Mental Health Act Annual Statement December 2009

North East London NHS Foundation Trust

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 provider. All decisions must be lawfully informed by good practice and consistent with the Human Rights Act 1988. Commissioners expect these principles to underpin all decisions and, clinicians, managers, and all those involved in providing care 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 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 Annual Health Check 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 CQC’s assessments of organisations in relation to registration requirements, through evidencing ongoing compliance with the Mental Health Act and Code of Practice.
A list of the wards visited within this Trust is provided at Appendix A.

Background
North East London NHS Foundation Trust (referred to in this statement as “the Trust”) provides a range of inpatient, outpatient and community mental health services for the populations of Barking and Dagenham, Havering and Redbridge and Waltham Forest. It also provides a range of rehabilitation services across the Trust and Psychiatric Intensive Care Unit (PICU) facilities at Goodmayes Hospital.

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
The relationship between Mental Health Act Commissioners and senior managers of the Trust has remained constructive throughout the reporting period (1 November 2008 – 31 October 2009). The final Annual Report of the Mental Health Act Commission was received positively by the Board although no formal written response or action plan was published by the Trust. However, the findings and recommendations made in the Annual Report have been monitored by visiting Mental Health Act Commissioners on their visits during the reporting period.

Some progress was found in a number of areas. Particularly notable were the improvements found during a visit to Naseberry Court in March 2009. Following the appointment of a Modern Matron, a successful recruitment drive had resulted in permanent ward managers being appointed to each of the male and female wards. A full time inpatient psychologist and a full complement of nursing, domestic, and administrative staff had also been recruited. There had been a significant reduction in the use of agency staff, staff sickness and an obvious medical presence on each ward was noted. The number of consultant psychiatrists attached to each ward had been reduced to one for each ward, dramatically reducing the amount of administration and freeing up nursing time to allow for more 1:1 sessions and Patient Protected time. A significant improvement in the quality and content of patient progress notes and care plans was also noted.

With some exceptions the Trust’s administration of the Mental Health Act has generally been of a high standard across the Trust. Visiting Commissioners have always found the Mental Health Act Law Manager, Robert Keys, and Mental Health Act administrators, Ms Jackie Mustafa Ms Julie King, and Ms Brenda Shaw, to be helpful in facilitating visits, addressing and resolving issues arising in relation to the statutory documentation, and facilitating the training needs of staff in their understanding and operation of the Mental Health Act and Code of Practice.
A number of organisational changes have also taken place during this visiting period. The Commission welcomed the closure of the rehabilitation unit based at Tomswood Close. Residents transferred to Hawkwell Court, offering a better structured and supportive therapeutic environment for patients undergoing rehabilitation back into the community.

At Mascalls Park, the mixed sex inpatient rehabilitation services based at the Woodside Villa closed and transferred to Goodmayes Hospital in May 2009. Female patients were transferred to the new Emily Bronte Unit and male patients to the existing Bridge, thus enabling the service to be provided on single sex wards in line with Government guidance on best practice, and giving patients more accessibility to local community based rehabilitation resources and transport services.

At Mascalls Park, all elderly care patient services transferred to Marigold Ward, following the closure of Magnolia Ward. In the longer term, alongside other inpatient wards at Mascalls Park, the Elderly Care Unit will move to the new building currently under construction on the site of Chapters House at Goodmayes Hospital. The new facility will also comprise of a detox unit. It is anticipated that the new build will be completed in late November 2010.

Unfortunately, less progress has been made in other areas. Response times to the visiting Commissioners feedback summaries have continued to be slow, and in the main, have been of poor quality, often failing to reassure the Commission that a resolution to a particular problem has been found or being considered, or that steps that will be taken by the Trust to bring about systemic change in the particular area of concern. As a consequence further correspondence and/or action has been required of the Trust.

This issue and other specific issues, such as the lack of clinical and psychological input for patients on Pathways PICU, and the absence of a dedicated activities coordinator for the elderly care unit, at Woodbury, issues which have been raised both on visits and, via the other functions of the Care Quality Commission in monitoring the operation of the Act, formed the basis of a positive and constructive meeting in October 2009, between the Named Commissioner, CQC Mental Health Operations Manager and, the Trust’s Chief Executive Officer and senior managers. The outcome of the meeting and the approach to be taken by the Trust in bringing about a resolution to these specific issues was encouraging.

It was also reassuring to hear of the continued efforts of the Trust to improve the experience and treatment outcomes of people who are inpatients on the various wards/units across the Trust, through the Productive Ward, Star Ward and Ward Transformation initiatives. The Trust is commended for its continuing commitment to involving service users in the evaluation and improvement of services through the User Quality Action Team. The Commission looks forward to seeing the results of these initiatives during its visits over the next 12 months.

**Mental Health Act and Code of Practice**
The following points highlight those Mental Health Act issues raised by Commissioners on visits that the Commission considers most serious. 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 Care Quality Commission at the Nottingham office.

**Detention**
The visiting Commissioners were able to check the lawfulness of a patients’ detention through scrutiny of the relevant statutory documentation available on patient files. In one instance, the Commissioner found that the content of the two medical recommendations for a Hospital Order imposed by the court, upon a patient detained on Mark Twain Ward, raised issues over the lawfulness of the order, as the criteria for such an order appeared not to have been met. The Trust took immediate steps to alert the patient’s solicitors in order that the appropriate action could be taken.

In other cases the Commissioners found that where errors had been found on the statutory documentation, they had been picked up during scrutiny by the Mental Health Act Administrators, corrected, and steps taken to ensure that such errors were not repeated.

**Section 58**
A number of deficiencies were found in this area relating to poor clinical practice and record keeping across the Trust, resulting in breaches of Section 58 and/or the associated Code of Practice. Such breaches included incidences of unauthorised prescribing and a number of failures to attach a completed T2 or T3 to the medication chart were found. There were several incidences of failure to record discussions between the Responsible Clinician and the patient regarding the nature, purpose and effect, of medication, or any documented formal assessment of the patient’s capacity when negotiating consent to treatment, particularly in the first three months of treatment. There was also no apparent evidence in a number of cases of any documented entries made by statutory consultees relating to discussions with Second Opinion Appointed Doctors (SOADs) or of the Responsible Clinician’s requirement to record the conversation that they had with a patient following the SOAD’s visit.

The Commission is particularly disappointed about its findings in this area given the Trust’s commitment to make improvements as set out in the comprehensive action plan that was outlined in the Trust’s response to this issue raised in the Mental Health Act Commission’s 2007 report. It was further highlighted as an area of ongoing concern in the Commission’s final report of 2008. Such findings indicate that little progress has been made in the last two years.

The Trust is requested to take further steps to address deficits in this area of practice, and is reminded that in future, continuing failings in this area will inform the registration process being developed by the wider Care Quality Commission.

**Section 17**
Evidence of good record keeping, and compliance with the provisions of the Code of Practice, were generally found across the Trust in respect of Section 17.
Section 132
There has been some further improvement in this area through the use of the Trust’s standard forms for recording, and regular audits for compliance with the Code of Practice and the Trust’s own policy on Section 132. However, visiting Commissioners found some instances, where either patients interviewed by the Commissioners evidently did not understand their rights and/or where it was clear from the Section 132 documentation on the patient’s notes that staff had not made repeated attempts to convey information even when the patient was recorded as not having understood the information on the first attempt.

This was of particular concern in the case of two patients who were detained under Section 2 of the Mental Health Act 1983, and did not understand their legal rights on the first attempt. Subsequent attempts were not made within a reasonable time to enable the patient to exercise his/her right to apply to a Mental Health Review Tribunal within the prescribed time limit.

This was an issue highlighted in the Commission’s Annual Reports of 2007 and 2008, and further effort is required on the part of ward staff and managers to ensure patients’ rights are protected.

Care Programme Approach (CPA) / Section 117
Across the Trust, visiting Commissioners saw some improvement in the quality and content of a number of care plans that were scrutinised in patient files held on RIO. However, in interviews with Commissioners, patients often said that they were not involved in the development of their care plans or in discussions concerning treatment options. The Commission recognises that fluctuations in a patient’s mental state may impede their ability to retain or recall information about care planning discussions, however, there was often little evidence in patient files of patient or carer participation and in some isolated cases there was little evidence of any evaluation of care.

The Trust is reminded that one of the fundamental principles set out in the Code of Practice, is the “Participation” principle (paragraph 1.5) which states:

“Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing, and reviewing their own treatment and care to help ensure that it is delivered in a way that is appropriate and effective for them as possible.”

Such participation requires a collaborative approach that seeks to empower and involve patients (and their carers) in their care planning, in line with the principles set out in the Code of Practice, the Care Programme Approach and the Trust’s own Care Planning Standards.

The Trust is requested to consider further auditing and training of staff in this area to ensure genuine user participation in the care planning process.
Other Issues Raised from Mental Health Act (MHA) Visiting Activity

Bed Occupancy
Evidence of bed over occupancy was found on Pine Ward with reports of patients being slept on other wards or Section 17/home leave, being used to manage bed occupancy. Incidences of high occupancy levels were also reported to the visiting Commissioner to Naseberry Court. The Trust has assured the Commission that high occupancy tends to be a problem for short periods. Bed management procedures are in place and occupancy monitored at a senior level. The Commission will keep this issue under review during its visits over the next 12 months.

Informal Patient Status
Visiting Commissioners were concerned to note that in some areas of the Trust staff did not fully understand the difference between the rights of detained and informal patients. On one visit to Naseberry Court, the use of the terms “Absent Without Leave (AWOL)” and “absconded” were recorded by nursing and clinical staff to describe the status of an informal patient. The Trust is reminded of Paragraph 21.36 of the Code of Practice which states:

“Patients who are not legally detained in hospital have the right to leave at any time. They cannot be required to ask permission to do so, but may be asked to inform staff when they wish to leave the ward.”

The circumstances in which patients are considered to be “AWOL” are set out in Chapter 22 of the Code of Practice, none of which relate to informal patients. The use of the terms “absconded” and “AWOL” in the case of an informal patient is inappropriate and misleading.

The Trust is requested to ensure that staff throughout the Trust, receive further training on the Mental Health Act and Code of Practice in understanding the difference between the rights of detained and informal patients, so that the Commission can be assured that patients' human and legal rights are protected and respected.

Privacy and dignity
The visiting Commissioners continued to find bedrooms on wards across the Trust without appropriate screening for patient bedroom windows and/or observations panels in bedroom doors. Patients reported that in some bedrooms appropriate screening had been missing for several weeks, as evidenced by the visiting Commissioner at Naseberry Court. The Trust has since responded with a plan to conduct weekly environmental audits to pick up issues that may compromise patient privacy and dignity.

Ward Environment
The visiting Commissioners continued to raise concerns about the poor state of some areas of The Bridge, particularly as this rehabilitation unit now accommodates additional male patients from Mascalls Park. It is understood that wardrobe rails that appeared to be weight bearing have been removed following a Commission visit some months ago, however many parts of the ward remain in a poor state of repair, in need of redecoration and refurbishment. Staff reported to visiting Commissioners
in March 2008 and May 2009 that they feel very isolated. The Bridge is the only inpatient unit left in the main building of the hospital and staff continue to feel vulnerable to the possibility that there would be little or delayed support in the event of an incident on the unit. Staff reported that they still cannot access the building by the main entrance during out of hours.

The Trust acknowledged in 2008 when this matter was raised, that the current interim location of The Bridge was unsatisfactory, and that the long-term plan was to move the unit, probably to Chapters House, although more recently the Trust has indicated that the unit is to be refurbished.

The Commission recommends that the Trust gives urgent attention to the environmental matters on The Bridge and its impact on the quality of life for the male patients who are residing there.

**Recommendations for Action**

1. The Trust’s continuing number of breaches in compliance with Section 58 of the Mental Health Act and the Code of Practice is unacceptable. The Trust is requested to review the findings of the Care Quality Commission, and former Mental Health Act Commission about poor compliance in this area of practice and to implement firmer measures to ensure compliance in the future.

2. The Trust is requested to continue its efforts in training staff, monitoring and auditing for compliance with Section 132, particularly for those patients detained under Section 2.

3. The Trust is recommended to provide further training to clinical and nursing staff to strengthen practice in relation to patient participation in the care planning process in line with the fundamental principle of “Participation” at paragraph 1.5 of the Code of Practice and, the revised CPA guidance. Further steps should be taken by the Trust to provide regular monitoring and auditing in this area.

4. Regular audits on patient bedrooms should be implemented to ensure adequate safeguarding of privacy and dignity at both doors and windows, particularly on mixed sex wards.

5. The Trust is requested to address the environmental issues and staff concerns on The Bridge as a matter of priority.

6. Further training should be given staff to ensure that they are clear about the status and rights of all patients, particularly informal patients. Clear best practice policy guidance should be implemented by the Trust on the management of informal patients, to ensure that their legal and human rights are protected.

**Forward Plan**

Mental Health Act Commissioners will continue to visit the Trust 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 Trust’s services.

During the year the Named Commissioner will meet with senior managers as required to review progress on the issues raised in this report, and any matters of concern that may arise from visits during the course of the year.
Appendix A: List of wards visited at North East London NHS Foundation Trust

<table>
<thead>
<tr>
<th>Date</th>
<th>Hospital</th>
<th>Detained patients seen</th>
<th>Records checked</th>
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<tr>
<td></td>
<td>Woodbury Unit</td>
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<td>23 Jun 2009</td>
<td>Ward 1</td>
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<td>Ward 2</td>
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<td>Naseberry Court</td>
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<td>12 Mar 2009</td>
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<td>Mascalls Park</td>
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<td>The Bridge</td>
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Total Number of Visits: 16  
Total Number of Wards visited: 19  
Total number of Patients seen: 59  
Total Number of documents checked: 56