Care Quality Commission

Mental Health Act Annual Statement January 2010

Ealing Forensic Services
West London Mental Health NHS Trust

Introduction
Mental Health Act Commissioners from the Care Quality Commission (CQC) visit all places where patients are detained under the Mental Health Act 1983. Mental Health Act Commissioners meet and talk with detained patients in private and also talk with staff and managers about how services are provided. As part of the routine visit programme information is recorded relating to:

- Basic factual details for each ward visited, including function, bed occupancy, staffing, and the age range, and gender of detained patients.
- Ward environment and culture, including physical environment, patient privacy and dignity, safety, choice/access to services and staff/patient interaction.
- Issues raised by patients and patient views of the service provided, from both private conversations with detained patients and any other patient contacts made during the course of the visit.
- Legal and other statutory matters, including the scrutiny of Mental Health Act documentation, adherence to the Code of Practice, systems that support the operation of the Act and records relating to the care and treatment of detained patients.

At the end of each visit a “feedback summary” is issued to the Trust identifying any areas requiring attention. The summary may also include observations about service developments and / or good practice. Areas requiring attention are listed and the Trust is asked to respond stating what action has been taken. The response is assessed and followed up if further information is required. The information is used by the CQC when verifying the NHS Health check and making decisions about the inspection programme in both the NHS and Independent Sector. In future years it will be used to inform the registration decisions

Background
This report draws on findings from visits by Mental Health Act Commissioners both under the auspices of the Mental Health Act Commission (MHAC) and those which took place after 1 April 2009 when the functions of the Mental Health Act Commission were taken over by the Care Quality Commission

The Annual Statement provides an overview of the main findings from visiting, highlighting any matters for further attention and / or areas of best practice. It is published on the CQC website, together with other publications relating to individual mental health providers.

The Commission has visited all the wards within the Ealing Forensic Services during the last 12 months.

Main findings
Relations between Mental Health Act Commissioners and senior managers and the staff of the Trust have remained constructive throughout the reporting period. The Commission wishes to extend its gratitude to the staff, especially the Mental Health Act Administrator, for the help in arranging the visits.

This can be a difficult area of mental health work and staff are commended for their efforts and patience with patients who can be complex and volatile. Approaches made to Commissioners by medical staff to discuss difficult patient situations have been welcomed.

The Commissioners who visit the forensic services at Three Bridges Regional Secure Unit (RSU), The Orchard Unit and Tony Hillis Wing are pleased that the response times to issues raised are improving on previous years. They have also welcomed the resolution of the concerns raised by Commissioners about the inconsistency in the Trust's approach to searching the visiting Commissioners.

Mental Health Act and Code of Practice
The following points highlight those Mental Health Act Issues raised by Commissioners on visits. The detailed evidence to support them has already been shared with the Trust and is not rehearsed here. For further discussions about these findings please contact the authors of this report via the Care Quality Commission at the Nottingham office.

Detention & documents related to detention
The visiting Commissioners generally found statutory documentation in order and on the occasions where errors have been found, they have been quickly corrected.

Evidence of detention is fundamental to all that follows and must be available for scrutiny at all times. Some of the deficiencies identified by the Commission include:

- Copies of detention papers not being filed in the notes.
- Unlawful detention on Rollo May.
- On Derby 1 one of the patients' detention was allowed to lapse on 6 December 2008 and he was placed on section again on 9 December 2008.

The Commission has reported concerns about whether the Trust is adequately staffing Mental Health Act Administration to cope with the increasing workload from more detained patients on this site with the arrival of the Orchard Unit as well as the extra burden Supervised Community Treatment has brought. Many Mental Health Act issues raised regularly by the Commission could be alleviated by more robust internal audit of Mental Health Act systems. It is also apparent that specific issues raised in one ward will continue on other wards, indicating a lack of overall action to address issues across the whole Trust at a strategic level.

Recommendation for Action
The Trust review Mental Health Act issues raised during the last year of visits in order to identify an effective audit programme to tackle recurring themes across all services

in the Trust. The Trust's Mental Health Act Manager should review current administration services to confirm whether they are able to cope with increased demands and fulfil existing core administration and audit requirements.

Section 58
Over the last year the visiting Commissioners found various incidents, some of them very serious, of breach and non-compliance with the requirements of Section 58.

Incidents of unlawful treatment were found on Derby 2, Derby 1, Avebury and Aurora Wards. On Aurora Ward 50% of patients were found to be treated unlawfully.

Responsible Clinicians (RCs) continue to fail to record assessments of capacity following their discussions with patients about treatment and their attitude to it, that should be recorded from the outset of an admission. Consent or refusal of treatment is only possible for patients who have the capacity to make these decisions at the material time and the assessment of capacity will dictate the legal safeguards that follow.

There was also the frequent failure on their part to outline treatment plans prior to the Second Opinion Appointed Doctors (SOAD) visits. The requirement that Responsible Clinicians record the conversation they have with a detained patient following the visit of a SOAD remains patchy.

The medicine charts require that the legal status of the patient and authorisation to treat is recorded with the relevant time-scales. This is not always completed although the authority contained in the forms T2/T3 are usually found attached to the charts

There were widespread failures from the parts of the Statutory Consultees to make a record of their consultation with the SOADs.

It has to be pointed out that the reoccurrence of the above issues continue to arise despite the Trust's reassurance that effective systems have been put in place to address the issues of non-compliance with the requirements of Section 58.

Most of these issues were identified in the previous year and were included in the Mental Health Act Commission's Annual Report in 2008. In response to this the Trust agreed that they had to do more work to improve and that the Trust has put a number of systems such as audits, a letter from the Medical Director to all the RMOs (RCs), and the introduction on a proforma, to achieve the improvements.

The proforma introduced by the Trust has proved to be very effective where it is used. Unfortunately the use of this proforma is variable. However the Commission wishes to acknowledge that on the few wards the proforma is regularly used improvement in compliance was noted. It was widely used on Barron 1 Ward and on Glynn Ward. On Glynn Ward, the Commissioner was pleased with the standard maintained by Dr Andrews in regard to his record keeping in regard to the Mental Health Act issues, especially consent to treatment and renewal of detention.

The Commission recognise the difficulties that the Trust has experienced in relation to accessing SOADs within the required timeframes. This has been due to the unpredicted extra burden on the SOAD service of SCT that has necessitated an increase in the use of Section 62 and Section 64a emergency medication.

The Mental Health Act administration has been responsive to ideas for improvement such as the safe haven fax system and the development of SOAD day and half day sessions.

Recommendation for Action
The Trust should instigate more vigorous audit systems to ensure compliance with the requirements of the section 58. The Medical Director to address consent to treatment issues with medical staff. The Trust board should ensure that all the clinicians and clinical teams use the proforma across all departments throughout the whole Trust.

Section 132
While the Commissioners established that there had been good compliance with the requirements of section 132 in some wards, they found deficiencies in this area on a regular basis, in many. In some cases patients have also shown little understanding of their rights. In others patients seem acquainted with their rights but staff are failing to document that they have performed their duties under section 132 on admission and at intervals thereafter. Despite assurances to each visit feedback summary that this will be rectified, there is no consistent approach across forensic services.

Recommendation for Action
The Trust must adopt a system of undertaking section 132 duties and recording that these have been performed in a manner that is meaningful for the patient.

Section 17 Leave
Leave is extremely important to this group of patients who are often in hospital for long periods of time. While the nursing staff try to facilitate section 17 leave, a number of patients, from different wards, have raised concerns that escorted section 17 leave is not facilitated at times, due to staff shortage.

The Commissioner was also informed that according to the Trust policy agency staff are not allowed to undertake escort duties. Hence the use of agency staff does contribute to the cancelling of the escorted leave.

Recommendation for Action
The Trust, especially the ward management, to ensure that the agreed section 17 leave for all the patients are facilitated.

Access to Advocacy
Access to advocacy is variable and the duty to inform patients of their right to an IMHA and the duty to provide access to one under section 130A (commencement date 1 April 2009) has not been observed by Commissioners to date.

Recommendation for Action
Ealing Forensic services should ensure that patients have information about and access to the services of an IMHA as soon as possible.

Supervised Community Treatment
Section 17A is a new discharge provision that has become available for certain detained patients. The Mental Health Act office reports 18 Community Treatment Orders in this Trust, in the period to the end of September many of these from forensic services. The Commission has recently carried out a visit to monitor this part of the Act and this has been reported back on separately.

The Ward Environment
Though there had been some improvement in the ward environment in general, concern over environments was raised on a number of visits. These concerns range from lack of cleanliness, rodent infestation, poor decorative condition, ward temperature to general repair issues. The Commission is aware that many wards have been undergoing considerable physical changes and there are plans for refurbishing some other wards.

The Commission wishes to acknowledge the considerable improvement made to the ward environment on Tom Main ward.

The seclusion room on Tagore was of concern to the Commissioner visiting as its location and ventilation were noted as less than ideal.

The Orchard Unit provides an environment of a high standard however access to baths, food quality and storage of possessions have been issues raised over this period.

Recommendations for Action
The Trust should ensure that environmental issues raised by the patients, ward staff and the Commissioners, during visits are tackled promptly.

When refurbishment of wards is carried out attention to the location and climate control of seclusion rooms should be considered.

Staffing
Nursing staff have been praised in many reports and patient comments have often been positive. However a recurring theme has been concern expressed by patients about poor interactions with some nursing staff from being too busy to talk to them to more negative comments. This issue is central to the patient experience of care. There have been concerns expressed by the staff about having to work with less than adequate staffing levels from time to time. On a visit to one of the wards the Commissioner found that all but one Nursing Assistant were bank or agency nurses who did not know the ward very well.

Some members of the nursing staff have also expressed the concern about the over-dependency on bank and agency staff, which in forensic facilities can place an extra burden on regular staff who have more knowledge of patients as well as the burden of doing more escorting or moving patients around the unit.

Recommendation for Action
The Trust and the nursing directorate takes further action to address concerns about the less than adequate staffing levels and poor patient experience. The Trust may need to strengthen its recruitment process to ensure that the vacancies are filled promptly and high calibre nurses are recruited.

Access to Fresh Air
On a number of visits the Commissioners were approached by patients raising the concern that they do not get adequate access to fresh air. On one of the wards the patients complained that the access to the garden attached to the ward was very infrequent.

Access to fresh air at the Orchard is good with walk out areas from all wards available to patients that should be replicated when new buildings are designed.

Recommendation for Action
The Trust to ensure that all the patients have adequate access to fresh air.

Smoking
The smoking ban has been very difficult for patients on this site and has preoccupied many patients during interviews with Commissioners. The concerns of staff have included increased levels of patient agitation, risks of fire as patients are smoking in bedroom and bathroom areas, concerns over the disruption to therapeutic relationships that increased searching has brought about and disproportionate amounts of leave being spent smoking leaving little time for rehabilitative activities. Patients who feel they have had their rights curtailed by being detained feel further punished by a rule that isn't applicable to prisoners. Patients have expressed a wish to move to units or return to prison where they can smoke. Commissioners have been informed that patients are paying large amounts of money for one cigarette.

While the efforts put into health promotion and smoking cessation are welcomed by some patients there is a significant group who will not comply and indeed have been observed in large numbers smoking in the grounds of the hospital. It is reassuring that the Trust has been responsive to reviewing their policy and has recently provided limited smoking opportunities for patients who want to smoke and do not have leave to do this.

Recommendation for Action
Efforts are made to encourage smoking cessation but for patients choosing to continue to smoke all wards should offer access to an outside area at reasonable intervals in which to do this.

Physical Health
The lack of routine physical health care for the Orchard Unit has been a recurrent theme on visits. However it is pleasing that a Health Suite is underway that will provide access to a General Practitioner (GP) and practice nurse. Services such as breast and cervical screening and routine dental and eye care appointments should be available to these patients without the indignity of being handcuffed to go outside the unit and reduce the escort burden for staff.

Violence
On visits to Tom Main and Benjamin Zephaniah Wards, patients expressed their concern about their safety due the high levels of violent incidents. It was also reported that a number of staff were attacked over the few months prior to the visit and needed to take sick leave.

Of concern was the lack of police involvement when patients are attacked by other patients. Opportunities to be interviewed as victims of crime seem impeded by police systems and effectively discriminating against detained patients who are not at liberty to attend a police station. It is very encouraging to hear of the pilot Designated Police Officer Project that began in March 09 and it is hoped that this will be continued to address issues in this area

Recommendation for Action
That the Trust to continue to address the issue of safety and prevention of violence on wards

Care Programme Approach (CPA)
CPA meetings appear to occur at frequent intervals and most patients could articulate what the agreements at the last meeting had been. However a number of patients indicated that they were not given a copy of their CPA care plans and were not always clear when they could expect another meeting.

Recommendation for Action
The Primary Nurses/care co-ordinators should ensure that all the patients are given copies of their care plans.

Ethnicity recording
Though the overall recording of patients' ethnicity is found to be quite good and has certainly improved, the visiting Commissioners have identified some remaining deficiency in recording ethnicity on some wards.

Recommendation for Action
To ensure that all the patients have their ethnicity recorded throughout their notes, in accordance with the DH categories.

Deprivation of Liberty Safeguards (DOLS)
The CQC recognises that as all patients in this service are detained under the Mental Health Act, the necessity to make an application under the Mental Capacity Act's DOLS is unlikely to arise. It would, however, be good practice for clinical staff to be aware of the main points of the legislation. Of more relevance here, is the need to offer continuing training to ensure staff understand the provisions of the Mental Capacity Act and when treatment in a person's 'best interests' may be given to this patient group perhaps for physical interventions where capacity is diminished.

Recommendation for Action
Staff are reminded of the provisions for patients who lack the capacity to make informed decisions about their care and treatment and the requirements to record when capacity is diminished and decisions are made in a patients 'best interests.'

Forward Plan

- Mental Health Act Commissioners will continue to visit Ealing Forensic Services in the coming year to monitor the operation of the Act and to meet with detained patients in private.

- Mental Health Act Commissioners welcome approaches from staff who may require assistance on individual or collective patient issues relating to their detention.

- The Mental Health Act Commissioners will work with other colleagues within the CQC to develop an integrated approach to the regulation of the hospital's services.

- The Commission is committed to maintaining good working relationship with the staff and management of the Trust.

Appendix A

Commission Visit Information for West London Mental Health NHS Trust Forensic Services Covering the period between 1 November 2008 and 19 January 2010

Date	Ward	Det. Pats. seen	Records checked
Ealing Forensic			
15 Nov 2008	Benjamin Zephaniah (Forensic)	7	5
19 Nov 2008	Brunel Ward (Independently Owned	2	3
	Tom Main (Forensic)	4	3
23 Dec 2008	Derby 1 (Forensic)	5	7
4 Feb 2009	Pearl	5	5
12 Feb 2009	Mott House (Forensic)	2	3
14 Feb 2009	Blake (Forensic)	5	5
28 Feb 2009	Rollo May (Forensic)	8	8
17 Mar 2009	Tagore (Forensic)	4	3
21 Mar 2009	Bevan (Forensic)	6	6
28 Mar 2009	Glynn (Forensic)	7	6
29 Apr 2009	Wells Unit (Forensic)	4	5
23 Jun 2009	Benjamin Zephaniah (Forensic)	4	4
25 Jun 2009	Tom Main (Forensic)	5	5
11 Jul 2009	Barron 1 (Forensic)	7	4
5 Sep 2009	Derby 2 (Forensic)	4	5
28 Sep 2009	Blenheim (Forensic)	1	6
3 Oct 2009	Avebury (Forensic)	6	5
18 Nov 2009	Derby 1 (Forensic)	5	5
21 Nov 2009	Brunel Ward (Independently Owned	5	5
12 Dec 2009	Mott House (Forensic)	2	5
15 Dec 2009	Rollo May (Forensic)	8	6
19 Dec 2009	Glynn (Forensic)	6	6
Total for Ealing Forensic		**112**	**115**
Orchard Unit (Ealing Forensic)			
29 Nov 2008	Aurora	5	7
3 Feb 2009	Elstar	1	1
12 Feb 2009	Russett	4	4
18 Mar 2009	Garnet	5	0
9 Jun 2009	Aurora	3	5
7 Jul 2009	Russett	4	4
14 Nov 2009	Melrose	4	4
9 Jan 2010	Garnet	0	0
Total for Orchard Unit (Ealing Forensic)		**26**	**25**

Total Number of Visits: 30
Total Number of Wards visited: 31
Total number of Patients seen: 138
Total Number of documents checked: 140