REGIONAL INTERAGENCY PROTOCOL ON THE OPERATION OF PLACE OF SAFETY & CONVEYANCE TO HOSPITAL UNDER THE MENTAL HEALTH (NORTHERN IRELAND) ORDER 1986

Author	Social Care Commissioning Lead for Adult Mental Health
Director responsible	Director of Social Care and Children
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1.0 INTRODUCTION

The purpose of this document is to provide a framework for co-operation and joint working between Police Service Northern Ireland (PSNI), Northern Ireland Ambulance Service (NIAS) and Health and Social Care Trusts (HSCT) to ensure that people with / appear to have a mental disorder are managed in a safe, efficient and effective manner when agencies and professional staff are discharging their duties under the Mental Health (NI) Order 1986 (referred to in this document as The Order).

This protocol is based on:

- Mental Health (NI) Order 1986;
- Mental Health (NI) Order 1986 Guide;
- Mental Health (NI) Order 1986 Code of Practice;
- GAIN Network (2011), Guidelines on the Use of the Mental Health (Northern Ireland) Order 1986;
- NPIA (2010), Guidance on Responding to People with Mental Ill Health or Learning Disabilities;
- Police and Criminal Evidence (NI) Order 1989; PACE Codes of Practice (2008);
- Human Rights Act (1998).

The GAIN (Guidelines and Audit Implementation Network) (2011) Guidelines outline professional roles and responsibilities for staff and agencies. They also describe pathways and key processes for assessment and treatment under The Order. It is not the intention to

repeat these here, but rather to identify the potential interfaces between professionals and organisations and promote improved working relationships across these interfaces.

2.0 INTERFACES

The key interfaces when agencies and practitioners are required to work together to ensure the care and safety of a person with a mental disorder and/or the safety of others are:

- When a warrant is required under Article 129 (4 warrants within Article 129) to gain entry and remove patient, if necessary
- When Police use powers under Article 130[1] to remove someone to a “Place of Safety”;
- When Police and ambulance support is required in the course of an assessment under The Order;
- When conveying someone believed to be suffering from a mental disorder to or between hospitals.

3.0 LEAST RESTRICTIVE OPTION

The Code of Practice for The Order[2] outlines a number of principles which include that people experiencing a mental disorder should: “receive any necessary treatment of care with the least degree of control … consistent with their safety and the safety of others”, and “be

[1] Mental Health (Northern Ireland) Order 1986

[2] HMSO (1992), pp 3 - 4)

discharged from any form of constraint or control to which they are subject under The Order immediately this is no longer necessary". In effect patients should be subject only to the level of restriction appropriate to their individual needs and/or to assure the safety of themselves or others; and only for so long as it is required.

If the person found in a public place is willing to accept assistance then the PSNI Officer can offer/provide assistance without having to use any powers.

If the person is compliant; not in need of emergency medical treatment; and the risks are such that they could be safely managed; the person should be returned home by the PSNI and their GP or GP Out of Hours service notified.

If the person is willing to accept assistance, and in need of medical treatment, they should be taken to the nearest hospital Emergency Department (ED) where their medical needs can be attended to and an emergency, urgent or routine mental health assessment arranged by ED staff as appropriate.

In all of these circumstances Police can hand over responsibility for the care and treatment to the relevant health care professional as soon as it is safe to do so.

Clarity in communication between Police Officers and Health Care staff is essential in respect of legal status of the patient (i.e. detained and brought to a Place of Safety under Article 130; or brought voluntarily or at the request of the patient. Police Officers and Healthcare staff should

disclose / discuss any known risks, and be clear about any hand over of responsibility.

4.0 LEGAL CONTEXT

Article 130 of The Order provides the legal basis for Police Officers to act when they find a person in a public place who appears to be suffering from mental disorder. If the individual is in immediate need of care or control Police are empowered to remove that person to a Place of Safety. Police may also detain them for a period of up to 48 hours to facilitate a medical examination by a Medical Practitioner (patient's medical practitioner Article 6) and an interview by an Approved Social Worker (ASW).

Making the decision to use powers under Article 130 does not require the Officer to reach an exact diagnosis, but the person "appears to him to be suffering from a mental disorder and to be in immediate need of care and control".[3]Police should record their rationale for the decision using the National Decision Model

It is important to note that the decision to remove a person to a place of safety does not automatically engage the power to detain that person at the place of safety. These are two separate powers which need to be separately considered by the officer, and detention does not necessarily follow from the decision to remove a person.

[3] Appendix 5

https://www.app.college.police.uk/app-content/national-decision-model

At any stage in the process it is essential that all agencies communicate their decisions to the other agencies / people they are working with.

Police should record a clear rational for decisions using the National Decision Model

4.1 Criteria for Using Powers under Article 130

- The person must be in a place to which the public have access[4].
- It must appear to the Officer that the person may be suffering from a Mental Disorder.
- Removal to a Place of Safety must be in the interests of that person or for the protection of others.

All three criteria must be met before a person may be removed.

5.0 CHOOSING A PLACE OF SAFETY

Article 129 (7)[5] defines a Place of Safety as; any hospital designated as such by the managing Health and Social Care Trust; any Police station, or any other suitable place the occupier of which is willing to temporarily receive the person requiring a Place of Safety. The hospitals designated as Places of Safety by their managing Trusts are contained in Appendix 3.

[4] If the individual is in private premises Article 129 of the outlines the powers available to Police Officers and health professionals to gain access to that person for the purpose of assessment under The Order.

[5] Mental Health (Northern Ireland) Order 1986

5.1 A Person's Own Home

The person's own home may be a suitable Place of Safety providing there is a responsible person willing to keep the person safely until the medical practitioner and ASW can attend. This particularly applies where the individual's residence is a registered residential care or nursing home, or a supported housing scheme where twenty-four hour care staff are available. A partner, spouse or other caring relative may also be able to keep the person safe in a private dwelling until the GP and ASW can attend. This option should be based on the agreement of the carer; the carer's capacity to keep the patient safe; and the officer's assessment of the risks. Considerations to be taken into account include:

- The individual is not in need of immediate medical attention;
- There must be a responsible carer over 18 years who is willing and able to keep the patient safe;
- There has been no threat of violence (particularly towards the carer);
- There is low risk of absconding;
- The carer is not intoxicated or otherwise appears to have limited capacity to undertake the role.

5.2 Hospital

The Emergency Department is the most appropriate place to take an individual if they have sustained injury, are suspected of having taken substances, or have other pressing medical needs.

At present all five Health and Social Care Trusts have identified their hospital Emergency Departments as their designated places of safety.

It is incumbent on Trusts to ensure that their Emergency Departments have the knowledge and resources to fulfil the Place of Safety function.

5.3 Police Station

A Police station should only be used when risks are such that the person could not be managed in any other environment, or a crime/offence has been alleged and it is deemed necessary to keep a person in Police custody until his or her mental health condition has been more clearly determined.

Taking someone to a Police station can wrongly convey the impression that the person has committed a criminal offence. Some Police stations are not well designed for the observation of people who may be at risk of self-harm or who are disturbed. Good practice suggests than an Inspector should be consulted prior to removing an individual to a PSNI custody suite as a place of safety if no criminal behaviours are suspected.

6.0 POLICE SUPPORT AT THE PLACE OF SAFETY

If Police use their powers to remove under Article 130 (or Article 129) the person may be detained in a Place of Safety for a period of up to 48 hours so that they can be examined by a doctor and interviewed by an ASW. The decision to detain the person is a separate power and must be justified separately from the decision to remove the person to the place of safety.

Health and Social Care staff do not have powers (under the Mental Health NI Order 1986) to detain the individual until after the doctor has made a medical recommendation, and an ASW (or Nearest Relative[6]) has made an application for a compulsory admission. Therefore on arrival at a hospital the Officer should alert staff that the person has been brought in under Article 130 (or Article 129), and ensure that the GP and ASW are requested immediately, alongside any triage for medical treatment. The Police should record the time of the request along with the estimated time of arrival of the GP and ASW.

Article 130(3) requires the officer to inform, where practicable, some responsible person residing with that person and the nearest relative of that person of that removal.

GAIN guidance[7] states that local protocols be developed to specify the length of time that an officer can reasonably be expected to remain with the patient at the Place of Safety. This is a difficult challenge as there are a number of factors to be considered.

6.1 Emergency Department

Hospital Emergency Departments currently have a 4 hour target to see and treat all patients; therefore a decision to hold the person to facilitate an assessment under the Order will be made in this timeframe. It may be necessary for PSNI to remain in attendance due to the on-going presentation of the individual and assessed on-going

[6] Article 32

[7] GAIN 2011 p 380

risk. This will require the nursing staff to get a medical practitioner to carry out an assessment under the MHO (see next paragraph)

Subsequent to a medical examination an ED doctor may advise that the patient's presentation would not meet the threshold for a compulsory admission and advise diversion into mainstream services. The Police Officer should at that point discontinue the detention on the basis of the medical advice and hand over the patient to HSC staff for treatment. Any need for on-going Police involvement thereafter should be negotiated on the basis of risks associated with normal policing responsibilities.

6.2 General Practitioner / Medical Practitioner

It is not possible to estimate the response time of GPs as this will be dependent on other clinical pressures and priorities. In an Emergency Department (ED) an ED doctor can make the recommendation in a case of **"urgent necessity"**[8], but this will be judged in terms of clinical need rather than organisational or work pressures. Where a person's own GP, or another GP, can undertake the medical examination under the MHO then they should be asked to do so (Appendix 5)

6.3 Approved Social Worker

ASW standards require a response within one hour of a referral by a doctor who is considering making a medical recommendation for detention. However an ASW cannot make an application before an appropriate doctor has made a medical recommendation.

[8] Article 6c MHO

6.4 Intoxicated Patients

It can be difficult to accurately assess someone's mental state if they are intoxicated. However the fact that the individual has taken alcohol or other substances should not in itself be used to delay the attendance of the medical practitioner, mental health staff or medical treatment. The capacity of the individual to be interviewed effectively should be determined by ED staff. Any decision to delay the attendance of the medical practitioner or ASW will necessarily extend the period of detention for the person. Any decision to delay the attendance should be fully justified and recorded.

The need for continued Police support once the patient has been conveyed to the Place of Safety should be monitored and agreed between police and Emergency Department staff. The Risk Assessment Form (Appendix 2) will assist in this assessment, which should be retained in the medical file.

6.5 The Criteria for Compulsory Admission is Not Met

If the conclusion of the Medical Practitioner's examination and/or /ASW assessment is that an application under the Order is not necessary as the criteria for compulsory admission have not been met, the patient should be released from custody[9]. HSC staff should consider and consult with the "patient" regarding advice and/or the provision of alternate treatment or care. .

The medical practitioner and ASW must ensure that ED and Police and any other practitioner or service involved are advised of the

[9] DHSSPS SSI (March 2005) p 15 Standard 5.3

outcome of the medical examination / ASW assessment before they leave the ED.

7.0 USE OF RESTRAINT OR FORCE

An Officer may use reasonable force, if necessary, in the exercise of powers under Article 130[10]. If force and/or restraint has been used, the Officer should inform health care or custody staff upon arrival at the Place of Safety about the type of restraint used and for how long. If CS spray has been used on a person officers must inform the healthcare staff before the person is brought into the ED. Information on the presence of drugs, alcohol and/or weapons, and any other known risks should also be provided.

Where medication/prescription drugs held lawfully by the patient[11] are found during a search, they should be secured and handed over to health care or custody staff immediately upon arrival at the Place of Safety. PSNI will only assist with a search where there are reasonable grounds to do so.

Officers should not administer medication/prescription drugs to a person with a mental disorder or allow a person with a mental disorder to self-administer their own medication except under direction from a medical professional unless it is in an emergency/life-threatening situation.

[10] Indemnity provided under Article 133 of the Mental Health (Northern Ireland) Order applies to Police Officers as well as Health and Social Care practitioners, "unless the act was done in bad faith or without reasonable care".

[11] As determined by a medicine box having the name of the individual labelled.

8.0 POLICE SUPPORT DURING A COMMUNITY ASSESSMENT

When Police use powers under Article 130 (or Article 129) then the legal custody considerations will largely determine the transfer of responsibility from Police to HSC personnel. However the requirement for Police involvement in these circumstances should be based on the specific risks pertaining at the time. Appendix1 contains a risk assessment that may be used to inform this judgement

Most requests for an assessment for compulsory admission do not come via Police. In circumstances where the GP and ASW are the first attenders, PSNI support should only be requested when the reason for Police attendance is consistent with their statutory functions (protection of life, prevention of crime, to prevent a breach of the peace), and based on an assessment of the risks (using the National Decision Model) associated with the specific circumstance.

Careful consideration should be given to the legal powers which the Police have available to safely manage any assessment conducted in private premises.

The Police have no legal power without warrant to do anything except:

- arrest following an attempted or substantive criminal offence;
- arrest to prevent a breach of the peace or its continuance.

Accordingly, there is no Police power to prevent anything that does not constitute an attempted or substantive criminal offence, or a breach of the peace; and no power to prevent the individual from:

- completely denying access (unless warrant issued);
- moving to a room which can be locked (bathroom/cupboard);
- picking up knives, cutlery or other (improvised) weapons;
- boiling kettles or picking up hot-drinks;
- accessing areas where there are windows/balconies;
- leaving the premises.

There should be no automatic assumption where such an individual leaves premises that Article 130 can automatically be used. The Police Officer must be separately satisfied that the criteria for Article 130 are met.

8.1 Gaining Access to a Person Believed to be Mentally Disordered in Private Premises

If access to a patient in private premises is denied, Article 129 of The Order enables a constable or a member of HSC staff to apply for a warrant to gain access to the person, and if necessary for Police to remove them to a Place of Safety for the purpose of assessment.

It should be noted that warrants granted under Article 129 do not give the ASW access to the private premises, only the constable and the doctor. Therefore if the householder continues to deny access to the ASW the person may need to be removed by Police to a Place of Safety so that the assessment can be completed.

In order to grant a warrant the magistrate must have reasonable cause to suspect there is a person suffering from mental disorder on the premises who:

a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control; or
b) being unable to care for himself, is living alone.

Given the nature of the information required the ASW will ordinarily be in a better position to satisfy the magistrate and therefore the ASW will normally make the application.

The PSNI position is that where there is an anticipated likelihood of resistance, aggression, violence or escape on the part of the person being assessed, the powers afforded by a warrant under Article 129 (1) and (2) significantly improve the abilities of the Officers to proactively deliver a safe conclusion without allowing matters to escalate to the point where a service user is arrested and/or that an attending professional or anyone else is injured.

9.0 TRANSPORT TO HOSPITAL

When Police use their powers under Article 130 (or Article 129) the mode of transportation to a Place of Safety is ultimately at the discretion of the detaining Police Officer, who remains responsible for the person until the GP/ASW assessment is completed and the ASW can take legal custody of the patient; or until the Officer decides that the use of powers is no longer required. Issues for consideration in reaching a decision about the most appropriate way to transport the

patient should include: the well-being and safety of the patient; the safety of Police officers and health and social care staff; the level of threat to the public; and the best use of resources.

9.1 Conveyance by Ambulance

Ideally, persons detained under Article 130 should be conveyed to the Place of Safety by ambulance[12] except where the delay in obtaining an ambulance would escalate an already difficult situation. If necessary the Police should accompany the person in the ambulance to the Place of Safety in order that they remain in the lawful custody. Where possible, gender issues should be addressed, i.e. it is preferable that one of the accompanying officer(s) should be of the same gender as the detained person.

Once the medical recommendation has been made and an ASW application for assessment (detention) has been made, the Order gives the ASW responsibility for making arrangements to have the patient transferred to hospital, along with powers to delegate this task to others. Where safe and appropriate, the ASW should attempt to arrange transport using family members/friends. Where this is not possible the task should be delegated to the ambulance service. On occasion the PSNI may be required to assist NIAS to transport the patient.

On arrival at the scene the Ambulance Crew will carry out a risk assessment in conjunction with the GP, ASW (and Police if they are present). Any on-going Police involvement to assist with conveyance,

[12] GAIN 2011, p 386

including travelling in the ambulance, should be based on the assessment of the particular risks pertaining to that circumstance.

Ambulance crew will make reasonable attempts to assist a patient who may be passively resistant with persuasion, coaxing and/or physical guidance. However where formal, on-going physical restraint is required Police assistance will be sought in taking and conveying the patient to hospital.

Generally 999 calls in relation to mental health problems or suicide attempts are prioritised by Ambulance Control according to their status on the continuum from immediately life threatening through to low risk. An emergency ambulance should only be requested when there is a threat to life. In all other situations non emergency ambulance should be requested. It is therefore important that the Police Officer, GP or ASW making the request articulates the risks pertaining to a particular situation when requesting an ambulance, including the risk of further deterioration of the patient's mental health; distress to the patient and family members; any risks associated with a protracted wait; and any risk of absconding or harm to the patient or others.

GP's and ASWs have the facility to make a "Health care professional urgent" request for an ambulance within a specific timeframe. It may on occasion be appropriate for the GP to use this facility Given that the responsibility for ensuring conveyance falls to the ASW, NIAS call handling staff should not "refuse" the request or insist that it is made by a Doctor.

It is not uncommon for NIAS personnel to attend patients with mental

health problems who have capacity and refuse transport to ED / place of safety. On these occasions NIAS personnel will complete a comprehensive physical health assessment and attempt to maintain patient safety by ensuring the patient remains with a responsible person where possible. The patient will then be referred to their own GP / OOH service. It is not reasonable for NIAS personnel to remain on scene for protracted periods of time while awaiting the GP / OOH GP to attend. NIAS personnel will therefore leave the scene and request that the GP / ASW arranges the appropriate transport following their assessment.

9.2 Conveyance by Police

Where risks are such that a person needs to be conveyed in Police transport, and a requirement for medical supervision is identified, a member of the ambulance crew should accompany the person to the Place of Safety to ensure the immediate availability of personnel trained for medical emergencies and resuscitation. The ambulance should follow behind to ensure the immediate availability of medical personnel and equipment.

Only in exceptional circumstances should Police transport be used to convey the person to hospital for the purpose of obtaining medical care unrelated to their mental condition (e.g. visible wounds or suspected fractures). Such circumstances would include:

- where ambulance control have informed Police of a significant delay; or
- where there are life-threatening circumstances to justify the urgent removal of a person to hospital by Police transport.

Ultimately, this decision will rest with the officer at the scene after discussion with a NIAS clinical support paramedic.

9.3 Police Support where transferring a Patient with Mental Disorder between Hospitals/to Court.

In the course of their care it may be necessary to transfer patients who are detained under the mental health order between hospital settings or from hospital to court. Generally such transfers will involve ambulance service in the conveyancing of the patient. These patients will be known to the Trust and consequently the Trust will make arrangements to have sufficient Trust staff available to accompany the patient to ensure a safe transfer as determined by an assessment of the patient needs. The requirement for Police involvement in these circumstances should be an exceptional requirement based on the specific risks pertaining at the time i.e. a significant danger to the public or Trust staff and/or a high risk of absconding. The Appendix 1 risk assessment may be used to inform this judgement and the decision should be taken jointly between the Trust and the Police. It would only be in circumstances of High Risk under which Police involvement may be required.

10.0 JURISDICTION

If the Doctor and the ASW (or Nearest Relative) agree that the threshold for a compulsory admission has been met it is the responsibility of the medical practitioner involved to identify the hospital to which admission is being sought and to secure a bed. for the patient to b

It is the responsibility of the Trust where the patient is normally resident to admit the patient and consider their detention or otherwise under the Order. If the patient is normally resident outside of the Northern Ireland jurisdiction, it is the responsibility of the Trust in whose area the patient has presented to provide a bed and arrange subsequent transfer to their home area if appropriate.

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RISK ASSESSMENT MATRIX — Appendix 1

Previous History of Person	Current Circumstances	Police Support
Low Risk		
Person has a history of • violence; • active self-harm; • absconding; • other risk behaviour indicators currently present (other than very mild substance use) ***History is*** • ***Infrequent AND historic*** ***OR*** • ***Irrelevant due to circumstances***	Person presenting is ***NOT*** • violent • actively self-harming; • stated intention to abscond; • other risk behaviour indicators ***currently present*** (other than very mild substance use)	Police assistance ***will not be*** required.
Medium Risk		
More than infrequent history of violence or more than AOABH, involving weapons, sexual violence, violence towards HSC staff or vulnerable person **OR** ***LOW RISK patients*** who have disengaged from treatment and where there are MEDIUM RISK threats when disengaged	• Person currently presenting ***some*** behavioural indicators (including substance use) **OR** • Some recent criminal / medical indicators that the individual may be violent OR poses an escape risk OR is a threat to their own or anyone else's safety	Police assistance ***may be*** required.
High Risk		
Significant history of any of the medium risk indicators. ***MEDIUM RISK patients*** who have disengaged from treatment and where there are MEDIUM RISK threats when disengaged	Person currently presenting ***significant*** • behavioural indicators (including substance use) • recent criminal / medical indicators that the individual may be violent OR is a threat to anyone's safety	Police assistance ***will be*** required.

In cases of dispute the joint risk assessment (Appendix 2) will be completed in respect of the person

Appendix 2

JOINT RISK ASSESSMENT

This risk assessment should be completed by nurse in charge and police at emergency department (ED) to determine the need for on-going police involvement when the patient appears to be settled

Patient …… **DOB** ……

Hospital ……**H&C No. …… Date:……**

Please provide detail
Circumstances of attendance *(If under patient brought to ED under Article 130, medical assessment required)*
Has the person, on this occasion, needed restraint to prevent harm to self/others?
Does person's behaviour or history suggest a risk of absconding? [*refer to Missing person's Protocol]*
Has the person harmed/threatened to harm themselves?
Has the person assaulted/ threatened assault to anyone?
Is person suspected to have consumed alcohol/ drugs which is likely to impact on their behaviour?
Has the person been compliant since their detention/removal by Police to a Place of Safety?
Does the Nurse in Charge think the person cannot be managed safely without Police presence,?
Please give reasons not covered above why the Police are believed to be required to remain in attendance
What is the outcome of assessment at this time?
Initials of staff who completed this form (first assessment) - Police and Nurse

If there is a difference of opinion, then reassess in one hour then two hours time

Outcome of first reassessment

Time	Nurse's Name	PSNI Officer's Name	Agreed Action

Outcome of next reassessment

Time	Nurse's Name	PSNI Officer's Name	Agreed Action

Outcome of next reassessment

Time	Nurse's Name	PSNI Officer's Name	Agreed Action

Outcome of next reassessment

Time	Nurse's Name	PSNI Officer's Name	Agreed Action

If there still remains a difference of opinion, situation discussed between

PSNI Duty Inspector (Name…….) and

Senior Nurse on site (Name:…….)

Medical staff, if required (Name:…….)

Please retain this form in the patient's nursing notes/Police should take a copy with them

Appendix 3

HSC Trust Designated Place of Safety

BELFAST HSC TRUST	• ED, Royal Victoria Hospital, Grosvenor Road, Belfast • ED, Mater Hospital, Crumlin Road, Belfast
NORTHEN HSC TRUST	• ED, Antrim Area Hospital, Bush Road, Antrim • ED, Causeway Hospital, New Bridge Road, Coleraine
WESTERN HSC TRUST	• ED, Altnagelvin Hospital, Glenshane Road, Londonderry • ED, South West Acute Hospital, Enniskillen
SOUTHERN HSC TRUST	• ED, Craigavon Area Hospital, 68 Lurgan Road, Portadown • ED, Daisy Hill Hospital, Hospital Road, Newry
SOUTH EASTERN HSC TRUST	• ED, Ulster Hospital, Upper Newtownards Road, Dundonald • ED, Lagan Valley Hospital, Hillsborough Road, Lisburn

Appendix 4

Making best use of the Ambulance Service

INTRODUCTION

The Northern Ireland Ambulance Service Health and Social Care Trust is a regional service, providing emergency and non-emergency medical transport for patients throughout the province. NIAS respond to 600 emergency and 550 non-emergency calls daily. Like all of Northern Ireland's acute trusts we face an increasing workload and we hope that by working in partnership with colleagues across all of the Health Service, we will be able to offer better care to all those who require our assistance.

THE SERVICES WE OFFER:

Emergency calls

Where the patient has a genuine life or limb threatening condition, NIAS should be contacted on 999 for an emergency response,

Urgent calls

Where the patient requires transport to the ED / place of safety but where there is no life / limb threat, an urgent call should be placed to NIAS. Please advise whether you require an emergency ambulance or non-emergency ambulance. An emergency ambulance should only be requested where a patient requires continuous monitoring / assessment or treatment on route to hospital. To arrange this transport, please ring 02890 404040

Routine calls

Many people travelling from home to hospital for clinic appointments or outpatient investigations require ambulance transport because of their clinical condition. This transport is usually requested by the general practitioner for the first appointment and by the hospital department for follow-up visits. Due to the high demand for this service it is vital that it is only utilised by patients whose medical condition requires them to travel by ambulance rather than any other means. These journeys most often involve a minibus-style vehicle picking up several patients on a round trip, and as such are planned 1-2 days in advance. In order to accommodate as many patients as possible, an individual may be collected and left home at times that do not exactly match their appointment with the result that they may have to wait at the hospital before or after their allocated time. It is therefore very difficult to accommodate requests for routine transport at short notice.

Requests for routine transport can be made via our non-emergency control room in Altnagelvin on: 028 7134 7134

Appendix 5

GPs Carrying out Medical Recommendations for Seriously Mentally Ill Patients (Form 3)

Patient Circumstances	Agreed Position
1. Registered practice patient • In community (e.g. home address, school within practice area, social services day centre within practice area) • Monday – Friday (core hours 8.00am -6.30pm)	The patients practice should carry out the visit as part of best practice normal patient care. Form 3 to be completed by visiting GP. No circumstances when this would not apply.
2. Registered practice patient • In a hospital ward detained on a Form 5. Hospital is within the practice area • Monday – Friday (core hours 8.00am -6.30pm)	The patients practice should carry out the visit as part of best practice normal patient care. Form 3 to be completed by visiting GP. The patient is protected by the Form 5 and the medical recommendation (Form 3) visit can be planned (within 48 hours). The Trust need to be aware of the 48 hour "window". [13]
3. Registered practice patient • In A&E (hospital within practice area) • Monday – Friday (core hours 8.00am -6.30pm) (Please note a Form 5 cannot be completed for a patient in A&E)	The patients practice should carry out the visit as part of best practice normal patient care. This should be as soon as is reasonably possible. Form 3 to be completed by visiting GP. There may be a circumstance where the patient (or others) is at immediate risk of harm and the GP is unable to attend quickly enough. In this circumstance the practice is not expected to carry out a medical recommendation (Form 3), the Trust can then take action under "urgent necessity".
4. Registered practice patient • In community (within practice area) • Outside Core Hours (i.e. OOH)	The patient or others are at risk and an alternative arrangement needs to be provided OOH e.g. GP OOH

[13] Arrangements need to be put in place for weekends especially bank holiday weekends where the 48hour window is more likely to be breached.

5. Registered practice patient • In a hospital ward in the practice area • Out of Hours • Form 5 in operation	The patient is protected by the Form 5 and the medical recommendation (Form 3) visit can be planned (Within 48 hours). The Trust need to be aware of the 48 hour "window". [14]
6. Registered practice patient • In A&E(hospital within practice area) • Out of Hours	The patient or others are at risk and an alternative arrangement needs to be provided OOH e.g. GP OOH There may be a circumstance where the patient (or others) is at immediate risk of harm and the GP is unable to attend quickly enough. In this circumstance the GP OOH is not expected to carry out a medical recommendation (Form 3), the Trust can then take action under "urgent necessity".
7. Patient not registered • In practice area • In the community (core hours 8.00am -6.30pm Mon -Fri)	The contacted practice should carry out the visit as the patient needs care i.e. immediately necessary treatment for the assessment of mental state. Form 3 to be completed by visiting GP.
8. Patient not registered or not registered locally (i.e. outside practice area) • In hospital ward (anytime) (Form 5 in operation) • In A&E (core hours 8.00am 6.30pm Mon -Fri)	A local GP arrangement should be provided e.g. local rota under terms of LES
9. Patient not registered or not registered locally • In the community • Out of hours	The patient or others are at risk and an alternative arrangement needs to be provided OOH e.g. GP OOH
10. Any Patient • In a Police Station • Any time	Forensic Medical Officer to carry out medical recommendation.

[14] Arrangements need to be put in place for weekends especially bank holiday weekends where the 48 hour window is more likely to be breached.

Police Use of Place of Safety Powers under Article 130(1) & (2) of the Mental Health (NI) Order 1986