A member of:
Association of UK University Hospitals

NHS
Sussex Partnership
NHS Foundation Trust
Swandean - Trust HQ
Arundel Road
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West Sussex
BN13 3EP

Private & Confidential
Mrs Catharine Palmer
Assistant Coroner
Sent by email: [redacted]

10 February 2021

Dear Mrs Palmer

Re: The late Miss Elena WELLS

Thank you very much for your letter of 23rd November under cover of which you raised two matters of concern under Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulation 28 and 29 of the Coroner's (Investigations) Regulations 2013, arising from the inquest of Elena Wells concluded on 9th November 2020.

The Trust and Brighton and Hove City Council (BHCC) wish to reiterate our condolences to the family of Elena Wells. The Prevention of Future Deaths report has provided us with a further opportunity to address gaps in guidance and policy between the Trust and BHCC to ensure there is the provision of a continuous package of care, support and monitoring for voluntary patients, like Elena, who are waiting a short period of time for admission to an acute mental health bed.

This response has been developed in partnership between the Trust and BHCC. I want to take this opportunity to stress that both organisations recognise their joint responsibilities in these circumstances and whilst I understand BHCC will be required to respond separately, both organisations wish to ensure that communication between us is as constructive as possible.

The Trust and BHCC have a long history of partnership working and integrated service delivery. Both organisations have delivered integrated adults and older adults secondary mental health and adult social care services in the City for a number of years via a formal s75 Partnership Agreement.
The two key issues which both organisations have considered to formulate this response are:

1. **Actions taken to improve communication and clearly define responsibility between the Trust and the BHCC in order to improve the safety of patients with serious mental illness who are awaiting admission to an acute psychiatric hospital.**

In response, the Trust is in the process of developing a new Crisis Resolution Home Treatment Team (CRHT) Operational Policy. An interim policy was presented to the Operational Management Board in December 2020 and it was agreed the CRHT teams would work to this whilst the policy is further developed by the newly appointed Trust wide Urgent Care Pathway Lead.

The interim policy includes details of when an inpatient admission has been agreed for a patient but a bed is not immediately available, then the CRHT will support the person whilst they are waiting to be admitted. Within the interim policy it also details that if the level of risk increases and the CRHT are not able to safely support the patient, then this will need to be escalated to senior managers and support put in place from other urgent care services such as The Havens.

Along with support from the Adult Operational Services, the Urgent Care Pathway Lead will be leading on finalising the interim CRHT operational policy. This work which is underway, will include a clear referral pathway for AMHP's who have assessed a person as needing admission. This pathway will reflect the integrated working arrangements in Brighton and Hove and is being jointly developed by BHCC and the Trust's Operational Leads and will define the key responsibilities and tasks of the Approved Mental Health Practitioners, Urgent Care Services and Assessment and Treatment Services in the management of patients awaiting informal or compulsory psychiatric admission.

Operational Leads are also completing further work to identify points of contact within the Trust outside of the operational hours of CRHT. As this work is currently being completed, the Trust can forward this policy once finalised if required.

As widely reported nationally, the demand for acute mental health provision is profoundly challenged, in part, due to the impact of the Covid 19 pandemic. Both the Trust and the wider health and social care economy are undertaking a number of actions to improve the position which includes purchasing an additional 45 acute psychiatric beds in the independent sector within Sussex; to ensure that patients receive their care as locally as possible and to ensure we can facilitate acute admissions for patients with the least delay. The Trust has developed close working relationships with other Providers, enabling patients to receive the same level of care, treatment and discharge planning that they would if under the care of Sussex Partnership NHS Foundation Trust (SPFT). This includes attendance at weekly ward rounds and oversight of all admissions and discharges by our Clinical Lead Nurses for acute bed management and the recent development of our clinically led Intensive Support Teams (IST). The IST is a senior multi-disciplinary team of SPFT clinicians who work closely with independent sector providers to ensure optimum care for all our patients as well as discharge planning.

Locally, the Care Delivery Services [CDS] in Brighton has established an Urgent Demand Oversight meeting that enables the CDS Leads to have daily oversight of our patients requiring admission to hospital. This meeting is informed by the various Operational meetings that take place daily in our Community, Urgent and Acute Care Services and is described in the enclosed Terms of Reference (appendix 1).

The function of these meetings is to consider and review the service demand for the day ahead, confirming available resources and re-planning as needed to ensure teams are able to deliver services safely and as required. Representatives from these service areas then attend the Oversight Meeting, along with the Deputy Service Director and Bed Manager to review the overall demand for Urgent and Acute Care Services.
The Oversight Meeting provides a focus on patients like Elena, who are waiting in the community for inpatient care, confirms the support package that is being provided, and by whom.

The Trust and their Commissioners have developed a number of additional urgent care services posts, pre and during the Covid-19 pandemic, in response to the demand on services but also as part of the wider strategic investment into mental health services and the response to the NHS Long Term Plan. This includes the expansion of the Sussex Mental Health Line to become a 24 /7 Sussex wide free phone service, an A&E diversion service for Children & Young People, the opening of Crisis Cafes in Brighton, Worthing, Eastbourne and Crawley and clinical pathways to redirect patients with mental health presentations away from A&E departments.

The Trust has a system of clinical bed management led by senior nurses which operates 7 days a week. This system is supported by administrative bed managers and a single point of access for referrals to the Trust's Health Based Places of Safety (HBPoS) - both of which operate on a 24/7 basis. The Trust manages its acute bed provision on a Sussex wide basis to ensure patients can access acute care as soon as is practicable once a decision to admit has been made.

All demand for inpatient care is subject to clinical prioritisation as outlined in the Trust's Bed Management Policy and prioritisation is subject to immediate adjustment in light of continuous and dynamic risk assessment by the Trust's Urgent Care and Assessment and Treatment Services as outlined in the above point.

2. It is requested that the Trust consider ways of providing extra support and supervision to those patients who are waiting for an urgent admission, particularly those who may be left alone at home for any period until a bed is available.

When a patient is assessed as requiring admission but the person will need to wait for a bed to be available, the Approved Mental Health Professional (AMHP) will develop an immediate safety plan with the patient and family/carer aimed at keeping the person safe until a bed is sourced. As part of the process of requesting a bed this immediate safety plan will be shared as part of the CRHT gatekeeping process and the Lead Practitioner if applicable.

In addition, as part of the Sussex wide investment and developments in Urgent Care, the Trust is developing a trusted assessor model so that AMHP's and s12 Doctors can complete assessments on behalf of CRHT in order that patients can avoid being repeatedly assessed and can start receiving care and treatment sooner.

Current practice is that the CRHT will accept referrals as made by the Council's AMHP's; independent s12 Doctors and Lead Practitioners working within the Assessment and Treatment Services in order to provide patients with a package of care whilst an inpatient bed is identified.

This package of support would be formulated and delivered in partnership with other services, including the patient's family and carers as clinically indicated and depending on the assessed level of risk.

In June 2019, Brighton and Hove Mental Health Services opened the Haven at Mill View Hospital which has 4 Assessment Bays in Brighton - a psychiatric decision unit which provides a 24/7 service for patients to receive an extended period of assessment whilst presenting in crisis. Where patients present in extremis, provision can be made to accommodate them at the Haven for longer than 24hrs. During the early stages of the Covid 19 pandemic, the Trust developed an additional Haven in Worthing and expanded the capacity and opening hours of the Urgent Care Lounges in Eastbourne, Hastings and Crawley. Where the patient's individual profile and risk allow it, both Havens and Urgent Care Lounges throughout the Trust can be used to support patients, for a short period of time, i.e. patients who have been identified as requiring an admission to hospital whilst waiting for an acute bed to become available. This would be considered on a case by case basis and forms part of a total package of care and support for a patient based on an assessment of their needs and risk.

The Trust has five HBPoS co-located within acute psychiatric hospitals which are used for the assessment and treatment of patients who have been detained under Mental Health Act 1983 Section 136. During the first wave of the Covid pandemic, the Trust designated three of the Havens and Urgent Care Lounges as Alternative HBPoS in order to increase capacity and avoid patients having to attend Acute Trust A&E departments for support and treatment with mental health. In the event of significant acute bed demand and to meet patients assessed needs, in extremis the Trust can temporarily admit patients to a HBPoS whilst an acute bed is identified. When this occurs, the use of the HBPoS is actively monitored by the Clinical Bed Management Team with person seen as having top priority for an inpatient bed.

All Acute Hospitals across Sussex have 24/7 Mental Health Liaison Teams in place and therefore, in extremis patients can be supported to attend A&E departments to mitigate any risk whilst awaiting an acute inpatient admission. A&E Departments were formally classified as HBPoS in the national guidance in response to the changes to the Mental Health Act in December 2017. In the most urgent situation, if a patient's presentation alters dramatically, the Trust would seek support from Sussex Police or the South East Coast Ambulance Service as appropriate.

The Trust's core community secondary mental health care services are described as Assessment and Treatment Services (ATS). These are multi-disciplinary teams which provide care and treatment under the Care Programme Approach. Elena was known to the East Brighton ATS and had an allocated Lead Practitioner.

In the circumstances to which this response is directed, the patient's Lead Practitioner would provide a key part of the patient's care plan whilst waiting for an admission to acute psychiatric hospital, in partnership with other community and urgent care services, provision from the community and voluntary sector and any identified carers or family resources as appropriate. Any plan of care in these circumstances would be subject to the Trust's Care Programme Approach and Safe and Effective Assessment and Management of Clinical Risk Policies.

Our colleagues at BHCC approve and support the above arrangements and lines of communication between the local AMHP Services and the Trust is now clear on its clinical responsibility for patients like Elena.

I trust this letter reassures you that we have taken steps to improve the support that we provide to our patients at the point they are recommended for inpatient admission and throughout their pathway.

Yours sincerely

[redacted]
Chief Executive

Enc. Terms of Reference (appendix 1)

Appendix 1

NHS
Sussex Partnership
NHS Foundation Trust

B&H Adult CDS Urgent Demand Oversight Meeting

Ratification Date	February 2021	Owner	[redacted] Deputy Director

Purpose

The Urgent Demand Oversight Meeting (ODOM) enables the CDS Leads to have daily oversight of our patients requiring support from our acute and urgent care services.

Representatives from these service areas are required to attend the UDOM, along with the Deputy Service Director and Bed Manager to review the overall demand for Urgent and Acute Care Services.

Duties

Feedback will be reported from the various 'handover' or 'huddle' meetings that take place daily in our Community, Urgent and Acute Care Services by the nominated representatives.

The function of these meetings is to consider and review the service demand for the day ahead, confirming available resources and re-planning as needed to ensure teams are able to deliver services safely and as required.

The UDOM will receive an update from each service area for the purpose of:

1. Confirming that services across the CDS can be delivered safely as required
2. To consider the deployment of resources as needed
3. Identify any patients requiring urgent admission to acute care services, ensuring interim support arrangements are in place, by whom, and consider any barriers or additional actions that may be required
4. Confirm additional communication arrangements as needed

Members	Quorum
• Deputy Director (chair) • General Manager community (or nominated rep) • Clinical Lead Nurse Manager (or nominated rep) • Urgent Care Service Manager (or nominated rep)	Representation is required from acute, community and urgent care services.

• Bed Manager In addition to the above team level representation is required from: • MHLT • CRHTT • The Haven	

Frequency

Meetings will be held via Skype and take place daily at 12 noon.

Communication

The chair will share a brief summary following the meeting and will include:

1. Service area briefings
2. Acute care demand
3. Any identified actions and further communication arrangements

This will be shared with all attendees, senior operational managers, CDS Professional Leads and Clinical Directors, and Operations Director.

Reporting

The activity reported to the Urgent Demand Oversight meeting (UDOM) will be informed by the following arrangements:

Activity	Via	UDOM
Acute Care (all wards and HBPOS)	Daily Huddle meeting	Clinical Lead Nurse Manager
AMHP	AMHP Handover	Bed Manager
Community (all teams)	Huddle meetings (3 x weekly) and via Service Manager reporting (daily)	General Manager Community
CRHTT	Daily Handover meeting	CRHTT Team Lead
MHLT	Daily Handover meeting	Clinical and Team Leads
Haven	Daily Handover meetings	Team Lead

Review

These terms of reference will be reviewed in February 2021 and annually thereafter or as required.

These terms of reference can be made available in alternative formats if required

Brighton & Hove City Council

Chief Executive
Hove Town Hall
Norton Road
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BN3 3BQ

Private and Confidential
Mrs. Catherine Palmer
Her Majesty's Assistant Coroner
for the City of Brighton and Hove

By email only:

Date: 10 February 2021
Our Ref: [redacted]
Your Ref:
Phone:
Email: [redacted]

Re: The late Miss Elena WELLS

I write in response to your report to prevent further deaths, made under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The Inquest into Miss Wells' death highlighted miscommunication and misunderstanding between the Council's Approved Mental Health Professional (AMHP) team and staff within the Sussex Partnership Foundation Trust (SPFT) about the role of the AMHP after a Mental Health Act 1983 (MHA) assessment by an AMHP and two section 12 doctors conclude that a patient should be admitted to hospital for assessment or treatment. The AMHP is responsible for making an application for the patient to be admitted to hospital (section 11 MHA). Applications must be accompanied by two supporting medical recommendations (section 2 and 3 MHA).

The legislation and statutory Code of Practice is clear in the division of responsibility between the AMHP, as a local authority employee, and the NHS. The Brighton and Hove Clinical Commissioning Group (CCG) has contracted for the SPFT to deliver mental health services within Brighton and Hove city. Therefore references in the legislation to the CCG in relation to mental health are, for the purposes of Brighton and Hove, to be read as references to the SPFT.

Section 140 of the MHA places a duty on every CCG to notify every local social services authority of the hospital/s available to it for receiving patients in special urgency. A copy of that provision is attached.

The Code of Practice was produced in accordance with s118 MHA. The relevant paragraphs of that Code are at paragraphs 14.77 to 14.99. That extract is attached.

The extracted paragraphs relate to the CCG duty to make available suitable beds for the admission of patients, "it is not the responsibility of the applicant "[the AMHP] paragraph 14.77.

The AMHP should then be in a position to make the application for the patient's admission referring to the beds available to the patient as notified by the CCG.

In the event of delay identifying a suitable bed for the patient, paragraph 14.86 states "AMHPs should be supported by their local authority in these circumstances and should not be expected by commissioners and providers to address the delay themselves. In the meantime, commissioners should, in partnership with providers, ensure that alternative arrangements to meet the person's

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needs pending the availability of a bed are accessible, eg crisis houses, and should communicate those arrangements to the local authority."

Where an AMHP decides that an application for detention is not required the decision should be supported, where necessary, by another framework for care or treatment eg referring the patient to social, health or other services (paragraph 14.104).

The local authority role in supporting its AMHPs is dependent on the SPFT informing it of suitable resources available to meet the acute mental health needs of a patient particularly when there are no beds immediately available. Recent discussions with SPFT have clarified how the AMHP can ensure that an assessed patient is supported pending an admission to hospital.

Productive discussions have taken place between the local authority and SPFT staff to identify what policies, practice guidance and communications need to be produced or amended to clarify professional roles within the mental health legal framework. It is agreed that a simple Brighton and Hove flowchart describing how an AMHP can ensure a patient post-assessment receives necessary care or treatment without delay regardless of bed availability is essential. A draft flowchart has already been produced. There is also a need for AMHPs to be accepted as Trusted Assessors which would enable more efficient and faster referrals into SPFT services.

I have had the benefit of seeing a draft of the SPFT response to your regulation 28 report ahead of the drafting of my response.

Based on the positive working relationship that exists between the local authority and the SPFT, I am confident that we can achieve the clarity needed for our respective staff to be able to operate in an appropriate manner to ensure patient safety. This task is being prioritised within the local authority and we have agreed with the SPFT that the flowchart should be finalised by the end of March 2021 confirming a local protocol between our organisations. In the interim the measures that have been put in place already by SPFT eg. the introduction of a daily Urgent Demand and Capacity meeting conducted by the Care Delivery Service, the availability of the local Haven@Millview hospital and the agreement of operational management of the role of an AMHP, assure me that the confusion that was evident with some professionals involved in Miss Wells care in March 2020 should not arise again.

Yours sincerely,

[redacted]

Chief Executive
Brighton & Hove City Council

[140 Notification of hospitals having arrangements for special cases]

It shall be the duty of [every clinical commissioning group and of] [. . .] every [Local Health Board] to give notice to every local social services authority for an area wholly or partly comprised within the [area of the [clinical commissioning group or] . . .] [Local Health Board] specifying the hospital or hospitals administered by [or otherwise available [to the [clinical commissioning group or] [. . .] [Local Health Board]]] in which arrangements are from time to time in force[—

(a) for the reception of patients in cases of special urgency;

(b) for the provision of accommodation or facilities designed so as to be specially suitable for patients who have not attained the age of 18 years].

NOTES

Derivation

This section derived from the Mental Health Act 1959, s 132.

Initial Commencement

Specified date

Specified date: 30 September 1983: see s 149(2); for transitional provisions and savings see Sch 5 hereof.

Amendment

Section heading: substituted by the Mental Health Act 2007, s 31(1), (4).

Date in force: 3 November 2008: see SI 2008/1900, art 2(h); for transitional provisions and savings see art 3, Schedule, paras 1, 12 thereto.

Words "every clinical commissioning group and of" in square brackets inserted by the Health and Social Care Act 2012, s 45(1)(a).

14.76 When making recommendations for detention under section 3, doctors are required to state that appropriate medical treatment is available for the patient (see chapter 23). Preferably, they should know in advance of making the recommendation the name of the hospital to which the patient is to be admitted. If that is not possible, their recommendation may state that appropriate medical treatment will be available if the patient is admitted to one or more specific hospitals (or units within a hospital).

Commissioning and section 140 of the Act

14.77 If the doctors reach the opinion that the patient needs to be admitted to hospital, it is their responsibility to take the necessary steps to secure a suitable hospital bed; it is not the responsibility of the applicant. In some cases, it could be agreed locally between the local authority and the relevant NHS bodies and communicated to the AMHP that this will be done by any AMHP involved in the assessment.

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

14.79 The NHS Commissioning Board (known as NHS England) is responsible for the commissioning of secure mental health services and other specialist services. NHS commissioners should work with providers to ensure that procedures are in place through which beds can be identified whenever required.

14.80 Local authorities, providers, NHS commissioners, police forces and ambulance services should ensure that they have in place a clear joint policy for the safe and appropriate admission of people in their local area agreed at board or board-equivalent level by each party and each party should appoint a named senior lead ('senior lead'). It is good practice for the parties to the local policy to meet regularly to discuss its effectiveness in the light of experience and review the policy where necessary, and to decide when information about specific cases can be shared between relevant parties for the purposes of protecting the person or others, in line with the law. Persons carrying out functions for these parties should understand the policies and their purpose, the roles and responsibilities of other agencies involved, and follow the local policy and receive the necessary training to be able to carry out fully their functions.[7]

[7] Local crisis care policies and agreements should already in place through the Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis. Department of Health and Concordat signatories. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_ Health_Crisis_accessible.pdf

14.81 In order to promote a patient's recovery, NHS commissioners and providers should work together to take steps, with appropriate input from section 12 doctors and AMHPs, to place individuals as close as is reasonably possible to a location that the patient identifies they would like to be close to (eg their home or close to a family member or carer). This should take account of any risk assessment undertaken, the availability of services which can meet the patient's individual needs, any assessment in respect of the likely duration of the patient's stay, and any other factors raised by the patient and their family. The location of the placement, and considerations relevant to that decision, should be monitored and reviewed regularly. Where secure care is needed further issues become relevant (see paragraph 14.82). This will help to facilitate effective discharge and after-care planning (see chapters 32 and 33).

14.82 For individuals who require low and medium secure mental health services, consideration should be given, through clinical and risk assessment, to the type of care required, especially where this includes specialist care. Steps should be taken to place individuals as close as is reasonably possible to a location that the patient identifies they would like to be close to that is suitable for their needs. If an individual is assessed as requiring high secure mental health services, they will be placed in a high security hospital according to the defined catchment areas of these hospitals. Rampton Hospital is the provider of national services for women, deaf people and people with learning disabilities who require high secure mental health services. Decisions regarding the location and type of facility where restricted patients are placed will be determined by appropriate clinical and risk assessment of the type of care required to meet the needs of the patient and to protect public safety.

14.83 In cases where the patient lacks capacity to make a decision about the location they would like to be close to, a best interests decision on the location should be taken.

14.84 Having regard to the empowerment and involvement principle, commissioners should ensure as far as is possible that carers are involved in the decision about where to locate an individual, and are informed of the reasons for the decision taken. Commissioners should have in place a policy so that the patient and/or the patient's carers are able to challenge a decision.[8]

14.85 When a patient's carer informs the commissioner of difficulties in visiting the patient because of the distance that they need to travel, the commissioner should consider whether they can provide any assistance to support the patient's carer to visit and maintain contact with the patient. The commissioner should inform the carer that they can request a carer's assessment from the local authority. CCGs should work with the relevant NHS Commissioning Board regional team under these circumstances to seek to move the patient closer to their preferred location.

[8] The Department of Health and NHS Commissioning Board (NHS England) will work together to develop guidance for commissioners as to what should be included in such a policy.

14.86 Local recording and reporting mechanisms should be in place to ensure the details of any delays in placing patients, and the impacts on patients, their carers, provider staff and other professionals are reported to commissioning and local authority senior leads. These details should feed into local demand planning. AMHPs should be supported by their local authority in these circumstances and should not be expected by commissioners and providers to address the delay themselves. In the meantime, commissioners should, in partnership with providers, ensure that alternative arrangements to meet the person's needs pending the availability of a bed are accessible, eg crisis houses, and should communicate those arrangements to the local authority. The local authority should ensure that AMHPs are aware of these arrangements.

Action when it is decided to make an application

14.87 Most compulsory admissions require prompt action. Applicants have up to 14 days (depending on when the patient was last examined by a doctor as part of the assessment) in which to decide whether to make the application, starting with the day they personally last saw the patient. There may be cases where AMHPs conclude that they should delay taking a final decision in order to see whether the patient's condition changes, or whether successful alternatives to detention can be put in place in the interim.

14.88 Before making an application, AMHPs should ensure that appropriate arrangements are in place for the immediate care of any dependent children the patient may have and any adults who rely on the patient for care. Their needs should already have been considered as part of the assessment. Where relevant, AMHPs should also ensure that practical arrangements are made for the care of any pets and for the local authority to carry out its other duties under the Care Act 2014 to secure the patient's home and protect their property.

14.89 Applications for detention must be addressed to the managers of the hospital where the patient is to be detained. An application must state a specific hospital. An application cannot, for example, be made to a multi-site provider without specifying which of the provider's sites the patient is to be admitted to. Providers should identify a bed manager or other single point of contact who will be responsible for finding a suitable bed as soon as possible and telling the applicant the name of the site at which it is situated. Effective systems of bed management including discharge planning, possible alternatives to admission and demand planning should be in place. The bed manager should work closely with commissioners to proactively identify local need, and with assessing doctors and AMHPs to secure a bed. AMHPs should be adequately supported by their local authority in establishing working partnerships with other local agencies listed at paragraph 14.80.

14.90 Where units under the management of different bodies exist on the same site (or even in the same building), they will be separate hospitals for the purposes of the Act, because one hospital cannot be under the control of two sets of managers. Where there is potential for confusion, the respective hospital managers should ensure that there are distinct names for the units. In collaboration with local authorities, they should take steps to ensure that information is available to AMHPs who are likely to be making relevant applications to enable them effectively to distinguish the different hospitals on the site and to describe them correctly in applications.

14.91 Once an application has been completed, the patient should be transported to hospital as soon as possible, if they are not already in the hospital. However, patients should not be moved until it is known that the hospital is willing to accept them.

14.92 A properly completed application supported by the necessary medical recommendations provides the applicant with the authority to transport the patient to hospital even if the patient does not wish to go. That authority lasts for 14 days from the date when the patient was last examined by one of the doctors with a view to making a recommendation to support the application. See chapter 17 for further guidance on transport.

14.93 The AMHP should provide an outline report for the hospital at the time the patient is first admitted or detained, giving reasons for the application and any practical matters about the patient's circumstances which the hospital should know. Where possible, the report should include the name and telephone number of the AMHP or a care co-ordinator who can give further information. Local authorities should use a standard form on which AMHPs can make this outline report.

14.94 Where it is not realistic for the AMHP to accompany the patient to the hospital, it is acceptable for them to provide the information outlined above by telephone, fax or other electronic means compatible with transferring confidential information. If providing the information by telephone, the AMHP should ensure that a written report is sent to the admitting hospital as soon as possible.

14.95 An outline report does not take the place of the full report which AMHPs are expected to complete for their employer (or the local authority on whose behalf they are acting – if different).

14.96 If the patient is a restricted patient, the AMHP should ensure that the MHCS of the Ministry of Justice is notified of the detention as soon as possible. This information should be left during office hours, although a duty officer is available at all times for urgent queries.[9]

[9] At the time of publication, contact details are available at www.justice.gov.uk/contacts/noms/mental-health-unit, and the Ministry of Justice switchboard is contactable on 020 3334 3555. For urgent queries out of office hours the telephone number (operated by the Home Office) is 020 7035 4848: select option 5.

14.97 If the patient is a looked after child under the Children Act 1989, AMHPs should inform the local authority's children's services as soon as possible. If this patient is placed out of the area of the local authority that looks after the child ('responsible authority'), AMHPs should inform the children's services in both the responsible authority and the local authority in which the child is placed.

14.98 An application cannot be used to admit a patient to any hospital other than the one stated in the application (although once admitted a patient may be transferred to another hospital – see paragraphs 37.16 – 37.27).

14.99 In exceptional circumstances, if patients are transported to a hospital which has agreed to accept them, but there is no longer a bed available, the managers and staff of that hospital should assist in finding a suitable alternative for the patient. This may involve making a new application to a different hospital. If the application is under section 3, new medical recommendations will be required, unless the original recommendations already state that appropriate medical treatment is available in the proposed new hospital. The hospital to which the original application was made should assist in securing new medical recommendations if they are needed. A situation of this sort should be considered a serious failure and should be recorded and investigated accordingly.

Communicating the outcome of the assessment

14.100 Having decided whether or not to make an application for admission, AMHPs should inform the patient, giving their reasons. Subject to the normal considerations of patient confidentiality, AMHPs should also give their decision and the reasons for it to:

- the patient's nearest relative
- the doctors involved in the assessment
- the patient's care co-ordinator (if they have one), and
- the patient's GP, if they were not one of the doctors involved in the assessment.

14.101 An AMHP should, when informing the nearest relative that they not do intend to make an application, advise the nearest relative of their right to do so instead. If the nearest relative wishes to pursue this, the AMHP should suggest that they consult with the doctors to see if they would be prepared to provide recommendations.

14.102 Where the AMHP has considered a patient's case at the request of the nearest relative, the reasons for not applying for the patient's admission must be given to the nearest relative in writing. Such a letter should contain, as far as possible, sufficient details to enable the nearest relative to understand the decision while at the same time preserving the patient's right to confidentiality.

Action when it is decided not to apply for admission

14.103 There is no obligation on an AMHP or nearest relative to make an application for admission just because the statutory criteria are met.

14.104 Where AMHPs decide not to apply for a patient's detention they should record the reasons for their decision. The decision should be supported, where necessary, by an alternative framework of care or treatment (or both). AMHPs should decide how to pursue any actions which their assessment indicates are necessary to meet the needs of the patient. That might include, for example, referring the patient to social, health or other services.

14.105 The steps to be taken to put in place any new arrangements for the patient's care and treatment, and any plans for reviewing them, should be recorded in writing and copies made available to all those who need them (subject to the normal considerations of patient confidentiality).

14.106 It is particularly important that the patient's care co-ordinator (where they require support under the care programme approach (CPA) – see chapter 34) is fully involved in decisions about meeting the patient's needs.

14.107 Arrangements should be made to ensure that information about assessments and their outcome is passed to professional colleagues where appropriate, eg where an application for admission is not immediately necessary but might be in the future. This information will need to be available at short notice at any time of day or night.

14.108 More generally, making out-of-hours services aware of situations that are ongoing – such as when there is concern for an individual but no assessment has begun or when a person has absconded before an assessment could start or be completed – assists out-of-hours services in responding accordingly.

Resolving disagreements

14.109 Sometimes there will be differences of opinion between professionals involved in the assessment. There is nothing wrong with disagreements: handled properly these offer an opportunity to safeguard the interests of the patient by widening the discussion about the best way of meeting their needs. Doctors and AMHPs should be ready to consult other professionals, especially care co-ordinators and others involved with the patient's current care, and to consult carers and family, while retaining for themselves the final responsibility for their decision. Where disagreements do occur, professionals should ensure that they discuss these with each other.

14.110 Where there is an unresolved dispute about an application for detention, it is essential that the professionals do not abandon the patient. Instead, they should explore and agree an alternative plan – if necessary on a temporary basis. Such a