GIRFT
GETTING IT RIGHT FIRST TIME

NHS England

Urgent and emergency care (UEC) mental health in emergency departments

System escalation and action guide

2026-2027



1. ED mental health pathway
2. Section 136 management flowchart
3. Example escalation times and triggers
4. Action cards for system partners

Supporting urgent and emergency mental health care

Contents

Executive summary	4
What is the guide's aim?	4
Who should read this guide?	5
ED mental health pathway	6
Royal College of Psychiatrists example of best practice for ED mental health pathways	6
Section 136 management flowchart	9
Example escalation times and triggers	10
Key clocks to know	13
Blank escalation template	14
Regional action guide	16
ICB action guide	17
AMHP and local authority action guide	18
System Co-ordination Centre action guide	19
Ambulance trust action guide	20
Section 136 action guide – system and provider responsibilities	21
Police action guide – Section 136	22
Acute trust action guide	23
Mental health trust action guide	24
Key monitoring metrics	25

Contributors 27
Appendix 1 Section 136 handover timelines 29
Section 136 step management process 30
Section 136 key expectations 31
Definition of the Section 136 one-hour handover metric 31
Section 136 monitoring metrics 32
Example escalation matrix 34
Glossary 35
References 36

Executive summary

This guide provides a shared operational framework for reducing delays and improving the quality and safety of care for people with mental health needs in urgent and emergency care. It sets out national waiting-time expectations, escalation triggers, accountable roles and monitoring requirements for regional teams, integrated care boards, system co-ordination centres, acute and mental health trusts, local authorities, police and ambulance services. Local systems should use the guide to agree named leads, embed escalation routes, monitor performance and resolve repeated causes of delay.

What is the guide's aim?

This escalation and action guide provides a shared, practical framework for health, social care, police and ambulance partners to prevent avoidable emergency department (ED) attendance, reduce delays and improve the safety, quality and experience of urgent and emergency mental health care. It supports timely assessment, treatment, transfer and discharge for people of all ages, including children and young people, older adults, and people with a learning disability or autism, and strengthens the management of people detained under Section 136. By setting clear expectations for clinical ownership, multi-agency responsibilities, escalation, assurance and learning, the guide aims to ensure that people receive equitable, person-centred care in the most appropriate setting, that prolonged waits and avoidable police involvement are minimised, and that recurring system barriers are identified and resolved.

The escalation and action guide provides practical tools and guidance. The action cards do not duplicate assurance or monitoring processes.

There are specific actions outlined for:

- NHS regional teams;
- Integrated Care Boards (ICBs);
- System Co-ordination Centres (SCCs)
- Acute trusts;
- Mental health trusts;
- Local authorities, specifically approved mental health professionals (AMHPs);
- Police;
- Ambulance trusts.

To support use of the guide, a best practice example of UEC MH pathway, a best practice Section 136 management flowchart and an example of escalation times and triggers for UEC have also been developed.

Who should read this guide?

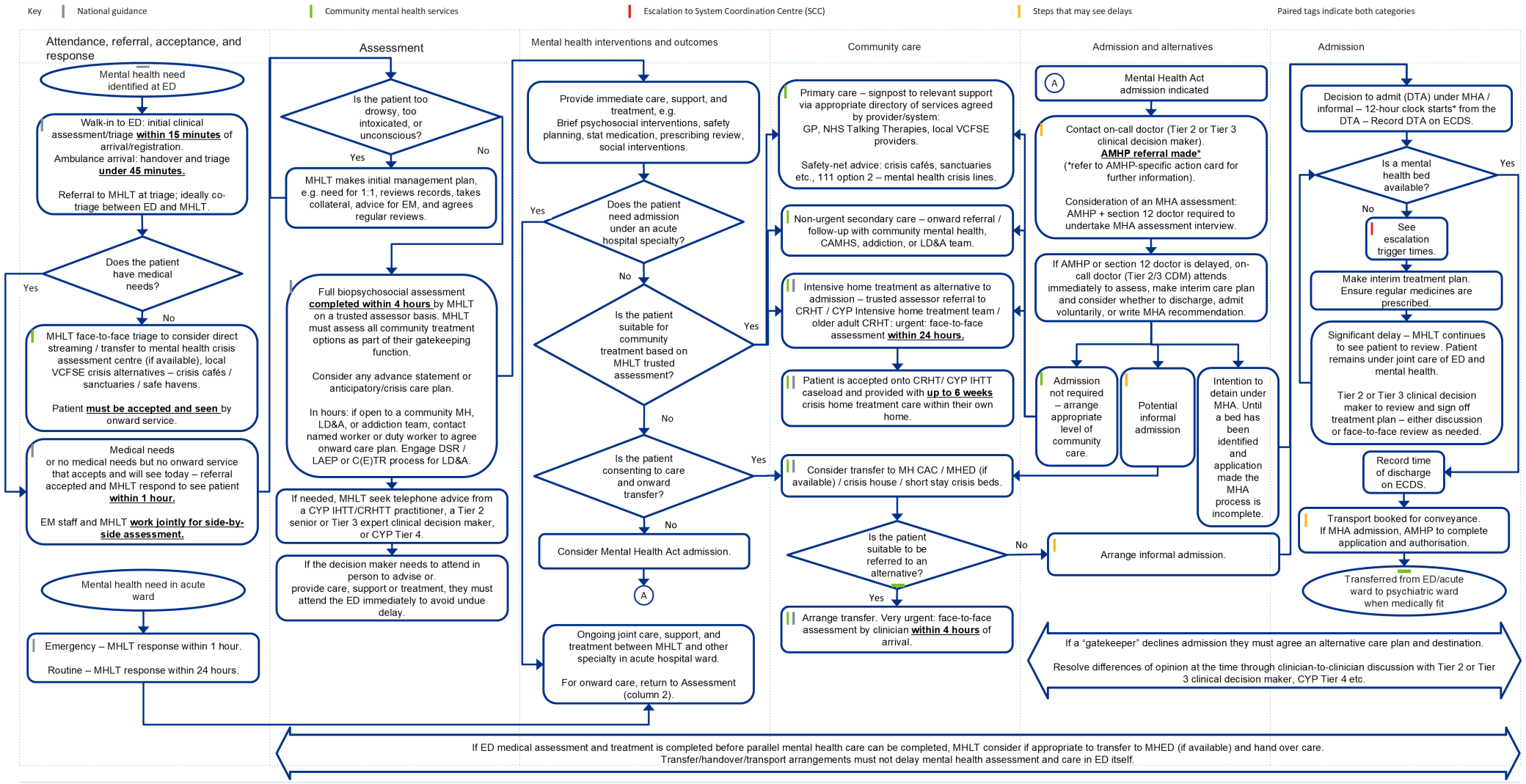
The escalation and action guide is expected to be actively used to support delivery of the medium-term planning framework.

This document is aimed at frontline clinicians in operational teams in acute and mental health trusts working in the UEC mental health pathway. It is also for managers, ICBs, local authorities, police forces, ambulance trusts and regional colleagues. All these groups have a role in:

- awareness and promotion - communicating these out to frontline staff;
- implementation in practice;
- monitoring impact.

ED mental health pathway

Royal College of Psychiatrists example of best practice for ED mental health pathways



Section 136

Purpose

The National Partnership Agreement: Right Care Right Person (RCRP) sets out for health systems to work towards enabling the police to complete handovers of care within one hour of arrival at a place of safety, unless mutually agreed otherwise on a case-by-case basis (e.g., significant levels of risk). In most circumstances, police should seek to use a health-based place of safety (HBPoS) where this option is available, rather than an ED or other place of safety. However, ED should be used where someone also has an urgent physical health need.

Local systems should determine the current average handover times across all places of safety and implement a plan with incremental targets. The targets should be monitored regularly and reviewed where required, including breaches and their causes. The plan should set a clear trajectory towards consistently achieving one-hour handovers.

Healthcare staff should determine when it is safe for the person and healthcare staff to accept legal responsibility for the individual or if the risks are such that police officers are required to continue to provide support. Healthcare staff should, however, seek to take responsibility for the person as soon as possible. This is in line with the commitment to work to end avoidable police involvement in the care of people with mental health needs.

A person may be held for up to 24 hours from arrival at the first place of safety following transport under S136. This does not reset if someone is transferred to another place of safety. If clinical reasons (not operational delays) prevent completion of the assessment within 24 hours, the examining medical practitioner may extend the period of detention to a maximum of 36 hours.

Definition of the Section 136 one-hour handover metric

The Section 136 one-hour handover metric is the elapsed time from the person's recorded arrival at the first designated place of safety, whether a health-based place of safety or an emergency department, to the point at which a registered healthcare professional formally accepts responsibility for the patient from the police.

The handover is completed when the accepting clinician has received sufficient information to assume responsibility safely, has explicitly confirmed acceptance to the police, and the acceptance date and time have been recorded in the relevant clinical or handover record. Police departure time may also be recorded, but if there are delays for police not leaving within the hour, due to non-related reasons i.e., incidents within

the ED, these should be recorded. The measure relates to transfer of responsibility and does not require the initial clinical assessment or Mental Health Act assessment interview to have commenced or been completed. Where formal clinical acceptance occurs more than 60 minutes after arrival, this should be recorded as exceeding the one-hour metric.*

(*local systems may have locally determined handover targets agreed on an interim basis. Performance against these should be monitored through agreed escalation and governance processes, including breaches and their causes, as part of a clear plan with incremental targets to consistently achieve one-hour handovers.)

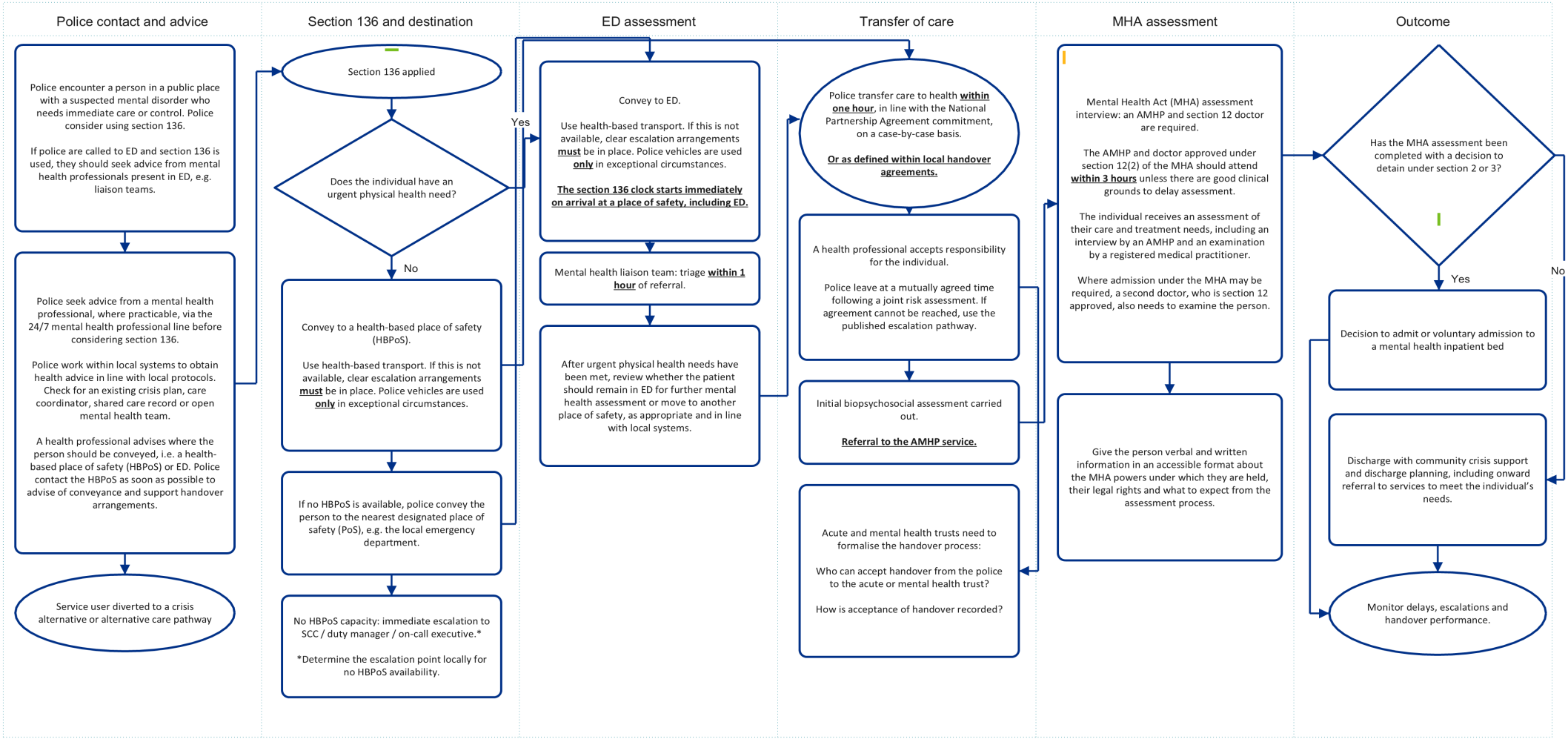
This aligns the measure with the national ambition for police-to-health handovers following use of Section 136 to occur within one hour and with the principle that police involvement should last only as long as necessary.

Local areas should have joint plans for how they work towards achieving this metric, so may be working to interim handover times other than 60 minutes.

Section 136 management flowchart

Example of best practice based on NHS England Right Care, Right Person guidance. See Appendix 1 for further information

Best practice: section 136 management flowchart



Key

| Section 136 applied or decision to detain

| Mental Health Act assessment interview

Example escalation times and triggers

For UEC mental health delays in ED

Situation	Trigger	Escalate from	Escalate to
Section 136 Handover* *Local areas **should** have locally determined/agreed handover targets agreed on an interim basis and therefore adapt this to locally agreed policy.		Police officer	Receiving clinical team
		Police officer	Site/duty manager
		Police officer	Executive
		Police	SCC
Patient waiting in ED for a mental health bed (after DTA)	4 hours	Acute Performance Manager	Mental health liaison ops manager (MH trust)
	6 hours	Divisional manager	Service manager (MH trust) and SCC
	8-12 hours	Deputy COO (Acute)	Head of service (MH trust) and SCC
	12 hours	Deputy COO (Acute)	COO at MH trusts, Regional NHS team and SCC
	24 hours	Acute COO	CEO or delegate officer at MH trust and regional NHS team/SCC
	48 hours	Acute COO (and ensure SCC is sighted)	CEO or delegate officer at MH trust and regional NHS team/SCC
	72 hours	Acute COO or nominated deputy	CEO or delegate officer at MH trust and regional NHS team/SCC

Situation	Trigger	Escalate from	Escalate to
Out Of Area patient in ED/local area mental health bed* * Mental health inpatients presenting at A&E should be supported to return to their mental health hospital placement as soon as clinically ready, with sending mental health providers keeping their bed open where possible. If this is impractical, or a longer spell is needed to treat a patient's physical health needs and the mental health provider closes the bed, the same escalation route for 'Patient waiting in ED for a mental health bed' should apply when they are fit to return to mental health inpatient care for continuing treatment. **Best practice** for patients needing a physical assessment is that they are referred to the relevant speciality, which will not usually be an ED team unless they have an injury.	4 hours	Acute Performance Manager	Mental health liaison ops manager (MH trust)
	6 hours	Divisional Manager	Service manager (MH trust) and SCC
	8-12 hours	Deputy COO (Acute)	Head of service (MH trust) and SCC
	12 hours	Deputy COO (Acute)	COO at MH trusts, Regional NHS team and SCC
	24 hours	Acute COO	CEO or delegate officer at MH trust and regional NHS team/SCC
	48 hours	Acute COO (and ensure SCC is sighted)	CEO or delegate officer at MH trust and regional NHS team/SCC
	72 hours	Acute COO or nominated deputy	CEO or delegate officer at MH trust and regional NHS team/SCC
Patient in Out of Area bed	Up to 24 hours	Patient Flow team	Clinical lead patient flow/AD/ Operational Director through 2 x daily patient flow meeting

Situation	Trigger	Escalate from	Escalate to
	24+ hours (and daily thereafter)	AD/Operational Director (with detail of plan/next steps	Ensure Mental Health COO is sighted on any escalations likely to come. SCC also sighted on plans.
	48+ hours	COO with detail of plan/next steps)	Ensure Mental health CEO is sighted on any escalations likely to come. SCC also sighted on plans.

Key clocks to know

- **Initial assessment (triage) in ED: ≤15 minutes** from arrival/registration. (NHS England, RCEM)
- **Mental health liaison response in ED: ≤1 hour** from referral by ED (face-to-face). (NHS England)
- **Mental health liaison response in ED: ≤24 hour from referral by ward (face-to-face). (NHS England)**
- **Full biopsychosocial assessment and plan (liaison/ED pathway):** within **4 hours** of ED arrival/ward referral (guidance for Core 24/liaison). (www.rcpsych.ac.uk)
- **A&E 4-hour standard (system):** constitutional **95%** seen/treated/admitted/discharged within 4 hours; current **planning aim ≥82%** in 2026/27. (Medium Planning Framework 26/27- 28/29)
- **Crisis service access (community/111/SPA/CRHTT): very urgent ≤4 hours; urgent ≤24 hours** (face-to-face). (NHS England, NHS England Digital)
- **Ambulance handover:** operational push toward **≤45 minutes** maximum handover. (NHS England)
- **12 hours from arrival in A&E:** reported nationally to track long waits (not a constitutional wait-time standard in England). (NHS England)
- **Right Care Right Person National Partnership Agreement:** local areas working towards handovers taking place within one hour as specified in local plans (unless mutually agreed in relation to a particular incident on a case-by-case basis). Police forces and local system partners **need to agree** implementation plans that maintain patient safety and do not impact on broader health services **(NHS England)**

Blank escalation template

Populate locally with agreed escalation contacts and routes

Situation	Trigger	Escalate from	Escalate to
Section 136 Handover* *Local areas **should** have locally determined/agreed handover targets agreed on an interim basis and therefore adapt this to locally agreed policy.			
Patient waiting in ED for a mental health bed (After DTA)	4 hours		
	6 hours		
	8-12 hours		
	12 hours		
	24 hours		
	48 hours		
	72 hours		

Situation	Trigger	Escalate from	Escalate to
Out Of Area patient in ED/local area mental health bed* * Mental health inpatients presenting at A&E should be supported to return to their mental health hospital placement as soon as clinically ready, with sending mental health providers keeping their bed open where possible. If this is impractical, or a longer spell is needed to treat a patient's physical health needs and the mental health provider closes the bed, the same escalation route for 'Patient waiting in ED for a mental health bed' should apply when they are fit to return to mental health inpatient care for continuing treatment. **Best practice** for patients needing a physical assessment is that they are referred to the relevant speciality, which will not usually be an ED team unless they have an injury.	4 hours		
	6 hours		
	8-12 hours		
	12 hours		
	24 hours		
	48 hours		
	72 hours		
Patient in Out of Area Bed	Up to 24 hours		
	24+ hours (and daily thereafter)		
	48+ hours		

Regional action guide

Priority	Required actions	Assurance/escalation
LEADERSHIP	• Set regional direction and co-ordinate provider improvement activity. • Agree escalation protocols with ICBs and SCCs.	• Maintain named regional leads. • Report mental health bed demand and pressures nationally as required.
LONG WAITS	• Maintain daily oversight of people waiting for a mental health bed across each ICB. • Confirm people remain in the most appropriate care setting while waiting.	• Track 12-, 24-, 48- and 72-hour ED waits. • Escalate cases through the agreed route.
PLACEMENTS	• Support ICB and local authority action on complex health and social care placements. • Attend MADEs where external challenge can unblock delay.	• Focus intervention where discharge delay risks prolonged ED waits.
SYSTEM SUPPORT	• Resolve cross-boundary disputes and coordinate mutual aid or specialist capacity. • Support providers when local resolution has been exhausted.	• Escalate unresolved constraints and confirm an accountable owner and next step.

Regional teams provide strategic oversight, unblock cross-system barriers and escalate pressures that cannot be resolved locally.

ICB action guide

Priority	Required actions	Assurance/escalation
GOVERN & ASSURE	• Apply system escalation protocols with providers and the SCC. • Seek daily assurance that people wait in the most appropriate setting. • Ensure that Section 140 arrangements/policies are in place.	• Monitor 12/24/48/72-hour waits by protected characteristics. • Escalate unresolved flow barriers to the region. • Monitor and assure Section 140 arrangement compliance.
CAPACITY	• Map demand and capacity across beds, HBPoS, crisis, housing and discharge services. • Commission Core 24, CRHTT, CAMHS crisis and alternatives to 24/7 specification.	• Address gaps and assure equity of access for adults and CYP. • Monitor implementation of GIRFT UEC mental health clinical operating standards.
ACCESS & PATHWAYS	• Maintain formal referral routes to community and crisis alternatives. • Provide ambulance and police with timely mental health professional advice.	• Keep services visible on the Directory of Services. • Monitor use, handovers and avoidable conveyance.
DIGITAL & FLOW	• Provide real-time visibility of demand, capacity, waits and CRfD status. • Enable shared access to care records and crisis plans.	• Work with social care, housing, MADEs and VCFSE partners to resolve discharge delay.

ICBs should align these actions with OPEL, local escalation protocols and existing commissioning and assurance arrangements.

AMHP and local authority action guide

Priority	Required actions	Assurance/escalation
24/7 ACCESS	• Maintain clear 24/7 arrangements to receive, triage and prioritise referrals. • Provide timely consideration under Section 13(1) of the Mental Health Act.	• Monitor access, decisions and outcomes. • Escalate demand that exceeds available response.
DECISION-MAKING	• Prioritise by risk, urgency, legal necessity and person-centred need. • Apply independent statutory judgement and least-restrictive principles.	• Document and communicate decisions clearly. • Do not assume every referral requires ED attendance or assessment.
ENABLE ASSESSMENT	• Co-ordinate access to the person, relevant information and a suitable environment. • Work with partners to secure Section 12 doctors and admission routes.	• Clarify responsibilities across NHS, local authority and emergency services.
ESCALATE DELAY	• Use multi-agency protocols for AMHP, medical-input or bed delays. • Treat bed and medical availability as system constraints. • Section 140 arrangement delays.	• Review recurring delays and variation in practice. • Preserve AMHP independence within governance arrangements.

AMHP decisions remain independent and statutory; system partners are responsible for enabling timely access, assessment and outcomes.

System Co-ordination Centre action guide

Priority	Required actions	Assurance/escalation
LIVE OVERSIGHT	• Maintain situational awareness of ED waits, CRfD, length of stay and bed demand. • Use real-time tools aligned with SCC operational standards.	• Confirm named leads for long waits, clinical escalation, social care and ambulance.
LONG WAITS	• Seek daily assurance that people remain in the most appropriate care setting. • Track 12-, 24-, 48- and 72-hour waits.	• Trigger local escalation at agreed thresholds. • Make all efforts to ensure patients never stay longer than 48h in ED unless clinically justified, for example a prolonged period of emergency medical treatment and stabilisation before mental health assessment
CO-ORDINATE	• Lead daily executive coordination during pressure. • Bring providers together to resolve flow barriers and disputes.	• Escalate through OPEL and the agreed governance route. • Record owners, actions and time stamps.
UNBLOCK FLOW	• Monitor extended length of stay during increased demand. • Convene focused meetings to resolve cross-system constraints.	• Track actions to closure and escalate barriers that remain unresolved.

The SCC co-ordinates system response and escalation; providers retain responsibility for progressing individual patient pathways.

Ambulance trust action guide

Priority	Required actions	Assurance/escalation
DECISION SUPPORT	• Give crews and control staff timely access to mental health professional advice. • Use shared care records and crisis plans where available.	• Test access to professional advice and shared information. • Escalate access gaps to the ICB.
ALTERNATIVE PATHWAYS	• Use formal referral routes to community and crisis alternatives. • Use the Directory of Services to support clinically appropriate disposition.	• Monitor pathway use and failed referrals. • Escalate gaps that drive avoidable ED or HBPoS conveyance.
CONTROL ROOM	• Use specialist mental health control-room support for CAT 3-5 demand where commissioned. • Apply mental health advice to safe hear-and-treat and conveyance decisions.	• Review demand, response and conveyance patterns. • Raise capacity or pathway constraints through system governance.
SYSTEM COORDINATION	• Nominate an ambulance lead for SCC oversight and escalation. • Share timely ambulance demand and pathway information with system partners.	• Report hear-and-treat, conveyance and CAT 2 response measures. • Follow agreed OPEL and local escalation routes.

Ambulance trusts should use professional advice, shared information and alternative pathways to support safe decisions and avoid unnecessary conveyance.

Section 136 action guide – system and provider responsibilities

Role	Required actions	Assurance/escalation
ICB	• Monitor monthly compliance with one-hour Section 136 handovers. • Review HBPoS utilisation, staffing and demand and capacity. • Commission improvement activity where recurring issues require system change.	• Report breaches to the Mental Health Programme Board. • Review recurring breach themes and track improvement delivery.
SCC	• Monitor every Section 136 handover exceeding 60 minutes.* • Maintain oversight of recurrent system-wide delay causes and support resolution. (*Local areas **should** have interim handover targets agreed. Therefore, adapt this to locally agreed timescales, monitoring breaches, as part of a clear plan to move towards consistently achieving one-hour handovers.)	• Escalate every breach over 60 minutes through the agreed system route.* (*Local areas **should** have interim handover targets agreed. Therefore, adapt this to locally agreed timescales, monitoring breaches, as part of a clear plan to move towards consistently achieving one-hour handovers.)
Acute trust	• EDs receiving Section 136 patients should provide clinician acceptance within one hour wherever safe. • Define responsibility while the person receives healthcare.	• Escalate when transport, staffing or capacity issues risk delaying handover.
Mental health trust	• Maintain 24/7 HBPoS staffing sufficient to accept Section 136 presentations. • Monitor HBPoS occupancy, AMHP and Section 12 availability, and transport delays.	• Executive review of repeated breaches. • Produce a monthly Section 136 dashboard including handover times against trajectory towards one hour metric.

Local systems should nominate accountable leads, define the escalation route and align measures with existing RCRP governance.

Police action guide – Section 136

Phase	Police actions	Handover/escalation
BEFORE S136	• Confirm Section 136 criteria are met and its use is necessary. • The Police must, if it is practicable to do so, consult the 24/7 mental health professional line and check the person's crisis plan or current mental health team.	• Seek health advice on the most suitable destination before conveyance, where practical.
DESTINATION	• Identify any urgent physical healthcare need. • Convey to the HBPoS as the preferred option; use ED when urgent physical healthcare is needed.	• Share relevant risk, legal status and situational information. • Record arrival time at the first designated place of safety.
HANDOVER	• Remain with the person until a registered healthcare professional formally accepts responsibility. • Transfer sufficient information for safe acceptance.	• Ensure the acceptance date and time are recorded. • Depart after acceptance unless a risk assessment agrees an ongoing police role.
DELAY	• Local areas **should** have interim handover targets agreed, as part of a clear plan to move towards consistently achieving one-hour handovers. Therefore, adapt this to locally agreed policy. For example: Trigger a warning at 30 minutes and operational escalation at 45 minutes. • At 60 minutes, escalate through the agreed published route.	• Record the reason for any >60-minute breach and support review within 72 hours.* (*Local areas **should** have interim handover times agreed as part of a clear plan to move towards consistently achieving one-hour handovers and therefore adapt this on locally agreed policy.)

Operational objective: formal healthcare acceptance within one hour of arrival at the first designated place of safety.
Source: NHS England RCRP Phase 4/National Partnership Agreement.

Acute trust action guide

Priority	Required actions	Assurance/escalation
FRONT DOOR	• Refer promptly to Mental Health Liaison and use joint triage to identify alternatives. • Code the primary reason for attendance accurately. • Implement the UEC Mental Health Clinical Operational Standards.	• Escalate when Core 24 response standards are not met. • Apply CYP gatekeeping and placement arrangements. • Assure that the UEC Mental Health Clinical Operational Standards are implemented.
MHA/AMHP	• Refer promptly when Mental Health Act consideration is required. • Provide access to the person, records and a suitable assessment environment.	• Maintain safety and clinical review while decisions are pending. • Escalate AMHP, doctor or bed delay.
CARE WHILE WAITING	• Prioritise by clinical need and risk; agree enhanced observation where required. • Communicate the process and next steps with the person and carers.	• Review CYP risk daily with acute and mental health clinical leaders.
FLOW & ESCALATION	• Add the person to the mental health admissions list and coordinate available beds. • Act on 12/24/48/72-hour escalation protocols.	• Report waits by protected characteristics. • Maintain named operational and executive leads.

Acute trusts retain clinical responsibility while a person is in ED and should use local escalation routes when pathway standards cannot be met.

Mental health trust action guide

Priority	Required actions	Assurance/escalation
LEAD & CAPACITY	• Maintain named operational and executive leads for long waits. • Report bed demand daily and activate staffing surge plans during escalation. • Implement the UEC Mental Health Clinical Operational Standards.	• Map UEC mental health capacity and escalate gaps to the ICB. • Assure PCREF-aligned action. • Assure that the UEC Mental Health Clinical Operational Standards are implemented.
ASSESS & DECIDE	• Jointly triage at the ED front door and consider crisis alternatives. • Provide consultant review for people awaiting a mental health bed.	• Recognise the AMHP/local authority lead for MHA assessment. • Reassess whether admission remains necessary.
TREAT & DISCHARGE	• Start treatment, parallel discharge planning and EDD review early. • Use CRHTT, CAMHS crisis, CMHT and care coordinators to support flow.	• Escalate CRfD delays requiring social support. • Review step-down opportunities daily.
BED FLOW	• Review vacant, closed and out-of-area beds; use mutual aid or OAP only as a last resort. • Balance ED risk against transfer risk and prioritise by clinical need.	• Act on 12/24/48/72-hour escalation protocols. • Track discharge improvement actions. • Patient staying over 40 days for adult acute admissions and > 90 days for older persons.

Mental health trusts should combine clinical ownership, active bed management and discharge planning to minimise avoidable ED delay.

Key monitoring metrics

Systems should routinely monitor the following metrics

Monitoring domain	Core metrics to collect	Key breakdowns/detail
Demand	MH-related ED attendances; ambulance demand; Section 136 presentations; bed requests; waiting-list size	Arrival route, service, location, age group, time/day
ED waiting times	Time from arrival to referral, assessment, decision, bed allocation and transfer/discharge; waits exceeding 12, 24, 48 and 72 hours	Provider, pathway stage and reason for delay
Clinical response	Core 24 responses within 1 and 24 hours; time to psychiatric review; frequency of clinical reassessment while waiting CRHT face to face responses within 4 and 24 hours	Adult/CYP, service, OPEL level
Bed capacity	Occupancy; available, vacant and closed beds; specialist-bed gaps; mutual-aid use; out-of-area placements	Bed type, locality and reason unavailable
Patient flow	Admissions; discharges; crisis-alternative diversions; avoidable ED conveyances; hear-and-treat rates	Referral source, destination and pathway outcome
Length of stay	Median and average LoS; distribution of LoS; patients staying over 60 days	Ward, diagnosis/pathway and cause of extended stay
Discharge readiness	Number of CRfD patients; days delayed after CRfD; estimated discharge dates set within 72 hours	Delay reason, including housing, social care and placement
AMHP/MHA pathway	Time from referral to triage, decision and outcome; AMHP and Section 12 doctor availability; assessment interview outcomes. Section 140 delays.	Out-of-hours, locality and source of delay.
Section 136	Place of safety used and reason if not HBPoS: HBPoS occupancy; handovers exceeding 60 minutes/locally agreed interim targets; transport delays; S136 cases where assessment and admission/discharge not completed within 24 hours.	Place of Safety site, police force area and reasons for delays including staffing/capacity cause.

Monitoring domain	Core metrics to collect	Key breakdowns/detail
Crisis alternatives	Service availability; referrals; acceptance and utilisation rates; outcomes; CRHTT in-reach.	Service type, population group, time/day.
Escalation	Threshold breaches; escalation time; response and resolution time; accountable lead; unresolved and repeated issues.	12/24/48/72-hour trigger and organisation.
Quality and outcomes	All reported patient safety/staff incidents; changes in admission need following review; discharge destination; reattendance/readmission; patient and carer experience.	Outcome, provider and pathway stage.
Equity	Variation in access, waiting, escalation, admission and outcomes.	Ethnicity, age, sex, disability, learning disability/autism and other protected characteristics.

Recommended universal fields: patient pathway stage, provider/site, geography, arrival route, date/time, OPEL level, accountable team and standardised delay reason.

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Appendix 1 Section 136 handover timelines

Purpose

The National Partnership Agreement: Right Care Right Person (RCRP) sets out for health systems to work towards enabling the police to complete handovers of care within 1 hour of arrival at a place of safety, unless mutually agreed otherwise on a case-by-case basis (e.g. significant levels of risk). In most circumstances, police should seek to use a health-based place of safety (HBPoS) when this option is available, rather than an ED or other place of safety. However, ED should be used where someone also has an urgent physical health need.

Local systems should determine the current average handover times across all places of safety and implement a plan with incremental targets. The targets should be monitored regularly and reviewed where required, including breaches and their causes. The plan should set a clear trajectory towards consistently achieving one-hour handovers.

Healthcare staff should determine when it is safe for the person and healthcare staff to accept legal responsibility for the individual or if the risks are such that police officers are required to continue to provide support. Healthcare staff should, however, seek to take responsibility for the person as soon as possible. This is in line with the commitment to work to end avoidable police involvement in the care of people with mental health needs.

A person may be held for up to 24 hours from arrival at the first place of safety following transport under S136. This does not reset if someone is transferred to another place of safety. If clinical reasons (not operational delays) prevent completion of the assessment within 24 hours, the examining medical practitioner may extend the period of detention to a maximum of 36 hours.

Section 136 step management process

- Police encounter person in a public place and consider Section 136 criteria.
- Police must consult health professionals wherever practical via 24/7 mental health professional line to check whether the individual has an existing crisis plan, care co-ordinator, shared care record or open mental health team.
- Apply Section 136 if criteria met.
- Determine whether urgent physical healthcare is required.
- Health professionals to advise location for individual to be conveyed to i.e., health-based place of safety (HBPoS) or ED.
- Convey to ED (if urgent physical health need or if no HBPoS capacity) or HBPoS (preferred if no urgent physical health need).
- Complete police-to-health handover. Seek to transfer care to health within one hour in line with the ambition under the National Partnership Agreement on a case-by-case basis or in line with locally agreed interim targets. Healthcare staff should determine if or when it is safe for the person and healthcare staff to accept legal responsibility for the individual or if police officers may be required to continue to provide support. Healthcare staff should be seeking to take responsibility for the person as soon as is safe to do so.
- Health service accepts responsibility for care.
- Initial assessment and Mental Health Act assessment process, including interview and examination.
- Outcome: inpatient admission/detention OR community crisis support/discharge planning.
- Monitor delays, escalations and pathway performance.

Section 136 key expectations

- Health-based places of safety (HBPoS) should normally be used for Section 136 presentations unless the person has urgent physical health needs requiring emergency department care.
- Police maintain a duty of care for the individual until healthcare staff formally accept responsibility for care.
- Acute and mental health trusts must define the provision the trust will put in place to relieve police of responsibility prior to agreeing to accept responsibility for the patient.
- Once a registered health care professional accepts responsibility for the patient, they must record the acceptance timestamp.
- Police should only need to remain where a specific risk assessment identifies an ongoing requirement.
- Once handover has been completed, police are not generally expected to remain at an HBPoS unless specifically requested due to individual risk or safety considerations.
- Local systems should maintain handover protocols, escalation processes and performance monitoring arrangements.
- Breaches of the 24-hour (or 36 hours with extension) hold time should be reason coded for the breach. The breaches should be reviewed within 72 hours and be reported through local RCRP governance arrangements. When repeated breaches occur conduct a thematic review to identify recurring causes such as staffing shortages, HBPoS capacity, transport availability, AMHP delays, Section 12 availability or other systemic issues should be reported to ICB and regional colleague.

Definition of the Section 136 one-hour handover metric

The Section 136 one-hour handover metric is the elapsed time from the person's recorded arrival at the first designated place of safety, whether a health-based place of safety or an emergency department, to the point at which a registered healthcare professional formally accepts responsibility for the patient from the police. The handover is completed when the accepting clinician has received sufficient information to assume responsibility safely, has explicitly confirmed acceptance to the police, and the acceptance date and time have been recorded in the relevant clinical or handover record. Police departure time may also be recorded, but if there are delays for police not leaving within the hour, due to non-related reasons i.e. incidents within the ED, these should be recorded. The measure relates to transfer of responsibility and does not require the initial clinical assessment or Mental Health Act assessment interview to have commenced or been completed. Where formal clinical acceptance occurs more than 60 minutes after arrival, this should be recorded as exceeding the one-hour metric* (***local systems may have locally determined handover targets agreed on an interim basis. Performance against these should be monitored through agreed escalation and governance processes, including breaches and their causes, as part of a clear plan with incremental targets to consistently achieve one-hour handovers.**)

This aligns the measure with the national ambition for police-to-health handovers following use of Section 136 to occur within one hour and with the principle that police involvement should last only as long as necessary.

Local areas should have joint plans for how they work towards achieving this metric, so may be working to interim handover times other than 60 minutes.

Section 136 monitoring metrics

- Number of Section 136 detentions.
- Arrival time at first place of safety.
- Social demographics of those detained (age, gender and ethnicity).
- Mode of transport and reason if health-based transport is not used.
- Transport delays and waits outside ED/HBPoS awaiting acceptance.
- Type of Place of Safety recorded e.g., ED, HBPoS or police station.
- Time taken for an AMHP to commence MHA assessment interview.
- Time taken for a doctor to commence psychiatric interview and examination as part of assessment process.
- Length of time police remain at Place of Safety.
- Handover duration from police to healthcare.
- Handover completion time.
- Police departure time.
- Percentage handed over within one hour.
- Proportion of detentions where clinical advice sought before detention.
- Response times for clinical advice via professionals' lines and unanswered/abandoned call rates.
- For people taken to ED: whether they had an urgent physical health need and, where applicable, why they were not accepted at a health-based place of safety (HBPoS).
- Average length of stay in HBPoS/proportion of stays exceeding 24 hours (including where decommissioned as a bed).
- Use of restrictive practice while held in HBPoS/emergency departments.
- Numbers and reasons for handovers exceeding one hour, including HBPoS occupancy at time of breach.
- Section 12 delays for MHA assessment requests.
- AMHP delays for MHA assessment interview requests.
- HBPoS utilisation and capacity.
- Total time to complete assessment, including time from detention to completion of assessment process (i.e., not just interview and examination).
- Repeat Section 136 detentions.
- CYP specific metrics.
- Serious incidents recorded relating to someone in ED (or HBPoS) detained under S136.
- Incidents involving delayed access to HBPoS or of someone in ED detained under S136.
- Delays relating to inpatient bed availability.

- Assessment outcomes and onward care arrangements e.g., conversion rates of S136 to MHA admissions, informal admission, community follow up or discharge.
- Equality impacts and variation across different population groups.

Example escalation matrix

Responsibility	Role	Lead name and job role
Accepting handover at HBPoS	HBPoS nurse/clinician	
Accepting handover at ED	Mental Health Liaison/ED clinician	
Escalations	Site manager	
Capacity issues	Duty manager	
System breaches	System Co-ordination Centre	
Executive review	On-call director/executive	

Glossary

AMHP- Approved Mental Health Professionals

CAT- Category

CEO- Chief Executive Officer

CETR- Community Care, Education and Treatment Reviews

COO- Chief Operating Officer

CRfD- Clinically Ready for Discharge

CRHTT- Crisis Resolution Home Treatment Team

CTR- Community Care and Treatment Reviews

CYP- Children and young people

DSR- Dynamic Support Register

DTA- Decision to Admit

ED- Emergency Department

EDD- Estimate Discharge Date

GIRFT- Getting It Right First Time

HBPoS- Health Based Place of Safety

ICB- Integrated Care Board

IHTT- Intensive Home Treatment

LAEP- Local Area Emergency Protocol

LD&A- Learning Disability and Autism

LoS- Length of Stay

MH- Mental Health

MHA- Mental Health Act

MHCAC/MHED- Mental Health Crisis Assessment Centre/Mental Health Emergency Department

MHLT- Mental Health Liaison Team

PCREF- Patient and Carer Race Equality Framework

PoS- Place of Safety

RCPsych- Royal College of Psychiatrists

RCRP- Right Care Right Person

SCC- System Coordination Centres

UEC- Urgent and Emergency Care

VCFSE- Voluntary, Community, Faith and Social Enterprise

References

- Guidance on implementing the National Partnership Agreement: Right Care, Right Person https://www.england.nhs.uk/long-read/guidance-on-implementing-the-national-partnership-agreement-right-care-right-person/#4-phases-of-right-care-right-person-implementation

- Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps02_2013.pdf?sfvrsn=905f05d1_4

- GIRFT UEC Mental Health Clinical Operational Standards April 2026. GIRFT-MH-UEC-Clinical-Operational-Standards-FINAL-April-2026.pdf

- Initial assessment (triage) in ED: ≤15 minutes from arrival/registration. (NHS England, RCEM)

- Mental health liaison response in ED: ≤1 hour from referral by ED (face-to-face). (NHS England)

- Ambulance handover: operational push toward ≤45 minutes maximum handover. (NHS England)

- Full biopsychosocial assessment & plan (liaison/ED pathway): within 4 hours of ED arrival/ward referral (guidance for Core 24/liaison). (www.rcpsych.ac.uk)

- A&E 4-hour standard (system): constitutional 95% seen/treated/admitted/discharged within 4 hours; current planning aim ≥82% in 2026/27. (Medium Planning Framework 26/27- 28/29)

- Crisis service access (community/111/SPA/CRHTT): very urgent ≤4 hours; urgent ≤24 hours (face-to-face). (NHS England, NHS England Digital)

- 12 hours from arrival in A&E: reported nationally to track long waits (not a constitutional wait-time standard in England). (NHS England)

- Section 140 advice on the implementation of Section 140: S140 MHA Act 1983: briefing for clinical commissioning groups and local authority partners

- Dynamic Support Register: Dynamic Support Register and Care, Education and Treatment Review Policy and Guidance:

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