Public – To be published on the Trust external website

Allocation of responsible clinicians

Ref: MHA-0015-v1.4

Status: Ratified
Document type: Policy

Contents

1. Introduction

An approved clinician (AC) is a mental health professional approved by or on behalf of the Secretary of State to act as an approved clinician for the purposes of the Mental Health Act 1983 (MHA). Some decisions under the MHA can only be taken by people who are ACs.

The majority of ACs employed by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) are registered medical practitioners.

The AC role can be undertaken by a Psychologist, Nurse, Social Worker or Occupational Therapist who has completed the necessary training and registration process.

The term non-medical AC will be used throughout this document to denote an AC who is not a registered medical practitioner.

Under the MHA the responsible clinician (RC) is the approved clinician (AC) with overall responsibility for the patient's case.

Certain decisions, such as the renewal of detention, authorisation of leave or placing a patient on a community treatment order can only be taken by the responsible clinician.

This policy supports the trust in the delivery of Our Journey to Change and our ambition to create safe and personalised care. It helps us deliver our strategic goals as follows:

- This policy supports the trust to co-create a great experience for all patients, carers and families by ensuring the most appropriate responsible clinician is allocated to the patient and can meet their assessment and treatment needs.

1 Why we need this policy

1.1 Purpose

Paragraph 36.3 of the Mental Health Act 1983 Code of Practice (CoP) requires hospital managers to have local protocols in place for allocating responsible clinicians to patients.

1.2 Objectives

The protocols in place should:

- Ensure that the patient's responsible clinician is the available approved clinician with the most appropriate expertise to meet the patient's main assessment and treatment needs
- Ensure that it can be easily determined who a particular patient's responsible clinician is
- Ensure that cover arrangements are in place when the responsible clinician is not available (e.g. during non-working hours, annual leave etc.)
- Include a system for keeping the appropriateness of the responsible clinician under review

This document does not attempt to describe all eventualities, but there are three basic principles which should be used to determine the correct course of action.

- All detained / CTO patients must have an RC at all times.
- A patient can only have one RC (but more than one AC may be involved in their care).
- The RC can change from time to time.

2 Scope

2.1 Who this policy applies to

This policy applies to all approved clinicians employed by TEWV.

2.2 Roles and responsibilities

Role	Responsibility
Medical Director	• Is responsible for ensuring that there is a system in place to ensure that medical staff appointed to undertake RC roles have the necessary approval.

Director of Nursing & Director of Professional Therapies	• Is responsible for ensuring that there is a system in place to ensure that staff within their discipline that are appointed to undertake RC roles have the necessary approval.
Approved Clinicians	• Are responsible for maintaining their approval, including necessary refresher training.
Hospital Managers	• Are responsible for maintaining a register of all staff who are registered as ACs on the Department of Health database for ACs and Section 12 approved doctors. • Are responsible for having protocols in place for allocating responsible clinicians to patients.

3 Policy

3.1 Recording RC on Electronic Patient Records

The RC must be recorded on the electronic patient record.

It is the responsibility of the RC to ensure that this is done.

When RC is changed, it is the responsibility of the RC taking over care of the patient to record the change of RC.

There is no need to change RC on the electronic patient records for short-term changes, e.g. leave and sickness cover.

3.2 Initial allocation of RC

Unless there are other factors to be considered, the RC will be determined by the current location of the patient. E.g., if the patient has been admitted to Tunstall Ward at Lanchester Road Hospital, the RC will be the inpatient consultant for Tunstall Ward.

Where there is more than one AC available at the patient's location, the RC will be the available AC with the most appropriate skills and experience to meet the needs of the patient.

Wherever possible, the clinician responsible for the care and treatment of children and young people should be a child and adolescent mental health services specialist. Paragraph 36.6 CoP.

3.3 Non-medical ACs

If the most appropriate person to be RC is not a doctor, it may be necessary to allocate a second AC who is a doctor. For example, the most appropriate RC for a particular patient is a psychologist who is not a prescriber.

The clinician in charge of the treatment must be an AC if treatment is being given:

- Without the patient's consent
- With the patient's consent, but on the basis of a certificate issued under section 58 or 58A MHA
- Pending compliance with section 58 and with the consent of a CTO patient who has been recalled to hospital, in order to avoid serious suffering

The second AC must be recorded on the electronic patient records.
It is the responsibility of the second AC to ensure that this is done.
If this AC is changed, it is the responsibility of the AC taking over to record the change of AC.

3.4 Community Treatment Orders (CTOs)

For further information see:

- **TEWV Community Treatment Order (CTO) Policy**
- **Mental Health Act (MHA) Code of Practice, chapter 29**

Unless there are other factors to be considered, the RC will be determined by the location of the patient, e.g., if the patient is being discharged under the care of the Redcar and Cleveland Psychosis Team, the RC will be the community consultant for the Redcar and Cleveland Psychosis Team.

Where there is more than one AC available at the patient's location, the RC will be the available AC with the most appropriate skills and experience to meet the needs of the patient.

On recall, unless there are other factors to be considered, the community consultant will remain the RC.

If the CTO is revoked, allocation of RC will be as described at 3.2 Initial allocation of RC.

3.4 Cover when RC not available

The functions of the RC cannot be delegated, but the patient's RC can change from time to time and the role may be occupied on temporary basis in the absence of the usual RC. This may be necessitated by:

- Annual, professional or study leave;
- Sickness;
- Part-time working;
- Out of hours cover

For planned leave (including annual and study leave) the RC is responsible for making arrangements with a suitably qualified AC to act as RC in their absence.

If the RC is unable to make such arrangements, they must approach their lead psychiatrist or associate medical director to resolve the matter.

For unplanned leave (including sick leave) the lead psychiatrist for the service is responsible for arranging cover from an appropriately qualified AC.

3.5 Out of hours cover

Each locality / clinical area in TEWV has established arrangements for duty consultant cover outside normal working hours. The duty consultant, who is an AC, will provide cover out of hours for RC functions. This will include providing advice for any nominated deputies (i.e., the nominated junior doctor on call) who are not approved clinicians (or doctors approved under Section 12 of the Act).

3.6 Functions that can only be performed by the RC

If an AC is providing cover as described at 3.5 or 3.6 above to perform a function that can only be performed by the RC, for example to recall a CTO patient or to authorise S17 leave in an emergency, it is important to note that they are acting AS the RC and not acting ON BEHALF OF the RC.

3.7 Change of RC

As the needs of the patient may change over time, it is important that the appropriateness of the responsible clinician is kept under review throughout the care planning process. It may be

appropriate for the patient's responsible clinician to change during a period of care and treatment, if such a change enables the needs of the patient to be met more effectively.

If the patient requests a change their reasons should be established.

In considering such a change it is also important to take account of the need for continuity and continuing engagement with, and knowledge of, the patient. The process for considering a patient's request will be overseen by the appropriate lead psychiatrist or Associate Medical Director) for the inpatient unit (or in the case of a CTO the community team) in which the patient is being treated.

Where a patient's treatment and rehabilitation require movement between different hospitals or to the community, successive responsible clinicians need to be identified in good time to enable movement to take place.

The existing responsible clinician is responsible for overseeing the patient's progress through the system. If movement to another hospital is indicated, responsible clinicians should take the lead in identifying their successors.

When the RC is changed, it is the responsibility of the RC taking over care of the patient to record the change of RC.

There is no need to change RC on the electronic patient record for short-term changes, e.g. leave and sickness cover.

4 Definitions

Term	Definition
Approved Clinician (AC)	• A mental health professional approved by the Secretary of State or a person or body exercising the approval function of the Secretary of State, or by the Welsh Ministers to act as an approved clinician for the purposes of the Act. Some decisions under the Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.
Non-medical AC	• An AC who is not a registered medical professional (doctor).
Responsible Clinician (RC)	• 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 responsible clinician.

Section 12 Approved Doctor	A doctor who has been approved under the MHA as having special experience in the diagnosis or treatment of mental disorder. • Doctors who are ACs are automatically treated as though they have been approved under section 12.
Detention (and detained)	Being held compulsorily in hospital under the MHA for a period of assessment or medical treatment. This process is often referred to as 'sectioning'.
Community Treatment Order (CTO)	A CTO provides legal authority to discharge a patient from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary. A CTO patient can only be recalled by the RC.
Hospital Managers	In the context of the Mental Health Act, this term refers to the organisation Tees, Esk and Wear Valleys NHS Foundation Trust not the operational management team of each hospital within the Trust. The Hospital Managers are responsible for detaining patients and ensuring that the requirements of the MHA are met.

5 Related documents

- TEWV Community Treatment Order Policy
- Mental Health Act Code of Practice

6 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.

6.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Staff undertaking AC role	Face to face refresher training	Full day	5 yearly
All clinical staff	Mandatory MHL e-learning	3 hours	2 yearly

7 How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	AC's retain registration	North East Approval Panel (NEAP) team monitor active registrations and requirements of AC's.	Issues raised with MHL committee each quarter

8 References

Department of Health. (2015). Mental Health Act 1983: Code of Practice. TSO.
Department of Health. (2015). Reference Guide to the Mental Health Act 1983. TSO.

9 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	20 December 2023
Next review date	20 December 2026
This document replaces	MHA-0015-v1.3 Allocation of Responsible Clinicians Policy

This document was approved by	Mental Health Legislation Committee
This document was approved	07 November 2022
This document was ratified by	Management Group
This document was ratified	20 December 2023
An equality analysis was completed on this policy on	13 November 2023
Document type	Public
FOI Clause (Private documents only)	NA

Change record

Version	Date	Amendment details	Status
1	08 Feb 2017	New policy	Withdrawn
1	24 Mar 2020	Extended review date from 08 Feb 2020 to 01 June 2020 to allow review work to be done	Withdrawn
1	01 Apr 2020	Review date extended to 30 Sept 2020 to allow consultation process.	Withdrawn
1.1	16 Dec 2020	3 yearly review. Policy template updated. Additional clarification on roles and responsible in section 3.2	Withdrawn
1.2	15 Mar 2023	Minor change only. Updated “clinical Director” to “lead psychiatrist” and updated “associate clinical director” with “associate medical director”. This is to ensure the policy reflects the new organisational structure.	Withdrawn
1.3	07 July 2023	Minor change In sections 4.1, 4.3 and 4.8 “paris” has been changed to “electronic patient record”	Withdrawn
1.4	20 Dec 2023	3 yearly review. Policy template updated.	Ratified

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Mental Health Legislation Department
Title	Allocation of responsible clinicians
Type	Policy
Geographical area covered	Trustwide
Aims and objectives	To ensure compliance with the MHA Code of Practice
Start date of Equality Analysis Screening	04 October 2023
End date of Equality Analysis Screening	13 November 2023

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Patients subject to the Mental Health Act and TEWV employees involved in the provision of care to patients subject to the Mental Health Act
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	
Describe any positive impacts / Human Rights Implications	Procedure will formalise existing arrangements for allocation of responsible clinician and when followed will ensure accuracy of recorded information regarding responsible clinician and provide a standard procedure for patients to request a change of responsible clinician

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Mental Health Act Code of Practice Mental Health Act See References
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
If you answered Yes above, describe the engagement and involvement that has taken place	
If you answered No above, describe future plans that you may have to engage and involve people from different groups	Changes to this policy will be based on update in law and statutory national guidance. An updated Code of Practice will be published at a national level and this will be published following engagement in a wide range of stakeholders

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	Any changes to current processes will be incorporated into Mental Health Legislation Training online and face to face training. Procedure will be disseminated through staff intranet.
Describe any training needs for patients	No
Describe any training needs for contractors or other outside agencies	No

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2. Rationale		
Are reasons for development of the document stated?	Yes	
3. Development Process		
Are people involved in the development identified?	Yes	
Has relevant expertise has been sought/used?	Yes	
Is there evidence of consultation with stakeholders and users?	Yes	
Have any related documents or documents that are impacted by this change been identified and updated?	N/A	
4. Content		
Is the objective of the document clear?	Yes	
Is the target population clear and unambiguous?	Yes	
Are the intended outcomes described?	Yes	
Are the statements clear and unambiguous?	Yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	
Are key references cited?	Yes	

Are supporting documents referenced?	Yes	
6. Training		
Have training needs been considered?	Yes	
Are training needs included in the document?	Yes	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Yes	
8. Equality analysis		
Has an equality analysis been completed for the document?	Yes	
Have Equality and Diversity reviewed and approved the equality analysis?	Yes	20 Dec 2023 AH
9. Approval		
Does the document identify which committee/group will approve it?	Yes	
10. Publication		
Has the policy been reviewed for harm?	Yes	
Does the document identify whether it is private or public?	Yes	Public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Yes	
Do all pictures and tables have meaningful alternative text?	Yes	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Yes	