S13 (1A)(b) states that in concluding if they are satisfied that an application should be made an AMHP should have regard to any wishes expressed by the relatives of the patient (Reference

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http://www.kent.gov.uk/about-the-council/partnerships/kent-community-safety-partnership/domestic-homicide-reviews

guide MHA 8.36). This extends the scope of consultation beyond that of the nearest relative but does not affect the obligations toward the nearest relative (Reference guide MHA 8.37). Similarly the MHA COP directs AMHPs to consider consulting ('In so far as the urgency of the case allows') with family members and carers as part of their assessment to help determine the level of risk MHA COP 14.9, 14.10 and also to enable a holistic assessment of the person's situation MHA COP 14.8, 14.66, Reference guide MHA 8.32, 8.36; where the person being assessed is under 18 years of age the AMHP should consider consulting their parents or other people who have parental responsibility, assuming they are not the person's nearest relative anyway MHA COP 14.67. Additionally, MHA COP 14.68 lists several areas for AMHPs to consider in deciding on the appropriateness of consulting carers or other family members.

Further to consulting with nearest relatives, family and carers the MHA COP also directs AMHPs to consult wherever possible with other people who have been involved in the person's care including their care coordinator (if they have one) and also other statutory, voluntary or independent services they may have contact with MHA COP 14.69. Additionally, if a person has an attorney or deputy under the Mental Capacity Act 2005 (MCA) where this person is known to exist AMHPs should take reasonable steps to contact them and seek their opinion MHA COP 14.70.

It is recognised that with some assessments accessing, collating and giving due consideration to the background material may take several hours. In all assessments this is a fundamental aspect of the assessment process and should not be disregarded or carried out in a superficial manner. Equally consulting with others prior to an assessment can be time consuming and at times involve some element of investigative work. However, it is also an integral part of an assessment which should not be dispensed with unless there is an overriding urgency. All unsuccessful attempts at consultation i.e. phone numbers being obsolete, people not answering, other services not responding should be documented in the AMHP Report.

The overall process of preparatory tasks required to undertake a MHA assessment to the standard envisaged within the Act**,** MHA COP and Reference guide MHA is time consuming. To complete it to this standard may realistically take several hours. When reviewing serious incidents arising within the Kent AMHP service a lack of in-depth preparation has consistently been found to be a factor in that practitioners have not been aware of risk issues which had relevance to the assessment and should have been taken into consideration.

The MHA Code of Practice 16.47 states: - Assessment by the doctor and Approved Mental Health Professional (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.

User feedback has highlighted the negative impact and distress caused to the detained person from excessive delays in assessment. It should be noted that that the MHA does not always require the attendance of a second section 12 doctor for assessment purposes under Section 136.

- **Section 136 Assessments at a Health based Place of Safety (HBPOS)**

In all cases, including those in acute trust sites, the 836 coordinators will alert the Patient Flow Team that a person has been detained on a s136. This will enable them to plan for a possible admission.

Once it is agreed that a person detained under Section 136 is fit for interview the AMHP should arrange the assessment process, with an aim for this to commence within the 4-hour standard by: -

Contacting the on-call Duty Consultant Psychiatrist and if required an independent Section 12 Approved doctor to arrange the earliest time when a joint assessment can take place.

Where the clinical presentation of the detained person indicates a complex mental health issue, contact a second Section 12 approved doctor to be involved in the assessment. The final decision remains with the AMHP but may be informed by the background, 836 Coordinator, Place of Safety (POS) staff on initial screening, relevant history and discussion with the consultant psychiatrist.

In cases where only one Section 12 doctor is involved in the assessment this must always be a KMPT senior psychiatrist.

If the assessment is for someone under the age of 18 then this must be a doctor specialising in the mental health of children and young people. For a person with specific needs, e.g., learning disability, physical disability or communication needs AMHP should endeavour to involve a colleague in the assessment with appropriate skills and knowledge.

The AMHP and Consultant psychiatrist are supported in their decision making by the POS staff and decisions taken following assessment are supported by KMPT.

AMHPs take a lead role in the joint assessment of the detained person with the Consultant Psychiatrist/Section 12 doctor and complete the AMHP section of the 136-record form.

If admission is required, the AMHP completes a handwritten/electronic outline report to go with the person to the ward and adds a progress note to RIO.

Section 136 Assessments in A&E

There are 2 reasons why service users maybe detained under Section 136 and at an acute hospital site.

1. They require medical assessment/treatment.

2. All KMPT places of safety are occupied.

With the introduction of the Police and Crime Act 2017 it is likely that service users falling into category 1 may be able to have their detention extended. This can only be considered if the persons physical or mental condition make an assessment impracticable.

Extensions can increase the timeframe up to 36 hours. During this period acute hospital staff and the AMHP Service must regularly review the service user but unless the person is medically optimised so acute admission is no longer required an assessment under the Act will not take place.

AMHPs will need to be satisfied that this intervention does not impact on their ability to interview in a suitable manner. Consideration needs to be given to any impact that pending results, investigations or treatment may have on a service user's presentation, mental state and the likelihood that they will disengage if the s136 is discharged.

Any service user falling into category 2 must be assessed under the Mental Health Act as soon as possible and this may need to take place on the acute site.

An acute site is the least desirable location for such assessments due to the uncontained environment, other vulnerable acutely unwell people, expensive sensitive equipment, difficulties managing aggressive and violent behaviour, preventing absconding and maintaining client confidentiality and dignity.

If a person has been medically cleared, and there is sufficient time on the S136 clock, they should be transferred to a health-based place of safety, if there is space.

Priority for Mental Health Act assessments will continue to be given regarding needs, risk and timeframes. The order of allocation on priority will be decided by the AMHP Coordinator.

If a Mental Health Act assessment for a service user detained under Section 136 takes place on an acute site, the AMHP must have access to the following:

- Clear information from the nurse in charge of the acute ward/A&E of the service user's ability to be assessed. The AMHP must be able to interview the service user in a suitable manner. Intoxication, sedation, tiredness, effects of physical treatment, and waiting for physical interventions may prevent the service user from being interviewed in a suitable manner.

- Clear information about risk to staff.

- Details of the service user and known mental health needs (particularly for those outside of KMPT), contact details for any carers and family.

- Trust Section 12 Doctor.
- Independent S12 Doctor if indicated.
- A suitable confidential room for the interview to take place and for the assessing team to discuss the service user prior to and following the assessment.
- Assistance from acute staff if the service user is likely to become distressed.
- The service user will remain subject to detention under s136 until interviewed by an AMHP and necessary arrangements for their treatment and care have been put in place. This means the police will need to remain beyond the assessment while resources are being secured and organised.

Following the Mental Health Act assessment, it is likely that the AMHP will need to make follow up calls to conclude the assessment. The AMHP will need a confidential space to complete this work.

The AMHP at no time will be responsible for the service user in terms of risk to self and/or others and provision of risk reduction measures remains the responsibility of the acute hospital staff and police.

The AMHP does not have to remain once the Mental Health Act assessment has been completed. The service user can remain subject to the Section 136 'until making any necessary arrangements for his treatment or care' S136 (2) have been finalised. The AMHP and assessing team will advise as to the needs/actions after the assessment, so the acute hospital staff can ensure these are followed.

Following completion of the assessment, the AMHP agrees an outcome and plan with, if possible, the person, the assessing doctor and other services involved examples include CRHT, CMHT, Support & Sign Posting, CAMHS, Social Care Teams and the Patient Flow Team. Potential outcomes may include:

a) Admit informally

b) Compulsory admission under Section 2 or 3 as necessary.

c) Home treatment, support from the CRHT.

d) Referral back to Community Mental Health Services

e) Sign posting or referring to other services

f) Discharge to GP

g) If any further action is required

- **Obstacles to completing an application for detention.**

To be able to make an application (for MHA S2 and 3) a bed must have been identified within a hospital willing to accept the person who has been assessed (although it is noted that a hospital is not under a legal obligation to accept an application and they have the discretion to refuse to do this see Jones *Mental Health Act manual* (19th Ed) 1-111 note on MHA S6 (1) TO HOSPITAL) and the application must be addressed to this specific hospital (MHA COP 14.89, Reference guide MHA 8.65); MHA COP 14.90 adds that where units under the management of different bodies exist within the same site or even within the same building they will be different hospitals for the purposes of the MHA.

In Kent it is the responsibility of the Patient Flow Team or other appropriate bed managers (e.g. CAMHS or out of area teams) to locate beds in relation to admissions arising from MHA assessments.

The issue bed availability within the local area/county of Kent can have implications in terms of being able to make an application. Other factors arise around the appropriateness of the application/admission when a bed has been identified in a hospital hundreds of miles away from where the person and their family live. This is not an issue on which definitive advice can be given and professional judgement needs to be exercised on a case-by-case basis.

It is not lawful to detain a service user in A&E but if admitted and the hospital agree to accept an application then the AMHP can complete papers to an acute trust. In such cases the acute trust Site Manager or Nurse in Charge of the ward must complete a H3 form formally accepting the patient. The AMHP must involve PLS who will support acute staff complete the form and then upload a copy to RIO clinical documentation. Once a psychiatric bed has been identified the acute trust must complete a H4 form (s19 MHA). Once the papers have been accepted by the acute trust the AMHPs duties have been dispensed and all other arrangements fall to the acute trust supported by PLS.

- **If a s136 Lapses**

On occasion it is not always possible to undertake an assessment within the statutory timeframe and the S136 will lapse.

If the person is in a HBPOS then KMPT should look to their own policies and procedures about how to manage such a situation.

If the person is in an acute hospital trust they should be given the option to remain voluntarily. If they have been admitted and unwilling to do this a doctor can consider s5 (2) of the Mental Health Act 1983.

In all cases the person should be referred to the Psychiatric Liaison Team who will monitor, review and decide on the next steps.

In all cases the person will be referred to their local Social Care Team and considered for a Social Care Assessment under the Care Act 2014.

- **CAMHS s.136s that do not have a MHA Assessment**

As with adults, occasionally a Child/Young Person under s.136 cannot be assessed within the 24-hour (or extended) timeframe due to not being fit for interview or still requiring medical treatment at expiry.

The purpose of s.136 is for 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 (CoP 16.25).

In these circumstances and to enable this to happen the KCC pathway is as follows:

- A new referral should be made to Children's Services – Front Door via the Kent Children's Portal system (live on 12th October 2020).

  https://webapps.kent.gov.uk/KCC.ChildrensPortal.Web.Sites.Public/Default.aspx

  Ensure all known basic demographic details are included on the form (Name, DOB, NHS No, Address etc).

- Add details regarding the reason for their s.136 to provide context.

- Make clear on the referral they the child/young person has not been assessed by an AMHP and therefore further investigation needs to be made regarding their social care needs or potential safeguarding concerns.

- All team leaders within the Front Door Service are aware that these referrals may be coming through and thus there may be very little information on the referral but that this will need to be followed up by them.

- Responsibility for completing this referral will be with the Shift Coordinator (can be delegated to a SWA).

** This process does not replace any referral to Children's Services that a Child/Young Person may require if they are at risk or any referral that may be made when a MHA assessment has occurred.

In these circumstances and to enable this to happen the Medway Council pathway is as follows:

The Medway AMHP or AMHP Team Senior will contact Medway children's services on 01634 334466 and make an urgent referral for children not currently open to Children's Social Care.

The AMHP must ensure they have:

- All the known basic demographics (Name, DOB, Address, NHS No.)
- Make it clear to Children's Services that they have not assessed and the reasons why, explaining that further investigation needs to take place as the AMHP team holds very little information about the Child/Young Person.

For Children known to Children's Social Care, the AMHP or AMHP team Senior will liaise with the Child's allocated worker or worker's manager to provide the relevant information relating to the current situation.

POST ASESSMENT

In the event of the person requiring admission under section, AMHP to liaise with the Patient Flow Team to discuss bed availability and plans to convey to a bed if this is not on site.

Patient Flow Central Number: 07887 826 440.

If the person is under the age of 18 the CAMHS CRHT are responsible for identifying a bed.

If the person requires informal admission HBPOS, CAMHS or acute trust staff are responsible for making the arrangements.

Where admission to hospital is not required but Support and Signposting input is required the AMHP will liaise with the service to discuss the support plan.

Where admission to hospital is not needed but CRHT input is indicated the AMHP will liaise with the local team to discuss treatment and support.

Where the decision is to refer the client back to their local Community Mental Health Team for support; the AMHP will ensure that a referral is made by the next day.

Where referral to secondary mental health services is not indicated, ensure that the local Community Mental Health Team is made aware of the Section 136 assessment, in case of future presentation.

Record all appropriate information in the electronic patient records system (Rio).

CONVEYING A DETAINED PERSON POST ASSESSMENT

Once an application for detention in hospital under MHA S 2 or 3 has been 'duly completed' the applicant (either AMHP, Nearest Relative or any person authorised by the applicant has the legal authority to take and convey the person to the hospital named in the application MHA S6 (1) **(**MHA COP17.8, Reference guide MHA 8.66**)** within the time frames discussed previously above. They are thereby considered to be in legal custody see MHA S137 (1)-(3) (Reference guide MHA 11.2 & 11.4) and subject to the implications which arise. These include the authority to prevent the person from absconding. If the person were to abscond prior to their admittance to hospital they can be retaken within the relevant time period in respect of the application which has been made i.e. either 14 days or 24 hours (Reference guide MHA 8.68, Reference guide MHA Chapter 11 Fig 44). See also MHA S138 (1) (b) and Jones *Mental Health Act manual* (19th Ed) GENERAL NOTE 1-1351.

Once an application has been completed (conferring on the applicant the authority to take and convey the person to hospital the person should be transported to hospital as soon as possible (MHA COP 14.91); they should not however be moved until it is known that the hospital will accept them (MHA COP 17.20). Where the AMHP is the applicant, they have a professional responsibility for making sure that all necessary arrangements are made for the person's conveyance to hospital; all other agencies should co-operate fully with the AMHP to ensure safe transportation to hospital (MHA COP 17.9). In the circumstance where the nearest relative is the applicant, then the AMHP and all other involved agencies should support them (MHA COP 17.11); if their actions are deemed to be lawful and justified (MHA COP 17.11).

If a person had agreed to an informal admission to hospital after assessment under the MHA, then conveyance would still need to be arranged but this would be with the consent of the individual (MHA S131) and without the use of statutory powers. In this situation responsibility for arranging conveyance is with the nurse in charge of the relevant department.

When deciding on the appropriate means of transportation to hospital the AMHP should take several factors into consideration. MHA COP 17.3 states that 'patients should always be transported in the manner which is most likely to preserve their dignity and privacy consistent with managing any risk to their health and safety or to other people.' MHA COP 17.6 lists a considerable number of factors to be taken into account when deciding on the most appropriate means of transportation; these include the person's age and gender, any physical disability that

they might have, any risks to their health and safety and any support, supervision and clinical care they may need en-route (particularly so if sedation has been or may be used) and also any risk that they may be violent and/or seek to abscond.

AMHPs should make decisions on the appropriate means of transportation in consultation with other professionals involved, the person being admitted and their carer (as appropriate); the decision should be informed by a risk assessment based on the best available information (MHA COP 17.12).

If the person is likely to be unwilling to be moved then authorisation should be given by the AMHP (applicant) to those providing the transport (including ambulance staff or police); this will invest them with the legal authority to convey (MHA S6(1), MHA COP 17.13). There is a form produced by Kent County Council entitled 'Authority to convey' and AMHPs should ensure they have copies of this when undertaking assessments. This is not a statutory form and the power to convey is based on the duly completed application; however, it would be prudent to use this form as it may well ease the conveyance process, provide a 'paper trail' and allay any anxieties which other professionals may have in respect of using force to convey a person to hospital.

If it appears that the person's behaviour is likely to be violent or dangerous then the police should be asked to assist (MHA COP 17.14); even in this scenario where practicable an ambulance should be used to transport the person. If the circumstances were such that a police vehicle needed to be used, due to the presenting risks, then it may be necessary for the highest qualified member of the ambulance crew to travel in the police vehicle with the ambulance following to be able to provide support as required (MHA COP 17.16). Those people who have been authorised by the applicant to transport the person act in their own right and not as agents of the applicant; they can act on their own initiative to use restraint and prevent the person absconding when necessary (MHA COP 17.16). Where they are the applicant AMHPs retain professional responsibility in ensuring the person's conveyance is undertaken in a lawful and humane manner and to this end they should give guidance to those asked to assist (MHA COP 17.18).

The MHA COP 17.19 states that the person being conveyed may be accompanied by another person; in agreeing this the AMHP and the person in charge of the vehicle would have to be satisfied that this will not increase the risk of harm to the person being conveyed or to anyone else.

A private vehicle can be used, with the AMHPS agreement, to transport a person to hospital. This course of action should only be undertaken where the AMHP is satisfied that the person being transported, and others will be safe from risk of harm and that it is the most appropriate means of conveying the person (MHA COP 17.17). In such an eventuality there should be a medical escort for the patient other than the driver (MHA COP 17.17).

The time waiting for other services to provide conveyance can be considerable. This can present AMHPs (and backups) with a number of challenges e.g. having to contain an individual who is mentally unwell, who may be distressed by the assessment and angry at the prospect of being taken to hospital. When making decisions around conveyance AMHPs should be guided by the direction of MHA COP 17.3 and should not be guided by a desire to short cut the process necessary to achieve this. However, if AMHPs believe they are at immediate risk of physical harm they should withdraw and take the necessary actions/seek the necessary support to keep themselves (and others) safe.

Before the person is moved the applicant should confirm that the relevant hospital is expecting them and knows when they are likely to arrive; where possible the name of the person who will formally receive the person should be obtained (MHA COP 17.20). Where the applicant (AMHP) is not travelling with the person then the application and medical recommendations should be given to the person authorised to convey with instructions for them to be given to the receiving hospital staff (MHA COP 17.21).

RETURNING THE PERSON HOME AFTER THE S136 ASSESSMENT

When an assessment takes place in a HBPOS responsibility for making arrangement to return the person home is with POS Staff.

When an assessment takes place in at an acute hospital site responsibility for making arrangement to return the person home is with hospital staff and the police.

KCC REPORT WRITING

Within five days of the assessment the AMHP completes a full report, updates the IT system and email the Administration Team informing them this has been done.

KCC AND ADMINISTRATION PROCESS

Following an assessment, the AMHP informs the shift coordinator of the outcome and the shift report is updated.

Administration Team check the report daily and based on outcome send out appropriate letter to the Nearest Relative.

On receipt of notification by the AMHP that a report is complete they send a copy to the GP and any other parties requested.

Once all activity is complete the Administration Team Close the referral.

For those cases that do not progress to a full MHA Assessment the shift coordinator will ensure the referral is closed.

ESCALATION KENT COUNTY COUNCIL FOR STAKEHOLDERS

If there is a concern about AMHP response times the first point of contact is the shift coordinator via the central AMHP number.

The coordinator will be able to explain why there is a delay in the context of numbers of referrals and competing demand. It is worth noting delays may not be an AMHP challenge and could originate due to other factors such as doctor and bed availability. Delays have a knock-on effect in the AMHP service as staff are prevented from attending or moving on to the next assessment.

In office hours, if you feel the response from the coordinator does not address your concerns then you can contact the AMHP Team Duty Manager but at times of extreme challenges they will already be aware of the outstanding assessments, what has been prioritised and why. This level of contact would be from the Modern Matrons and Service Managers not frontline staff.

The next person to contact is the AMHP Service Manager. The Service Manager is only made aware of challenges if they are significant and additional resources are required from AMHPs not on the rota.

The Final contact would be KCC Assistant Director for Countywide Services. Contact with the Assistant Director would be through their equivalent in partner agencies.

AMHP Coordinator - 03000 422 480 weekdays (08.00 – 17.00)

ESCALATION MEDWAY COUNCIL FOR STAKEHOLDERS

If there is a concern about AMHP response times the first point of contact is the AMHP Duty Senior on the main AMHP Team phone number.

The Duty Senior will be able to provide an explanation as to why there is a delay and the reasoning behind the delay (increased referrals and competing demands). Not all delays with assessments will be due to AMHP delays, it could be delays in securing an Independent Section 12 Doctor.

If you feel the response from the AMHP Duty Senior, does not address your concerns, the next point of contact will be the AMHP Team Manager. The AMHP Team Manager will be aware of the competing demands on the service and the volumes of referrals each day.

The next point of contact in the process is the AMHP Team Head of Service and Medway Council's Principle Social Worker, who is only made aware of significant challenges and when additional resources have needed to be secured to meet the demands of the team.

The Final point of contact is Medway Council's Assistant Director for Adult Social Care. Contact with the Assistant Director should come from through her equivalent in KMPT or MFT.

AMHP Team Duty Senior 01634 331 888

KCC SEEKING MANAGEMENT SUPPORT OOH

If there is a concern about AMHP response times the first point of contact is the shift coordinator via the central AMHP number.

If you feel the response from the AMHP Duty Senior, does not address your concerns and the issue cannot wait until core hours the next point of contact will be the on-call Team Manager, who can be contact via the OOH number.

Agilisys (OOH) 03000 419 191