Mental Health Act Compliance in Acute Hospital Trusts

How compliant are acute trusts with the MHA, and do SLAs with mental health trusts ensure a safe and legal experience for mental health patients in their care?

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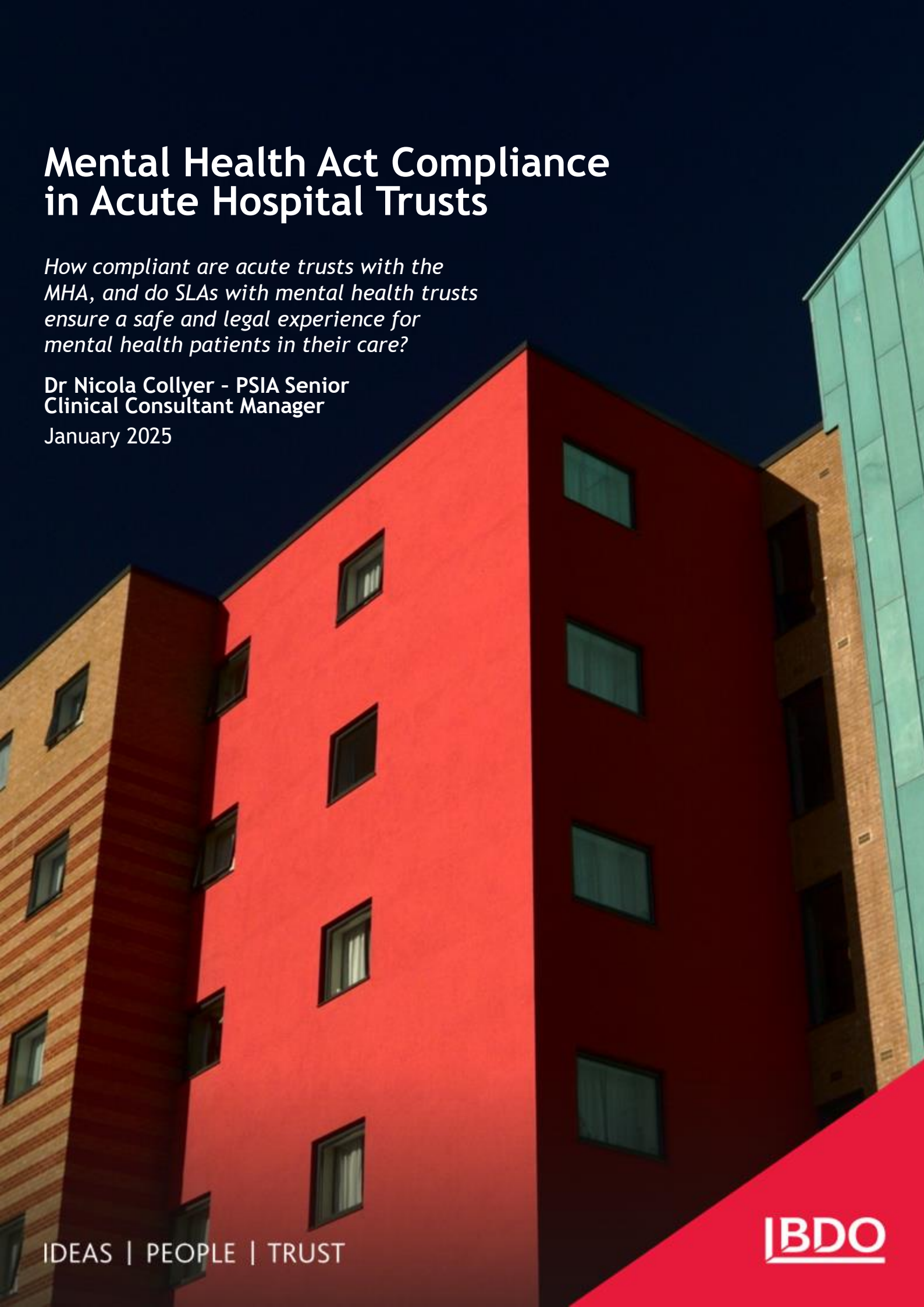

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Introduction

The Mental Health Act – Introduction and Executive Summary

INTRODUCTION

Usually, when patients are treated in hospital, they have agreed or volunteered to be there. However, there are cases when a person can be detained, also known as 'sectioned', under the Mental Health Act 1983 (MHA), and treated without their consent.

The MHA is the main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. Those detained under the MHA require urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

In October 2020, the Care Quality Commission (CQC) published a report, 'Assessment of mental health services in acute trusts'. Their key findings pertinent to acute trusts were:

- Trust Boards did not always see mental health care as part of the overall provision of care, with a lack of oversight
- Staff were often unclear about the MHA and the legal process for detaining someone in hospital
- Staff felt unsupported and unprepared to meet the mental health needs of their patients, and that training varied.

When a patient needs to be detained while in an acute hospital, staff need to be clear about what the legal process is for this. This includes informing a patient of their rights under the MHA, completing the paperwork required to detain a patient under the MHA, and sharing this with the relevant MHA administrator.

There are different sections of the Mental Health Act that have different aims, for example Section 2 allows compulsory admission for assessment, or assessment followed by treatment. It can last up to 28 days and is the most common way for people to be detained while receiving treatment in an acute hospital.

Most acute trusts delegate mental health care to a mental health trust they partner with, and the process is governed through a service level agreement (SLA). An SLA is a written contract between the acute trust and mental health trust that outlines the services to be provided, the standards to be met, and how performance will be measured.

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Best practice dictates that an SLA should include, as a minimum, the following criteria:

- **Parties involved** - Who is involved in the agreement, their roles and responsibilities, and how to contact them
- **Services** - What services will be provided, and any related details
- **Performance** - What the service availability and performance standards are, and how performance will be measured
- **Exclusions** - What services or aspects of service delivery are not covered by the agreement
- **Security** - What security protocols and standards the provider will maintain, and how they will protect customer data
- **Redress** - What penalties will be incurred if either party does not fulfil the terms of the agreement

Robust SLAs between acute and mental health trusts should ensure that due legal process is followed when detaining patients under the MHA, and that the health and wellbeing of the patient is safeguarded.

Our Briefing note

This paper outlines:

- Summary of the MHA and role of SLAs in the provision of mental health services to those patients detained at an acute trust
- Key themes that have arisen in our reviews of acute trusts partnering with mental health trusts
- Main factors Audit and/or Quality Committees should consider, and good practice observed at other organisations.

These are divided into four key areas:

- MHA policies, procedures and SLAs
- Section papers and scrutiny
- Patient rights
- Training

It should be recognised that case study examples provided here are illustrative and should not be taken as comprehensive. Inclusion of an example is also not an expression of opinion over the actual effectiveness of these measures. Users of this document should also be aware that effective SLAs should be sufficiently specific to each individual Trust, and achieved through appropriate stakeholder engagement.

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All the acute trusts we work with, that were included in this review, have a partnership with at least one local mental health trust for the delivery of mental health services to those patients detained under the MHA while in their care. Larger acute trusts sometimes have two mental health trust partners where the geographical location of hospital sites make this necessary.

Robust SLAs are crucial to ensure that all parties are clear as to who provides what service to mental health patients, what standards are expected, and how performance is measured. All but one of the acute trusts we work with were able to produce an SLA for us to review, however the veracity of the documents varied considerably, and left some trusts vulnerable to service gaps. The majority of SLAs reviewed were considerably out of date, and most were vague, with limited detailing of day-to-day operating procedures, responsibilities and obligations. As a result, a number of trusts we work with were unable to show consistent compliance with the MHA in key areas such as section paper documentation and the reading of patient rights.

Appropriate documentation is required by law to be in place to support the decision to detain a patient under any section of the MHA. The paperwork required to legally detain someone under the relevant section of the MHA is clearly defined, and copies of such completed documentation should be easily accessible and available to all staff responsible for their care. In addition, 'receipt and scrutiny' is the process of checking that the section papers for patients who are to be detained under the MHA are legally correct. On the whole, the trusts we work with demonstrated a rigorous receipt and scrutiny process, ensuring all the relevant paperwork required under the MHA was completed. The universal issue was in how and where this documentation was stored. As it is often the partnering mental health trusts' responsibility to document and store all the legal paperwork, this is mostly done on the mental health trusts electronic record system, meaning that staff at the acute trust have limited or no access to this important information. Our reviews highlighted instances where acute staff were unaware of the detention status of their patient, or were unable to provide the correct paperwork on request. This lack of oversight by the acute trusts has the potential to endanger the patient, or others, and thus places the acute trust(s) at significant risk.

Per the MHA, patients have the right to be informed about the reasoning for their detention under a section. This ensures that there is transparency, patient autonomy, and dignity in mental health treatment. Generally, the documentation of the reading of patients' rights was poor across all the acute trusts we reviewed. In most cases it was unclear as to whose responsibility it was to read the patient their rights; the acute staff or mental health trust staff. If a patient is not read their rights (or this is not documented appropriately), it is possible a patient will lose their right to appeal against their section. As such, all the trusts reviewed were largely

EXECUTIVE SUMMARY

non-compliant with this aspect of the MHA, and at risk of depriving their patients of their liberty.

For staff to provide high-quality care for their patients' mental health needs, they need to receive appropriate training. Although it is acknowledged that acute trusts are not mental health trusts, it is vital that those acute trusts looking after detained patients have specific programmes in place for staff to ensure that they are adhering to the MHA and giving the best possible care to their patients. Of the acute trusts we reviewed, most had inadequate training opportunities for staff, or failed to take up the training opportunities provided by their mental health trust partner(s). This appears to have led to significant knowledge gaps for acute staff in some areas of the MHA, and jeopardized their trusts compliance with this important legislation.

This report demonstrates there is clearly room for improvement in how acute trusts comply with the MHA, and the findings of the CQC 'Assessment of mental health services in acute trusts' report of 2020 are still valid. Most of the issues highlighted can be solved with a robust and tailored SLA in situ. It is vital that those acute trusts delegating tasks to a mental health trust partner spend the necessary time updating, or implementing, a detailed and specific contract that provides sufficient assurance that their mental health patients are being adequately cared for, in line with the legislation laid down in the MHA. Although governance structures have not been explicitly explored as part of this review, it is important that trusts examine their governance structures so they can be effectively assured as to their MHA compliance, and ensure there is sufficient scrutiny. If not already included, consideration should be given to including non-compliance with the MHA as part of the trust risk register.

This report did not delve into the issues around attitudes towards mental health and culture, however this is an important, additional consideration for Trust Boards. A positive and proactive approach towards mental health has been proven to be strongly correlated with MHA compliance. The delegation of mental health related tasks to a mental health partner does not absolve an acute trust of responsibility toward their patient, and a holistic and considered approach to a detained patient's needs should not only lead to a better patient experience, but a safe and legal one.

Key themes arising from BDO Compliance reviews at Acute Trusts

1. Policies, procedures and service level agreements

- A detailed, specific SLA with any partnering mental health trust(s) is crucial for ensuring standards are maintained, performance is measurable, and that there is sufficient oversight in place to guarantee compliance with all aspects of the MHA
- Regular reviews and updates of SLAs are vital to ensure trusts remains up-to-date with local and national policies, and MHA-specific legislation
- Sufficient oversight at Board level is necessary in terms of the cultural emphasis placed on the importance of looking after those patients detained under the MHA. The 'Tone from the Top' drives cultural change from one of apathy to one of care and empathy.

2. Section papers and scrutiny

- Clear and detailed SOPs pertaining to the detention of patients under the MHA should be available, and easily accessible, to all staff responsible for the day-to-day care of a sectioned patient
- A data sharing agreement between the acute trust and partnering mental health trust is necessary for the safe care of patients detained under the MHA
- A rigorous receipt and scrutiny process is essential to ensure patients have been detained legally under the MHA. A discreet, two-part scrutiny process is deemed to be the gold standard.

3. Patient rights

- Documentation pertaining to the reading of patients' rights is generally poor and demonstrates non-compliance with the MHA
- Clear SOPs regarding the responsibilities of reading and documenting patients' rights should be available to all staff who have a duty of care to the patient
- Regular reviews of the documentation regarding the reading of rights will help address areas of concern and highlight gaps in knowledge and written SOPs.

4. Training

- The SLA should include the yearly amount of training (in WTE hours) to be offered by the mental health trust to the acute trust
- A training needs assessment should be conducted to determine the extent of any knowledge gaps and to tailor any training accordingly
- Thought should be given to the inclusion of key MHA legislation to all clinical staff as part of acute trust induction, and through yearly mandatory training
- Any ad-hoc training opportunities for staff need to be clearly advertised
- All training offered should be monitored, with adequate attendance records kept, to ensure all staff who would benefit from MHA training are compliant
- A regular review of training uptake and content should be undertaken by the acute trust to ensure that staff are receiving sufficient and adequate instruction.

Policies, Procedures & Service Level Agreements

Policies, procedures & SLA considerations

All the acute trusts we work with have a partnership with at least one local mental health trust for the delivery of mental health services to those patients detained under the MHA while in their care. The larger acute trusts sometimes had two mental health trust partners where the geographical location of hospital sites made this necessary.

Robust SLAs are crucial to ensure that all parties are clear as to who provides what service to mental health patients, what standards are expected, and how performance is measured. Best practice dictates that an SLA should include, as a minimum, the following criteria:

- Parties involved - Who is involved in the agreement, their roles and responsibilities, and how to contact them
- Services - What services will be provided, and any related details
- Performance - What the service availability and performance standards are, and how performance will be measured
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- Security - What security protocols and standards the provider will maintain, and how they will protect customer data
- Redress - What penalties will be incurred if either party does not fulfil the terms of the agreement

Detailed and specific SLAs between acute and mental health trusts should ensure that due legal process is followed when detaining patients under the MHA, and that the health and wellbeing of the patient is safeguarded.

Case Study 1

At one acute trust we work with, we assessed whether their MHA policy and procedure documents were up to date, readily available to relevant staff, appropriately approved and included roles and responsibilities. Most of these documents were included within the SLAs with the two mental health trusts the acute trust collaborates with to provide MHA administration.

It is unclear whether the SLAs in place between the acute trust and the relevant mental health trusts were up-to-date. One SLA was out of date by over a year, and the other was not dated at all.

Despite this, the SLAs reviewed appeared comprehensive in terms of obligations and service specifications. Examples of good practice found within both SLAs included:

SLA One:

- Clear Standard Operating Procedures (SOPs) detailing how, by when, to whom, and by whom, Section papers should be stored with the Mental Health Law Office
- Up-to-date contact details for Mental Health Law Office Administrator and Psychiatric Liaison team in addition to Mental Health Act Operational Lead and Deputy Head of Mental Health Law
- Defined responsibility for the scrutinising of section papers
- Clear obligations for both the mental health trust and acute trust
- Detailed service specification.

SLA Two:

- Clearly defined obligations for both the mental health trust and acute trust
- Detailed service specification.

SLA One went into greater depth with SOPs than SLA Two. This was likely out of necessity owing to the larger population size at one of the acute hospital sites. As a result, the Mental Health Law Team based at the large acute site were able to present a range of materials that they have produced for ward staff, including:

- Mental Health Law Office contact information posters (displayed on all wards and within A&E)
- Webinar Training Information invitation sheets/emails (sent to all staff at regular intervals and displayed on trust notice boards)
- MHA Section Paper SOP flow charts for wards (available to staff electronically and displayed on all wards and within A&E).

The level of detail in the SOPs and obligations within SLA One seemed appropriate for the high number of patients that could be detained under the MHA at any one time on the large acute hospital site. Ward and A&E staff were familiar with protocols regarding the MHA and knew where original and copies of section papers should be stored. The Mental Health Law Office expressed some concern that ward staff did not understand their obligations in regards to the reading of Section 132 rights (a concern that was supported by the findings of our audit) or completion of H3/H4 forms, and as such they have largely taken on this role themselves. This could be an area where further training in SOPs would be valuable in ensuring consistently smooth and lawful detention under the MHA.

SLA Two was lighter on detail, and although obligations and service specifications were defined, there was less written guidance available to ward and A&E staff from the Mental Health Act Administrators on SOPs for the MHA. This meant that the service was reliant on individual staff knowing the system, as opposed to documented process. Although there were no reported concerns from the Mental Health Act Administrators, it does leave the system vulnerable to mistakes in the case of staff absence, staff turnover or unprecedented high volumes of patients requiring detention under the MHA.

Case Study 2

Another acute trust we work with receives mental health support through a Mental Health Liaison team (MHLT) and a MHA Administration Team from a local mental health trust. The individuals within these teams are employees of the mental health trust but work closely, and sit on site, with acute trust employees.

There is a service specification in place which details that a MHLT is to be provided by the mental health trust to the acute trust, commissioned by a CCG. This document was over a year past its review date, and a more current service specification was not in place. The version we reviewed had tracked changes and comments suggesting that it could still have been in draft. Additionally, the document referred to a CCG rather than an ICB, suggesting it was historical. It was also unclear as to who the author of the document was, a prior CCG, mental health trust, acute trust, or a collaboration.

The acute trusts' 'Sectioned Patients Policy' stated "[The mental health trust] have a defined Service level Agreement (SLA) with [the acute trust] and support the trust in the administration of the Mental Health Act for detained patients". However, the acute trust were unable to produce an SLA for our review.

The Sectioned Patients Policy outlined the scope of services the mental health trust provides to the acute trust to enable the acute trust to meet the mental health needs of their detained patients. This included the services provided by the Mental Health Liaison team and the expected outcomes from this, such as mental health assessments, training and direct patient care. MHLT Consultant Psychiatrists were Responsible Clinicians within the acute trust. As Approved Clinicians, they took overall responsibility for any mental health needs of detained patients at the acute trust, including decisions on section renewal, section discharge or community treatment orders.

Through our review of the policy, and detailed conversations with the acute trust Adult Safeguarding Lead, and mental health trust Lead Nurse, we determined that both the acute and mental health trusts were clear on who was responsible for what in terms of the service provision for detained patients at the acute trust. However, without an SLA, the acute trust cannot assure itself that activity is as agreed, or monitor the performance of the mental health trust in discharging its responsibilities. Without this ability, the acute trust leaves itself open to the possibility of failing its detained patients.

Case Study 3

A further Trust we work with has SLAs in place with two local mental health trusts for the provision of mental health services across their two acute hospital sites. The main services offered by the two mental health trusts are, the provision of scrutiny over mental health documentation, the handling of appeals, and a liaison service, where guidance is sought by the acute trust where cases are complex.

Acute trust staff are responsible for the completion of mental health administrative requirements, which are subsequently submitted to the respective mental health trust for scrutiny, whereby compliance checks are completed, and any gaps are identified.

SLA One:

The acute trust had an SLA in place with a mental health trust to provide several services to the Trust, which was signed by the Director of Business Strategy and dated. The SLA was reviewed six months later and extended for a period of six months. When we reviewed the SLA we identified that the agreement was out of date by over a year, and had limited detailed description for the provision of the mental health act administration services provided. The SLA only included Whole Time Equivalent (WTE) hours of service to be provided by the mental health trust. The SLA stated that monthly review meetings should be held between the parties to review overall performance. However, there was no evidence that these periodic reviews take place.

SLA Two:

The acute trusts second SLA had not been reviewed or updated for several years. The services outlined in the SLA focused on compliance checks on MHA documentation, specialist MHA administration support, and training. A significantly out of date SLA is very likely to result in inconsistent service delivery, due to organic changes in SOPs at the trust over time, affecting the quality and equity of care delivered to mental health patients. Lack of clear KPIs could also lead to service expectations not being addressed, therefore decreasing the trust's ability to assess the effectiveness and legality of care provided to detained patients.

Key Questions

- Does the acute trust have an SLA in place between it and its mental health partner trust(s)?
- Are the SLAs sufficiently robust, specific and within date, and do they have appropriate review dates in place?
- Do the SLAs include clearly defined KPIs agreed by both parties?
- Is there a monitoring mechanism in place to ensure that KPIs are reviewed regularly, and performance is measured against expectations? What are the governance arrangements to ensure that there is sufficient scrutiny over this?
- Do acute ward staff have access to written SOPs for all their obligations to the MHA e.g. ensuring Section papers are stored correctly, reading patients their 132 rights, completing H3/H4 forms etc?
- Do the SLAs include an arrangement for data sharing between the acute and mental health trust(s) as per NHS guidance?
- Are the SLAs being reviewed on an at least a three yearly basis to ensure they include service expectations, any changes in relevant regulatory standards or legislation, and that fees have been appropriately reviewed?

Section Papers and Scrutiny

Section Papers and Scrutiny

Appropriate documentation should be in place to support the decision to detain a patient under any Section of the MHA.

The paperwork required to legally detain someone under the relevant section of the MHA are as follows, and copies of all completed documentation should be easily accessible and available to all staff responsible for their care as per NHS guidance:

Section	Paperwork Needed
2	• A1 (application by Nearest Relative) or A2 (application by Approved Mental Health Professional) • A3 (joint medical recommendation) or 2 x A4 (separate medical recommendations) • H3 (record of detention in hospital)
3	• A5 (application by Nearest Relative) or A6 (application by Approved Mental Health Professional) • A7 (joint medical recommendation) or 2 x A8 (separate medical recommendations) • H3 (record of detention in hospital)
4	• A9 (application by Nearest Relative) or A10 (application by Approved Mental Health Professional) • A11 (note: only one medical recommendation is needed) • H3 (record of detention in hospital)
5(2)	• H1 (medical report)
5(4)	• H2 (nursing report)
17A/Community Treatment Order	• CTO1 (medical practitioner's application)
Community Treatment Order Recall	• CTO3 (notice of recall) • CTO4 (record of detention in hospital)
Community Treatment Order Revocation	• CTO3 and CTO4 (as for recall above) • CTO5 (notice of revocation)

The process for detaining patients under Section 2 (the most commonly used Section for patients in an acute hospital setting) involves two consultants making a recommendation. An application is then made by an Approved Mental Health Professional (AMHP). The recommendations are made via the completion of either an A3 form, or two A4 forms. The recommendations made by the two consultants should be, at most, five days apart, and one of the consultants must be Section 12 approved. The recommendations should be directed to the trust, including the name of the hospital the treatment is available at. The application from the AMHP is made through a completion of an A2 form. The AMHP should assess the patient within 14 days of the application date. An H3 form is signed and dated as a record of a patients' detention in the hospital.

'Receipt and Scrutiny' is the process of checking that the section papers for patients who are to be detained under the MHA are legally correct. Trusts have different mechanisms for this process, but it is crucial that it is done in a timely manner, with the necessary safeguards, and that documents are stored securely yet remain accessible to both acute and mental health trust staff.

Case Study 1

At one Trust we work with we selected a sample of 20 patients that had been sectioned under the MHA (Sections 2, 3, 4 and 5), to assess whether all the required section papers were completed and retained by the Trust.

12 patients were selected from the larger acute hospital site, eight patients from the smaller acute hospital site.

At the larger acute site, 11 out of the 12 patients were detained under Section 2 of the MHA, one was detained under Section 3. The Section paperwork for all 12 patients was found to be in order (scanned section papers were reviewed along with the scrutiny process findings for each patient).

The scrutiny process at this site consisted of two stages:

1. The Mental Health Law Team reviewed the Section Papers using a Scrutiny checklist. If any of the checklist areas highlighted in red were incorrect or absent, then the detention is unlawful and the team responsible for the patient were alerted
2. A final scrutiny was completed by a Consultant Psychiatrist on the 'Scrutiny Rota', which runs from a Friday to a Thursday. The Consultant received all the section papers within that period electronically and reports back to the Mental Health Law Team as to whether the scrutiny was a pass or fail. The emails confirming a pass or fail were kept as evidence within an electronic folder on the Mental Health law Teams computer. If a patient was transferred, this email evidence that the patient has met the threshold for detention was passed on. Occasionally there could be a conflict of interest if the Psychiatric Liaison Consultant who undertook the 1st Medical Recommendation was on the scrutiny rota, however in such instances the previous Consultant on rota would be asked to scrutinise instead.

At the smaller acute site, five out of the eight patients were detained under Section 2 of the MHA, three were detained under Section 3. The Section paperwork for all eight patients was found to be in order (scanned section papers were reviewed along with the scrutiny process findings for each patient).

The scrutiny process at this site was also a two stage process, but unlike the larger site, was undertaken solely by the Mental Health Act Administrators. Once the team had been made aware that a patient had been detained under the MHA via the daily (Monday - Friday) morning meeting, the scanned Section Papers are initially scrutinised by an MHA Administrator before being passed on to a Senior MHA Administrator for a second scrutiny. 1st and 2nd Scrutiny pass or fail is logged on a spreadsheet held electronically by the MHA Administrators. As is the case at the larger site, this pass/fail scrutiny is sent with the patient should they be transferred to confirm that their detention is lawful.

As per the MHA, the Trust have 14 days to get a new Medical Recommendation if scrutiny fails.

All 20 patients sampled across both sites had the correct section papers filed and completed correctly, suggesting staff have a comprehensive knowledge of what is required to detain someone lawfully, and that due process is followed in storing said papers as per the Trust guidelines.

The scrutiny process at both sites appeared comprehensive and fit for purpose given the differing patient volumes on each site. both the Mental Health Law teams were familiar with the escalation procedures for instances of failed scrutiny, with clearly defined timelines for correction.

Case Study 2

At another trust we work with we reviewed the section documentation for a sample of 10 patients, which consisted of:

- Six patients detained under Section 2
- One detained under Section 3
- Two under Section 5(2) who were then moved to Section 2
- One under Section 5(2) who was then moved to Section 3.

The process involved the Mental Health Law Team (MHLT) undertaking assessments, and completing the relevant forms for Section 2 and 3. These documents were then uploaded by the Mental Health Administration Team on to RiO, the electronic patient record system (EPRS) by the mental health trust.

The acute trust uses Sunrise as their EPRS, and there was no evidence of the completion of section documents retained on this system, only on RiO. As such, the paperwork for the seven patients detained under Section 2 and 3 was retained solely by the mental health trust. Staff at the acute trust had no access to this record system.

Section 5(2) gives doctors the ability to detain someone in hospital for up to 72 hours, during which time the patient should receive an assessment that decides if further detention under the MHA is necessary. For Section 5(2) patients, an H1 form should be completed. Of the three patients held under Section 5(2), and then moved to Section 2 and 3, no evidence of the H1 document was maintained on either Sunrise or RiO, however, when the patients were transferred to either a Section 2 or 3, documentation was retained on Rio.

Although the mental health trust MHLT was based in the same location as the acute trust Safeguarding Team, and the two teams appeared to have a close working relationship, whereby the mental health team would provide access to the acute trust to RiO records where required, it is still important to note that the acute trust did not hold their own records of section documentation. This means that ward staff could not easily access important, legal documentation pertaining to their own patients. Although the acute trust delegate certain responsibilities to the mental health trust, they are still legally responsible for their patients, and therefore should hold all relevant information pertaining to their patients.

Case Study 3

At another acute trust we work alongside we reviewed section documentation for a sample of 10 patients, which consisted of:

- seven patients detained under Section 2
- two patients detained under Section 3
- one patient detained under Section 5(2).

Policy dictated that a section checklist should be completed and attached to Epic (the trusts' EPRS), to confirm that all of the relevant section documentation had been completed.

From our review of Section 2 documentation at the trust, we identified the following exceptions:

- In one case, one A4 form was not attached onto the patient record on Epic. The document was instead found in an email issued to the Mental Health Lead, albeit correctly completed
- In another instance, the section checklist was not attached on file.

We did not identify exceptions in documentation for patients detained under Section 3 or Section 5(2).

When a patient is sectioned at the trust and then transferred to another hospital, the trust complete an H4 form. There is a designated section in the form which should be completed by the transferee hospital, and the form should be subsequently uploaded to Epic.

We reviewed the documentation of five patients that had been transferred to another trust under section, and found the following exceptions:

- In two cases, the H4 forms were not located on file
- In one instance, the H4 form completed by trust staff (as documented in the nursing notes) was not attached to the patients record on Epic.

When documentation to support the detention of a patient is not completed and retained by the trust, the trust is failing to comply with the MHA and the patient could be found to be held unlawfully.

Key Questions

- Does the trust have clearly defined SOPs for the completion and recording of section documentation, and are these easily accessible to staff?
- Does the trust have a robust receipt and scrutiny process in place to ensure all detentions under the MHA are lawful?
- Does the trust have a data sharing agreement in place with the mental health trust so that all staff caring for a detained patient have access to their section documentation?
- Does the trust conduct spot audits on a quarterly basis to ensure all relevant documentation is completed and uploaded to the patients record?
- Does the trust offer appropriate training to its staff on the completion of section documentation and the scrutiny process?
- Is the escalation process clear when documentation is incomplete and fails scrutiny?
- Is non-compliance recognized as a risk to the trust by inclusion within the risk register?

Patient rights

Patient rights

All patients who have been sectioned require their rights to be explained by the AMHP and site managers. Per the Mental Health Act, patients have rights to be informed about the decisions taken and the reasoning behind the detention under the section. This ensures that there is transparency, patient autonomy and dignity in mental health treatment. Rights should be read on admission/detention, if there has been a change of treatment, on appeal/fail of tribunal, and then at weekly intervals for patients detained under Section 2 or every three weeks for patients detained under Section 3.

If the patient doesn't understand their rights on day 1, the rights should be repeated for up to 14 days. If a patient is placed on a Section 2, they have the right to appeal within 14 days, so if the rights are not read (or documented they have been read) it is possible the patient will lose their opportunity to appeal. A Section 132 form should be completed by clinical staff, which confirms that the rights have been explained to the patient.

Case Study 1

At one acute Trust we sampled twenty patient records across two acute sites to confirm whether there was documented evidence that rights had been explained to the patient when they were sectioned.

At the larger acute site, none of the 12 patients sampled had documented evidence within the '132 Rights' tab of Section One (the electronic patient record system utilised by the mental health trust) that their rights had been explained to them at the point of detention, or within 24 hours of their detention.

At the smaller acute site:

- two of the eight patients had documented evidence within the clinical notes on Rio (the electronic patient record system utilised by the mental health trust) that their rights had been explained to them at the point of detention, or within 24 hours of their detention.
- For one patient, a request had been made by the Psychiatric Liaison team for their rights to be read by the ward team, however there was no evidence that their rights had been read within 24 hours
- For five of the eight patients there was no documented evidence within the electronic patient record that rights had been explained to the patient when they were sectioned, or within 24 hours of their detention, or throughout their entire inpatient stay.

Any issues regarding patients losing their right to appeal by not being read rights would require escalation to Ward Matrons, the Clinical Director and Borough Director.

The Psychiatric Liaison Team at the larger acute site recognised there was some work to be done regarding the reading and documenting of rights to patients on that site. It was unclear from the policies and procedures reviewed where the responsibility of the reading of rights lies, i.e. is it with the Psychiatric Liaison team or with the Ward staff of the acute trust where the patient resides? This definitely requires clarification, with appropriate training provided where necessary. Neither the psychiatric liaison teams or ward staff on both sites appeared to be aware of a 132 rights tab within System One/Rio. Given that the Mental Health Law Team at the larger acute site extrapolate the 132 rights tab information from System One to generate reports on adherence to reading rights, it might be that further training in this area is also needed to ensure that if patients are being read their rights it is documented in a way that the data is captured correctly.

Case Study 2

A Section 132 form is completed by clinical staff, which confirms that the rights have been explained to the patient. This is accompanied by the Reception of Rights table, detailing the outcomes/problems encountered whilst rights are explained to the patient and the number of attempts. The form is signed by clinical staff and the patient (where possible), prior to its upload onto the patient records on Epic.

At another Trust we selected a sample of 10 patients under Section to confirm whether a Section 132 form was completed and signed off to confirm that rights were explained to the patient. We identified the following exceptions:

In one case, the section 132 form was not located on the patient file, hence there was no formal sign off to confirm that the patient understood their rights. We found evidence that the patient had their rights explained in the nursing notes section on Epic. However, we were unable to verify this information through documentary evidence.

The Reception of Rights table was not sufficiently completed in four instances (40%), to outline whether the patient understood their rights or if there were any challenges in explaining the rights. In all four instances, the table was not completed for patients detained under Section 2.

There is a risk that, if staff are not sufficiently and formally recording that a patient has had their rights communicated to them, the Trust is not compliant with the MHA. Furthermore, if section 2 patients have not been made aware of their rights, they may not have been aware that they can appeal directly to the Tribunal within the first 14 days of detention; after this period, permission is required from the Secretary of State.

Case Study 3

At a third Trust we work with, the Trust have an Action Card (AC1), which forms part of the Trusts Sectioning Policy, which states that ward staff should:

"Remind detained patient of their rights verbally at weekly intervals (section 2) or 3-weekly intervals (section 3) and documented in EPR (Electric Patient Record) that this has been done."

We reviewed a sample of 10 sectioned patients to confirm whether the patient has been read their rights under Section 132 of the Act and that this was recorded on their electronic patient record. We identified that:

There was no evidence retained by the Trust for eight of the ten patients sampled that described whether the patient had been read their rights under the Act, either through the completion of a template form or through recording on the patient administration system, and that these rights had been understood by the patient.

The two records which evidenced rights had been read were not recorded in a consistent manner within the patients notes/record.

The completion of a Section 132 form at the acute trust was not recorded by the mental health trust on their separate electronic patient record system, RiO. Instead, the mental health trust maintain a caseload spreadsheet which states if patient rights have been read.

Again there is a risk that, if staff are not sufficiently, formally, and consistently recording whether a patient has had their rights communicated to them, the Trust is not compliant with the MHA. Furthermore, if section 2 patients have not been made aware of their rights, they may not have been aware that they can appeal directly to the Tribunal within the first 14 days of detention; after this period, permission is required from the Secretary of State.

Key Questions

- Is it clear whose responsibility it is to read patients their 132 rights and document this appropriately? Is this included in the SLA?
- Are there sufficient SOPs in place, that are accessible to ward staff, regarding the reading of patients' rights?
- Is the necessary training in place with regard to the communication and documentation of 132 rights?
- Are spot audits in place to identify gaps in administrative compliance?
- Are the reading of rights being documented within the electronic patient record as per trust and MHA guidance? This could be completed by implementing a Section 132 form which details what rights have been read to the patient and when. This could also include whether communication needs have been assessed and how this has been adapted in order for the patient to understand their rights.
- Is there a sufficient data sharing agreement in place between the two trusts to ensure all staff caring for a detained patient can document and view information pertaining to rights?
- Is non-compliance recognized as a risk to the trust by inclusion within the risk register?

Training

Training considerations

For staff to provide high-quality care for their patients' mental health needs, they need to receive appropriate training. Although it is acknowledged that most acute trusts are not Mental Health Trusts and therefore lack the comprehensive knowledge pertaining to mental health, it is vital that those acute Trusts looking after detained patients have specific programmes in place for staff to ensure that they are adhering to the MHA and giving the best possible care to their patients.

Case Study 1

At one Acute Trust that we work with who delegate their psychiatric work to two mental health trusts, the training obligations are clearly set out under both SLAs.

It was our understanding that there is no annual mandatory training for Trust staff around the MHA, although a small section of the induction training covers matters relating to it. However, at one of the acute sites, the Law Team emphasised that MHA training is available to all Trust staff via a Zoom Training session every fortnight (or on an adhoc basis if requested). The training provides an overview of the MHA, covering topics such as types of Sections, how long detentions last, consent, 132 rights, tribunals, Section 17 leave etc. The training is advertised periodically via email (evidence seen) and in poster format (seen in A&E and the Law Office but not seen on any of the wards visited). It is unclear what the uptake of these sessions are as no attendance logs are kept. The Mental Health Administrators on the other acute Hospital site did not provide any formal training on the MHA to ward staff but emphasised they were available and visible at regular meetings to provide help and support to staff when required.

Because of the lack of attendance records for formal training at one site, and the lack of evidence demonstrating the offering of training at the other site, is unclear whether the Trust receives the full allocation of training pledged from their Mental Health Partners, and how many staff have benefitted from said training. This, combined with confusion over responsibility regarding the reading of rights and the completion of certain forms, suggests more can be done to address the training needs of ward staff. The Zoom training sessions provided by the Law Team appear robust and fit for purpose, but the Trust could do more to raise awareness of the need for staff to access the training on a regular basis.

Case Study 2

At one Trust we work with we reviewed the quarterly Mental Health Group meeting minutes and found that there were high-level discussions on identifying staff training needs and designing training programmes. However, we identified that there was no reference to staff uptake, or any quantitative data to support the analysis of training gaps. If compliance with training requirements is not discussed, there is a risk of insufficient monitoring and scrutiny over completion of training (and subsequent escalation if required).

If training is not completed, there is a risk that the skills base of staff is not being developed to ensure that staff have the necessary skills and tools to undertake their roles and deliver to expected standards.

Case Study 3

At one trust we held discussions with the Lead for Safeguarding Adults at the acute trust and the Lead Nurse for the mental health trust they work alongside. We discovered that a training assessment to understand who should receive training relating to the mental health act had not been carried out.

Matrons at the acute trust are required to undertake mandatory training when they join the Trust regarding the MHA and the policies surrounding detained patients. There had recently been a refresher carried out, updating matrons on the new policy, however there was no set period for when refresher courses should be undertaken.

Outside of the training received by Matrons, no other formal training programme was offered to staff on wards relating to the MHA. There was also no active monitoring of the training in place at the Trust to confirm which matrons have completed their MHA related training and if/when they require a refresher.

The Lead Nurse for the mental health trust highlighted that they offer 12 full days' worth or training to the acute Trust, as per their SLA, however, this training had not been taken up. The mental health trust service specification highlights that the acute trust can make a request to the mental health trust for support with training, through a mixture of formal training sessions on core topics and informal learning, through working alongside the liaison psychiatry team.

The lack of a formalised training plan in place at the acute trust presents a risk that staff are not fully aware of requirements set under the Mental Health Act leading to incorrect or no use of the Mental Health Act.

Key Questions

- Does the SLA include a training requirement in WTE hours? Who is responsible for ensuring this training is delivered at the trust?
- Has a training needs assessment been undertaken recently to identify knowledge gaps in staff groups?
- Has a training plan been developed that prioritises higher risk staff groups, ie those staff receiving section papers. Is the training offered role and context specific?
- Do the trust induction and mandatory training programmes include MHA specific training for clinical staff (to include site specific SOPs on Section Papers, 132 rights, Section 17 leave, H3/H4 forms, observation levels etc.)?
- Is the content of any training up-to-date and in line with local and national policy, and regulatory and legislative requirements?
- How are training sessions recorded and is attendance monitored to ensure all relevant staff receive the appropriate training?
- How are staff made aware of training opportunities? Can this be improved?

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