Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title:	**Receipt and Scrutiny of Documents Policy**
Version:	**3**
Reference Number:	**MHL006**

Scope:

This policy assigns roles and responsibilities to certain staff groups and ensures that all actions in relation to the receipt and scrutiny of statutory Mental Health Act (MHA) 1983 documentation takes place within the policy framework.

Purpose:

The purpose of this policy is to ensure there are consistent, efficient and effective systems within the Trust for the receipt and scrutiny of MHA documents. This policy aims to reduce potential errors and protect patient's legal rights. The requirements of this policy aim to inform local protocols identifying staff responsible for the receipt and scrutiny and ensure adequate support and training is available.

Requirement for Policy

Mental Health Act Code of Practice (2015)

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Errors on section papers, rectifiable and non-rectifiable errors, statutory forms, checklist, Fundamentally Defective Applications, Section Paper

Supersedes:

Version 2

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Transferred to the new Trust Template. Appendixes have been designed as TAD and hyperlinked to the policy. Changed to MHL set of policies (Was CO078)

Owner:

Mental Health Law Manager

Individual(s) & group(s) involved in the Development:

This document has been developed in collaboration with the following interested parties:

- Mental Health Law Scrutiny Group
- Acute Care Forum
- Local Borough wide forums

Individual(s) & group(s) involved in the Consultation:	
The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: • Mental Health Law Scrutiny Group • Acute Care Forum • Local Borough wide forums	
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Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
MHL003	Section 132, 132A and 133 Patient Rights Policy
MHL005	Nearest Relative Policy
	Trust Guidance: Fundamentally Defective Applications
Policy Associated Documents:	
TAD_MHL006_01	Guidance Note- Fundamentally Defective Applications
TAD_MHL006_02	MHA Section Paper Checklist
TAD_MHL006_03	Mental Health Act – Statutory Forms (list)
TAD_MHL006_04	Scrutinised Section Papers
TAD_MHL006_05	Template Letter – for rectifying detention documentation under section 15
TAD_CL087_02	Mental Health Law Team (Contact List)
TAD_MHL006_07	List of acceptable names for detention documentation within Pennine Care FT
TAD_MHL006_08	Example of the delegated authority for each hospital: Originals to be kept by the Mental Health Law Manager and available on request.
Other external documentation/resources to which this policy relates:	
CQC Regulations **This policy supports the following CQC regulations:**	

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i. GUIDING PRINCIPLES

It is essential that all those undertaking the functions under the Mental Health Act 1983 (MHA) understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act.

The five overarching principles are:

Least restrictive option and maximising independence

Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Empowerment and involvement

Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Respect and dignity

Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness

Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity

Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Staff must apply all the principles to all decisions. All decisions must be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998 (HRA) and Equality Act 2010. All five sets of principles are of equal importance, and should inform any decision made under the Act. The weight given to each principle in reaching a particular decision will need to be balanced in different ways according to the circumstances and nature of each particular decision.

Any decision to depart from the directions of the policy and the Code of Practice must be justified and documented accordingly in the patient's case notes. Staff should be aware that there is a statutory duty for these reasons to be cogent and appropriate in individual circumstances.

1. INTRODUCTION

Applications under the Mental Health Act 1983 (MHA) must be received and scrutinised on behalf of the 'Hospital Managers'. People acting on these documents need to be assured they constitute authority for a patient's detention. The Trust recognises the importance of providing a clear policy for those staff charged with the delegated role and to protect patient's rights and liberties.

To ensure authority and avoid defective applications being received we delegate responsibility to a limited number of people, who are familiar with the relevant parts of the MHA and have access to training, support and the guidance as set out within this document. This protects patient's legal rights and offers assurance that their records are fit for purpose, accurate and dealt with appropriately and in accordance with legislative requirements.

The Code of Practice, particularly chapter 35 – Receipt and Scrutiny of Documents, has been used in the production of this policy. Key elements of the Code may be reproduced in the policy but it is essential that staff responsible for Receipt and Scrutiny are also familiar with the specific requirements of the legislation and the Code as this must be given due regard and may not be replicated in its entirety within this document.

2. PURPOSE

The purpose of this policy is to ensure there are consistent, efficient and effective systems within the Trust for the receipt and scrutiny of MHA documents. This policy aims to reduce potential errors and protect patient's legal rights. The requirements of this policy aim to inform local protocols identifying staff responsible for the receipt and scrutiny and ensure adequate support and training is available.

The Trust will ensure that the application of any part of this policy does not have an effect of discriminating, directly or indirectly, on grounds of age, gender, sexual orientation, gender status, disability, race, ethnicity, language, mental health need, religion, or belief or social origin.

3. DEFINITIONS

Mental Health Act 1983 (MHA)

The Mental Health Act is the legislation governing all aspects of compulsory admission to hospital, as well as the treatment, welfare, and after-care of detained patients. It also allows for the supervision of people in the community. It provides for mentally disordered persons who need to be detained in hospital in the interests of their health, their own safety or the safety of other persons. Compulsory admission to hospital is often referred to as "sectioning". Altogether there are over 149 separate sections, not all of them allow for detention. The MHA sets out when and how a person can be sectioned and ensures that the rights of those detained are protected.

Hospital Managers (HM)

Hospital Managers have a central role in operating the provisions of the Mental Health Act. In NHS Foundation Trusts, the Trust itself is defined as the 'Managers'. It is the Hospital Managers who have the power to detain patients who have been admitted under the MHA and who have the key responsibility for ensuring that the requirements of the MHA are followed. In particular they must ensure that patients are detained only as the Act allows that their treatment and care accord fully with its provisions and that they are fully informed of and are supported in exercising their statutory rights.

Responsible Clinician (RC)

The RC is the Approved Clinician with overall responsibility for a patient's case. Certain decisions (such as renewing a patient's detention or placing a patient on a Community Treatment Order) can only be taken by the RC.

Nearest Relative (NR)

The NR is identified through a hierarchical list contained within Section 26 of the Act although the patient, any relative, a person who the patient usually resides with or an Approved Mental Health Professional may apply to a County Court for displacement of the NR. The NR is the person who is informed (unless the patient objects) or consulted with regarding a patient's detention, including the right to order discharge of the patient and to object to some provisions of the Act. The term 'nearest relative' should not be confused by the term 'next of kin'.

Approved Mental Health Professional (AMHP)

AMHPs are responsible for key elements of the MHA in conjunction with medical practitioners. They perform a pivotal role in assessing and deciding whether there are grounds to detain mentally disordered people, who meet the statutory criteria, without their consent and completing applications or providing consultation to progress detention.

Duly Completed Application

In the case of civil detentions under Section 2, 3 and 4, a duly completed application comprises of the application form completed by an AMHP and the medical recommendation form(s) completed by the doctor(s).

Fundamentally Defective Applications (FDAs)

The managers may detain a patient on the basis of an application that appears to them (or in practice a person authorised on their behalf to receive it) to be duly made and founded on the necessary medical recommendations. Where the requirements of the MHA have not been complied with a detention may be deemed fundamentally defective and held not

to provide legal authority for continuing detention. This is covered in more detail later in the policy.

Section 15 of the MHA

Some errors on applications and recommendations may be capable of being rectified under s15 of the MHA. This can only be done in the period of 14 days, beginning with the day on which the patient has been admitted to hospital. Within Pennine Care it is only the Mental Health Law Offices who can authorise rectification.

Independent Mental Health Advocates (IMHA)

IMHAs are a statutory right and safeguard for people detained under the MHA. The objective of an IMHA is to provide support and represent the personal views of the patient. IMHAs may be involved in providing patients with information on their rights, medication and any restrictions or conditions to which they are subject.

Receipt of Documents

Receipt involves physically receiving documents and checking that they appear to amount to an application that has been duly made. Upon receipt of documents, checks will be made to ensure the application sufficient to give the managers the power to detain the patient.

Scrutiny of Documents

Scrutiny involves more detailed checking than receipt for omissions, errors and other defects and, where permitted, taking action to have the documents rectified after they have already been acted on

Within this policy we use the terms ‘must’ and ‘should’ and they are to be interpreted in the following way;

- Must – is used to indicate the requirement is a legal or overriding duty or principle. Where staff are unable to complete this requirement they must report this to a manager and request advice as to alternative ways to comply with the legislation.
- Should – is used where the duty or principle may not apply in all situations and circumstances, if there are factors outside the control of staff that may affect how you comply with the policy.

The term patient has been used throughout this policy although it is accepted other terminology may be appropriate such as service user.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

The Trust Board retains overall responsibility for the detention of patients under the MHA. However these powers are delegated to the Mental Health Law Scrutiny Group (MHLSG)

which is responsible for ensuring the requirements of this policy are adhered to. This may be done through the monitoring of issues escalated via the Mental Health Law Manager, Mental Health Law teams and the local borough MHL forums. The MHLSG will review all incidents of Grade 4 and above relating to fundamentally defective detentions.

The group will also take a lead role in ensuring practice lessons have been learnt and on behalf of the group the Mental Health Law Manager will embed findings in policy and training.

The Mental Health Law Forums are responsible for escalating issues to the Mental Health Law Scrutiny Group for investigation and monitoring the use of this policy in the local boroughs. They also have responsibility for ensuring a list is available locally identifying who can receive papers on behalf of the Trust. The MHL Forum will be the first point of escalation for local issues relating to this policy and ensuring training and monitoring is completed in compliance with this document.

Lead Managers, Team Supervisors, Health and Social Care Staff are responsible for the implementation of the policy. Any incidents or breaches of policy should be reported in accordance with the Trust Incident policy and any investigations or actions supported by Line Managers. Line Managers are also required to report any practical issues to the Trust Mental Health Law Manager to facilitate policy change if necessary.

Approved Mental Health Professional (AMHP)

AMHPs are responsible for checking both medical recommendations; as far as they are able, ensuring recommendations upon which the application is founded comply with the provisions of s12 of the MHA.

AMHPs are responsible for ensuring that their applications are completed in full, taking care to comply with the requirements of the Act at all times. If having signed the application form the AMHP discovers a minor and rectifiable error on one of the medical recommendations and it is not possible to contact the relevant doctor to right the error, it is permissible for the patient to be conveyed to the hospital on the authority of the application and for the error to be rectified within the 14 day period permitted by s15 of the MHA in conjunction with the MHL Office. The AMHP should ensure the receiving officer is aware of the error.

Consultant Psychiatrists

Consultant psychiatrists are responsible for ensure that their recommendations are complete in full, taking care to comply with the requirements of the Act at all times and keeping up to date with legal interpretation of the completion of recommendations as distributed through the Trust communication structures i.e. MHL forums.

Medical Managers within each hospital site must nominate a suitable doctor or rota of doctors to be responsible for the clinical scrutiny of medical recommendations on a minimum of a weekly basis (including allocating doctors to cover periods of sick and annual leave) to allow any rectifiable errors to be corrected within the 14 day period

following the patient's detention under s15 of the MHA. The Medical Manager is responsible for notifying the MHL Office of who the nominated doctor is at any time or any changes to the nominated doctor. This doctor must be a consultant psychiatrist.

MHL Administrators (MHLAs) and MHL Assistants

The MHL Offices are formally authorised to act on behalf of the Hospital Managers in receiving and scrutinising section documentation, escalating any issues concerning fundamentally defective applications (FDA – seeTAD_MHL006_01) to the Mental Health Law Manager (MHLM) or MHL Coordinator in the first instance, and rectifying any faults under s15 of the MHA within the statutory period and in consultation with the AMHP and recommending doctors. The administrators are also responsible for advice, training and support in relation to all receipt and scrutiny matters and in situations where an application is deemed to be fundamentally defective following agreement with the MHLM and RC.

MHL Offices are responsible for ensuring that the correct version of the Trust's checklist is used at all times and bring any departures of the use of the checklist for receipt and scrutiny of section papers to the attention of the MHLM.

Mental Health Law Manager (MHLM)

The MHLM has overall responsibility for the operation of this policy including the monitoring and escalation of Trust incidents relating to FDAs (see TAD_MHL006 _01) to the MHLSG, ensuring practices are reviewed and embedded within this policy and associated training. The MHLM is also available to offer advice to clinical teams and the mental health law teams in relation to issues around FDAs. Sections will only be ended following the completion of the FDA form with approval from the MHLM and the decision of the RC.

Ward Manager

Ward managers are responsible for ensuring registered mental health nurses have received adequate training before being added to the local list allowing them to receive and scrutinise statutory documentation upon admission/transfer. Any training needs should be identified and escalated by the ward managers to their local MHL Office in the first instance who will be able to provide training to the ward staff when required.

Ward managers should also ensure that all Grade 4 incidents relating to unlawful sections received by registered mental health nursing staff are discussed in staff handover and supervision sessions to ensure lessons have been learnt and appropriate action plans implemented accordingly.

Ward managers must ensure their staff have access to and an awareness of this policy and that staff work within the framework of this policy.

Ward Staff

During office hours the MHL Office must be contacted to attend the ward, receive and scrutinise all section documentation. For all out of hour's detention the named registered mental health nurse in charge of a ward admitting a detained patient must;

- Receive the statutory paperwork
- Carry out an initial check using the Trust section paper checklist (TAD_MHL006_02) to ensure that the paper work appears to be in order
- Complete form H3, record of detention in hospital only if satisfied that the statutory papers appear to have been duly completed.

Registered mental health nurses are also responsible for escalating any training issues with regards to receipt and scrutiny to their line manager in the first instance or contact the MHL Office for advice.

Ward Clerks/Unit Administrators/Medical Secretaries

Ward Clerks/Unit Administrators/Medical Secretaries are responsible for ensuring all section paperwork is filed within the Mental Health Legislation part of the medical notes including replacing these with copies of scrutinised section paper work as soon as practicable following receipt from the MHL Offices. They are also responsible for ensuring detention and renewal of detention legal documentation is always carried forward into the next volume of notes. This will allow the Care Quality Commission (CQC) to check the validity of detention documentation under the MHA.

5. DELEGATION OF POWERS BY THE TRUST BOARD

The following is a record of the formal delegation of the Trust Board for the powers of receipt and scrutiny. Notably the Trust Board only delegate the power to scrutinise to the Mental Health Law team.

Delegation of Power to Receive and Scrutinise Statutory Documents under the MHA

Pennine Care NHS Foundation Trust as the 'Managers' defined in the MHA authorise the:

- Mental Health Law Administrator
- Mental Health Law Assistant
- Mental Health Law Manager / Mental Health Law Co-ordinator

to receive and scrutinise statutory documents under the MHA at any time, which are to be received by them as the 'Managers'. In accordance with Regulation 4(2) of the MHA, Pennine Care NHS Foundation Trust also authorise the aforesaid to:

a) Consent under sub section (1) of s15 of the MHA to the amendments of the application or any medical recommendations given for the purposes of the application;

b) Consider the sufficiency of the medical recommendations in consultation with a consultant psychiatrist and, if the recommendation is considered insufficient, to give written notice as required by sub-section (2) of s15.

Pennine Care NHS Foundation Trust as the 'Managers' defined in the MHA authorise the:

- Modern Matron/Acute Services Manager
- Registered Mental Health Nurse – Identified by designation locally.

Employed by Pennine Care NHS Foundation Trust to receive statutory documents under the MHA which are to be received by them as the 'Managers' at any time including out of hours.

The Trust board delegate this authority with the assurance of the borough management teams that the staff identified to receipt paperwork will receive suitable training and be familiar with the Receipt and Scrutiny policy.

6. RECEIVING AND SCRUTINISING DOCUMENTS

During office hours the MHL Office must be contacted to attend the ward, receive and scrutinise all section documentation and complete the H3 form. Reasons for not contacting the MHL Office or the MHL Office not being available to accept paperwork must be recorded on the Section Paper Checklist (See TAD_MHL006_02).

When a patient is being received on the application of an AMHP the admitting officer should ask the AMHP to remain on the ward, while staff (ward or MHL Office) go through the documents and check their accuracy using the section paper checklist and completing column No.1.

Once the admitting officer has undertaken the scrutiny of the section papers and accepted them using the statutory form H3 (record of receipt) the original papers must be placed in a safe location and given to the MHL Office on the next working day.

Where papers have been received out of hours, the MHL Office will undertake a second scrutiny of the section papers using the checklist and complete column No.2. Once the section papers have been scrutinised and stamped to confirm MHL administration scrutiny has taken place the MHL Office will photocopy the full section papers and ensure these are taken back to the detaining ward on the same day of receipt. If column No.1. is completed by the MHL Office an additional check by the MHLA or assistant post will be necessary to complete column No.2.

The MHL Office will then ensure that all medical recommendations are medically scrutinised by a Consultant Psychiatrist to ensure the grounds for detaining the patient are appropriate.

This process should take a maximum of one week, allowing for medical scrutiny although administrative scrutiny and inputting of details onto systems must be done by the MHL Office within two working days of receiving the paperwork.

Once the medical scrutiny has taken place the MHL Office will photocopy the fully scrutinised section papers and return them to the detaining ward with a standard note (refer to TAD_MHL006_04) within a maximum of two days. The ward clerk is then

responsible for replacing previous copies of the section papers with the scrutinised copies to be filed away in the patient's medical records.

7. ERRORS ON SECTION PAPERS

When section papers are incorrectly completed, some errors can be corrected under s15 of the Act within 14 days of formal admission and the patient can continue to be legally detained for this period. Wherever possible, the GP/Section 12 doctor and the AMHP should remain on the unit until the papers have been checked to avoid having to return the section papers to rectify minor errors; otherwise it is the responsibility of the MHL Office to arrange for the amendments to take place.

The MHL Office must send the original section paper that requires the amendment to the person who signed the document with a standard Trust letter (refer to TAD_MHL006_05) highlighting the error and the required alteration. A photocopy of the original document must be retained in the MHA file as well as on the healthcare records until the original has been returned to the MHL Office.

A rectified document is then treated as if it had been correctly completed at the time when it was signed. If a document which contains a minor error is not rectified within the 14 day period because the person who signed the original document is on leave or off sick, the application is not thought to be invalidated as the rectification is primarily concerned with dealing with inaccurate recording only.

7.1 Examples of Faults Rectifiable under Section 15

Less serious problems with applications and recommendations may be capable of being rectified and patients may continue to be detained for a limited period while this is completed. The application or recommendation, may within 14 days of admission and with the consent of the managers of the hospital, be amended by the person by whom it was signed.

It is important for the MHL Office to be aware that section 15 does not apply to documents issued by the court, to documents given in support of a patient's transfer under s19, the renewal of the patient's detention under s.20 and s.20(A), the use of the holding powers contained in section 5(2) and (4) or to documents relating to community treatment orders.

Faults which may be capable of rectification include:

- Leaving blank spaces on the form, which should have been completed, other than the space for signing it or for record the doctor's reasons for believing the statutory criteria are satisfied.
- Failure to delete one or more alternative clauses in places where only one can be correct
- Errors in the spelling of names, addresses or places
- Discrepancies in the spelling of a patient's name, in circumstances where there is no doubt the documents refer to the same person.

7.2 Replacement of Insufficient Medical Recommendations

(Section 15(2) and (3) and Regulation 4)

If one of the medical recommendations on which an application is based is found to be insufficient or the two medical recommendations taken together are insufficient, it may be possible to correct the error by having a new recommendation submitted.

A medical recommendation may be insufficient because:

- It has been signed after the date on which the application was made
- The Doctor's reasons in the form do not appear to be sufficient to support the conclusions stated in it (but do not suggest that the conclusions are wrong or have no proper basis)

and recommendations taken together may be insufficient because:

- Longer than 5 clear days has elapsed between the patient being examined by the first and second Doctor
- Neither Doctor is approved under section 12.

If any of these problems turn out simply to be errors in the way the forms were completed (e.g. a date was entered incorrectly), they can be corrected with the consent of the managers as described above. Otherwise, the application is invalid, unless the position can be rectified by a fresh recommendation.

In that case, the managers may notify in writing the AMHP or nearest relative who made the application that the recommendation will have to be disregarded unless it can be replaced, managers may authorise officers to do this on their behalf. (In practice, the MHL Office will also notify the doctor concerned.) If the problem is with two recommendations taken together, the notice can be given in respect of either (but not both).

The applicant has 14 days starting with the day of the patient's admission to arrange for a replacement recommendation to be provided to the hospital managers. The replacement recommendation does not necessarily have to be from the same person who provided the first recommendation.

The new recommendation must comply with all the requirements with which the original recommendation should have complied, except (for obvious reasons) the deadlines by which the original recommendation had to be signed or by which the examination it was based on had to take place.

If a correct replacement medical recommendation is received by (or on behalf of) the managers before the end of the 14 day period starting with the day the patient was admitted, then the application is to be treated as if it were (and always had been) properly supported by the necessary medical recommendations. If not, the application ceases to provide any authority to detain the patient as of the end of the 14 day period.

As with rectification of minor mistakes, an emergency application (made under section 4) may only be corrected in the first 72 hours, unless a second medical recommendation has

been received and the application has, in effect, been converted into a section 2 application for detention.

7.3 Examples of Faults not Rectifiable

Certain faults cannot be corrected and in those cases the section may have to be considered as fundamentally defective and a fresh application made.

Examples of fundamental errors are:

- A review of detention or CTO not taking place before it expires leading to an illegal deprivation of liberty
- an application or medical recommendation which is unsigned, or
- an application signed by a person not qualified to complete it, i.e. an application not signed by an AMHP, a nearest relative, or a person authorised to exercise the nearest relative's functions, or
- a medical recommendation completed by a person without power to make such a recommendation, i.e. a medical recommendation from someone disqualified from making one by reason of section 12, section 12A or the Mental Health (Conflicts of Interest) (England) regulations 2008.[1]

If an application is discovered to be fundamentally defective because of the types of errors set out above (or for any other reason), there is no authority for the patient's detention.

In these circumstances, authority for the patient's detention can only be obtained through a new application (or, in the interim, by the use of section 5 if the patient is already in hospital and is assessed as meeting the criteria for this power).

All efforts should be made by staff involved to proactively deal with issues as quickly as possible, prioritising the work required to resolve the situation and involving the patient and relevant others in all steps taken and the reasons for those being necessary.

All FDAs must be escalated through the MHL Office in the first instance, who will liaise with the Mental Health Law Manager (MHLM) or MHL Coordinator (MHLC) in accordance with the Trust guidance on FDAs which can be found in (TAD_MHL006_01). Sections will only be 'ended' following the completion of the process below with the approval of the MHLM and decision of the Responsible Clinician (RC).

Upon discovery of the error the MHL Office will contact the MHLM or MHLC to discuss. This will be treated as a priority for the MHLM and MHLC and a response will be received within 4 working hours.

The MHL Office will also inform the RC of the error immediately and notify them again once the MHLM approval of the FDA has been returned. The MHL Office will be available to both the RC and nursing team throughout this process to offer advice or assist in any necessary reassessments.

The RC is then to consider information provided by the MHL Team, discuss with Multi-Disciplinary Team and ensure the Care Coordinator is informed. The RC will also lead on

[1] Mental Health (Conflicts of Interest) (England) regulations. 2008. SI 2008/1205.

the discussion with the patient; this will need to take place as soon as possible following receipt of the MHLM approval. Errors and reasons for the ending of the section will need to be clearly explained to the patient and revisited as necessary (revisiting may be delegated to nursing staff). A record of this discussion must be made in the medical notes including the patient's understanding, the FDA form may be used for this purpose to avoid duplicated recording.

The Patient should be offered the opportunity for an Independent Mental Health Advocate (IMHA) to be contacted on their behalf to assist them with their understanding of the reasons for ending the section.

The Doctor's assessment should be completed and recorded in the notes regarding the clinical necessity for continuing detention. If as a result of assessment is requesting a further application the RC may consider the use of emergency powers under section 5 while the actual assessment is completed. If a fresh application is identified as necessary, arrangements should be made following normal processes with support from the nursing staff.

Once all actions above have been completed it will be necessary for the MHL Office to record an incident at Grade 4 on the Trust's incident recording system, this will then generate a formal investigation report.

The MHL Office should also consider impact upon any pending tribunals or certificates of treatment and advise the RC and nursing staff accordingly. Where appropriate they must ensure patients legal representatives or advocates are involved and informed of the decisions taken by the Trust following the discovery.

If an error is detected which would fundamentally invalidate the admission documents out of office hour's assistance should be sought from the AMHP who completed the application and the on call Manager immediately.

8. APPLICATIONS REGARDING COMMUNITY TREATMENT ORDER (CTO)

There are no provisions in the Act for community treatment orders (CTO) and related documents to be rectified once made. Significant errors or inadequacies in the statutory paperwork completed for CTO themselves may render patients' CTO invalid, and errors in recall notices or revocations may invalidate hospital managers' authority to detain.

To avoid errors being made, the MHL Office should be contacted for advice about how the relevant forms should be completed and the Responsible Clinician should allow for opportunity to have them checked in advance by the MHL Office. To facilitate this Responsible Clinician's and ward staff should ensure the MHL Offices are informed of plans to place patients on CTO's at the earliest point following MDT discussions.

Applications for placing a patient on CTO together with supporting documentation must be sent directly to the MHL Office for scrutiny and to be processed accordingly.

The MHL Office must also ensure that all applications are scrutinised administratively by the office, entered onto systems and then medically scrutinised by a consultant psychiatrist. This process should take a maximum of one week, allowing for medical

scrutiny although administrative scrutiny and inputting of details onto systems must be done by the MHL Office within two working days of receiving the paperwork.

9. HOSPITAL ORDERS/COURT ORDERS

Section 15 (allowing the correction of some errors in statutory documentation) does not apply to Hospital Orders or other documents issued by a Court. Unlike civil sections, Hospital Orders are not 'accepted' by the hospital managers and paperwork can not be corrected. Any serious errors identified by the clinical team or MHL Office should be escalated to the MHLM before informing the Clerk of the Court, but should not be thought to invalidate a section unless there is a direction from the Court.

10. RENEWALS UNDER SECTION 20 AND SECTION S20A

All section renewal documents must be furnished to the MHL Office before the patients section expires. The MHL Office must scrutinise the statutory renewal forms to ensure that they have been correctly completed, signed, dated and the patient has been examined within the legal time frame (2 months before expiry).

Statutory forms which have errors, but are not covered by s15 of the MHA may sometimes be amended if for example the renewal date has not yet taken effect. Alternatively if the error is a minor one, it should not be thought to invalidate the section and a file note should be made and kept with the paperwork both in the MHL Office file and in the patient's healthcare records.

The MHL Office must ensure that all renewal applications are administratively scrutinised by the office and then medically scrutinised by a consultant psychiatrist.

The MHL Offices must input the details of the renewal onto the relevant systems within 2 working days of the renewal meeting or receipt of the renewal papers, whichever is the later, taking place.

11. TRANSFERS – SECTION 19

Section 19 allows the transfer of patients between hospitals. Upon receiving the paperwork from the other site (internal or external) the MHL Office must scrutinise the documents using a section paper checklist to evidence this has been done within two working days of admission.

To allow this to occur, other staff within the borough must notify the MHL Office at the earliest opportunity when a transfer is planned or has occurred. The MHL Forums should ensure bed management protocols include the requirement to notify the MHL Office for all detained patients.

When unplanned transfers occur in hours the MHL Office must be contacted to accept the transfer paperwork and complete the scrutiny. Out of Hours transfers must only be received by those authorised to do so.

Where transfers are planned in advance the MHL Office will contact the originating hospital and request current detention papers are faxed in advance wherever possible for scrutiny. This allows any issues to be resolved prior to transfer and avoids unnecessary impact on patients and staff at the receiving hospital.

If the papers for a transferred patient are found to be fundamentally defective then the stage of the transfer will dictate the response of the MHL Office and clinical staff;

- When notified of the transfer in advance and papers have been faxed to the MHL Office for scrutiny, issues will be communicated back to the admitting consultant, local ward staff and the current hospital by the MHL Office. This will outline the issues found and recommendation for action to be taken prior to the transfer being completed
    - When the patient has already arrived at the hospital and accompanying paperwork is found to be defective, the MHL Office will advise the admitting consultant, local ward and the transferring hospital staff of the errors and agreement should be reached prior to the transfer form being signed by the receiving borough. Outcomes may be;
    - Grant section 17 leave to the 'new' ward until the errors are rectified (not available if the error invalidates the detention).
    - FDA process completed by originating borough and decision made about legal process for either returning patient (patient consent needed) to the originating borough or new assessments being completed by the new ward and consultant.
    - Transfer is accepted but errors are rectified by new borough (minor errors or FDA dependent on individual circumstances).

12. TRAINING

The Trust Board delegate authority to staff who have undertaken the minimum suitable training in the requirements of the MHA relating to Receipt and Scrutiny of statutory documents, training is delivered by the MHL Offices as requested by ward managers and inpatient service managers.

A list must be available locally of the staff who have undertaken training with the MHL Administrators and are able to receive paperwork. The MHL team will be responsible for ensuring they are trained and able to receipt and scrutinise paperwork on behalf of the Trust Board.

The minimum standard for training is;

- An understanding of the requirements of the Act in relation to applications and recommendations
- A demonstrated ability to complete the section paper checklist
- Understanding of this policy and have read Chapter 35 of the Code of Practice

A list is to be kept in the MHL Office of all who have received training and evidence of receipt of the above document and available to ward managers or the MHLM on request.

It is expected that local induction programmes for the designations identified as being able to receipt paperwork will include MHL Administrator training. Ward Managers and Inpatient

Managers are responsible for updating local induction programmes and notifying the MHL Administrator at the earliest opportunity of new starters.

13. MONITORING OF THIS POLICY

The Trust will monitor each fundamentally defective application through the existing governance processes with each occurrence being recorded as a Grade 4 Incident which will generate an investigation report. It is the responsibility of the Mental Health Law Office to ensure this is completed with the local team.

The Trust will monitor the use of this policy through the Mental Health Law Scrutiny Group where incidents will be reviewed and recommendations made where appropriate. Audits will be recommended by the MHLSG as and when considered appropriate.

As part of the above monitoring the Mental Health Law Manager will consider how any learning requirements will be addressed with staff.

Ward views are distributed to the teams on a weekly basis by the MHL Offices and identify all detained patients. These ward views must be used by the ward managers to identify any patients that the MHL Office do not have the details of and discussing with the MHL Office immediately (if identified out of hours a message must be left on the answering machine). The ward views must also be scrutinised by the MHL team on a weekly basis and checked for accuracy.

Adherence to this policy is to be discussed in supervision with the staff identified as having delegated authority from the Trust Board.

The effective application of this policy, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

14. IMPACT ON REGISTRATION

This policy is evidence of the Trust's compliance with Outcome 21, Records of the Care Quality Commission Registration.

This policy will be available to visiting Mental Health Act Commissioners from the Care Quality Commission and will be included in responses to site visits.

This policy will be referred to when a Grade 4 incident relating to section papers is completed.

15. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using

the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure

16. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

17. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

18. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

19. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

20. REFERENCES

Mental Health Act Manual, Richard Jones, Eighteenth Edition

Code of Practice Mental Health Act 1983, Department of Health 2015

Reference Guide to the Mental Health Act 1983, Department of Health 2015