Mental Health Act Annual Statement August 2009

Cygnet Hospital Harrow
(Cygnet Health Care)

Introduction
The Care Quality Commission (CQC) visits 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.

Commissioners use the Guiding principles in the Code of practice (Published 2008) to inform opinions about the quality of care provided by the hospital. All decisions must be lawful, informed by good practice and consistent with the Human Rights Act 1998. Commissioners expect these principles to underpin all decisions, and clinicians and managers and all those involved in providing care are expected to balance application of the principles to provide the most effective and sensitive care to individuals.

At the end of each visit a “feedback summary” is issued to the Hospital 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 Hospital 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 Annual Healthcheck and making decisions about the inspection programme in both the NHS and Independent Sector. From April 2010, the Mental Health Act Commissioners’ findings will inform the Care
Quality Commission’s assessments of organisations in relation to registration requirements, through evidencing ongoing compliance with the Mental Health Act and the Code of Practice.

During the year the Commission has visited Springs Unit on 3 February 2009 and Byron Ward on 12 May 2009.

**Background**

Cygnet Hospital Harrow is part of the Cygnet Health Care group, a private provider of mental health care. Springs Unit is a specialist unit providing treatment and rehabilitation for patients with autistic spectrum disorders and mental health needs in conditions of low security. At the time of the Commission visit all 14 male patients were detained under the Mental Health Act. Byron Ward is an 18-bedded adult admission ward where the majority of patients are informal.

This statement draws on findings from visits by Mental Health Act Commissioners both under the auspices of the Mental Health Act Commission 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.

**Main Findings**

In general, detained patients spoke positively about their care and treatment, and of the staff who looked after them.

The Care Quality Commission is impressed with the rapid response from the Clinical Director and Mental Health Act Manager to the feedback following the Mental Health Act Commissioner’s visits.

**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 Hospital and is not rehearsed here. For further discussions about these findings please contact the author of this report via the Care Quality Commission at the Nottingham office.

**Detention**

All paperwork is scrutinised to ensure that all detentions are lawful. A minor error was noted by the Mental Health Act Commissioner on one application and this was amended within the permitted time limit.

**Section 58**

Responsible Clinicians failed to record assessments of capacity when negotiating consent to treatment, and did not make a record of the consent interview in the patients’ notes. Second Opinion Appointed Doctor (SOAD) visits were to take place and the Hospital was reminded of the requirements of Statutory Consultees and
Responsible Clinicians following a SOAD visit. Following the Commission visit a memo was sent by the Clinical Director and Mental Health Act Administrator to all Clinical staff, setting out the requirements of the Code of Practice in relation to Consent to Treatment, both for patients who consent and for those who are seen by a SOAD. This was also to form part of the Quality Improvement Plan (audit) for 2009/2010.

**Care Programme Approach (CPA)**
Patients showed an awareness of their Care Plans, and in most cases had written information relating to this.

**Section 17**
Those patients who had escorted leave said that staff were available to facilitate this leave.

**Independent Mental Health Advocacy (IMHA)**
An Independent Mental Health Advocate is available to qualifying patients, and the Section 132 monitoring form has been amended to include a question about the IMHA.

**Mental Capacity Act - Deprivation of Liberty Safeguards (DOLS)**
Written information has been given to Ward Managers about the Mental Capacity Act Deprivation of Liberty Safeguards, and the Commissioner was told that it was hoped that a training session could be arranged.

**The Physical Environment**
Both wards provide a comfortable environment for patients who are accommodated in single rooms.

**Recommendations for Action**
1. Cygnet Health Care should monitor compliance with Section 58 of the Mental Health Act, to ensure that in the one circumstance in healthcare where compulsion is permitted all the safeguards written into legislation and required to protect the fundamental human rights of the patient are met.

2. Responsible Clinicians should be reminded that they should demonstrate they have discussed consent and assessed capacity to consent during the first three months of a patient’s detention. This is in line with the Participation Principle Code of Practice paragraph 1.5, and the Code of Practice paragraph 23.37.

**Forward Plan**
- Mental Health Act Commissioners will continue to visit the Cygnet Hospital Harrow in the coming year to monitor the operation of the Act and to meet with detained patients in private.
- They will work with other colleagues in the Care Quality Commission to develop an integrated approach to the regulation of the Hospital’s services.