Mental Health Act Annual Statement December 2010

West London Forensic Services
West London Mental Health NHS Trust

Executive Summary

This statement reflects the findings of visiting Mental Health Act (MHA) Commissioners in the period between 1 October 2009 and 30 September 2010. Where appropriate this statement includes consideration of the responses given by the provider to those visits. During the reporting period the Care Quality Commission (CQC) has visited West London Forensic Services on 22 occasions, visiting 20 wards, interviewing 109 patients in private and scrutinising 100 sets of records.

In general the MHA Commissioners found that there were significant areas of improvement in the responsiveness of senior officers, physical healthcare provision and the ward environment. Areas for development are compliance with section 58, and section 132 and Code of Practice guidance in areas of information about rights and recording of capacity and consent. Response times and quality of responses is better but there remains a significant concern that good practice found in one place is not cascaded through the service.

Main findings

West London Forensic Services are part of West London Mental Health Trust and this Annual Statement should be read in conjunction with the ones prepared for Broadmoor High Secure Services and Ealing Local Services. West London Forensic Services provide medium and low secure services for men and enhanced medium, medium and low secure services for women. It also provides open mixed sex rehabilitation wards. These services are arranged across three sites within the same grounds in Ealing, Three Bridges Regional Secure Unit, The Orchard Women's Unit and the Tony Hillis Wing.

The following points highlight those Mental Health Act issues raised by Commissioners on visits and is drawn from the data presented in annex A. The detailed evidence to support them has already been shared with the provider through the feedback summaries and is not repeated here. For further discussion about the findings of this Annual Statement please contact the Care Quality Commission's Mental Health Operations Office located at The Belgrave Centre, Nottingham.

Relationships with the provider in the reporting period

The previous Annual Statement for West London Forensic Services written in October 2009 was received positively and an action plan published following the receipt of all three annual statements. This has been monitored by visiting Mental Health Act Commissioners on their visits during the reporting period and considerable progress noted in a number of areas.

While response times have generally improved to visit feedback summaries there were concerns raised earlier in 2010 about the quality and delay of responses to which assurances of review and improvement were forthcoming. It is noted that the quality of responses has improved. There are some good examples of response times from Tagore Ward, Melrose (12 June 2010) and Benjamin Zephaniah (BZ) however the general trend is for responses to be made after the required deadline. This is not the case at Broadmoor Hospital where managers, by comparison, are very swift in their responses. There are currently five feedback summaries awaiting a response, the oldest being seven months old. The Commission received the trust's response for Glynn Ward after 147 days from the day the feedback summary was issued to the trust. Other examples of overdue responses are Melrose Ward (14 November 2009) 75 days, Brunel Ward 62 days, Pearl Ward 61 days and Garnet Ward 57 days. Still outstanding is a response from a visit to Blake Ward on 3 March 2010 – a period of seven months has elapsed with the expected response time set for mid April.

Relationships with senior clinicians and managers have been constructive during the reporting period. Accessibility of the Chief Executive and Medical Director have been valuable and Commissioners have welcomed the opportunities for key training and RiO training that have resulted from these meetings making access to wards and records smoother and reducing the demands on nursing staff during visits. The response of the Chief Executive to concerns raised has been swift and encouraging.

Relationships with the Mental Health Act office remain consistently good and help is always provided to Commissioners swiftly and efficiently. The Commissioners are pleased to note that additional resources have been found to assist this busy office that was in great need of extra resources during the last reporting period. Staff are to be thanked for their assistance during visits to wards that come as additional duties in their already busy schedules.

Mental Health Act and Code of Practice Issues

Detention

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcome 7L

The patients in West London Forensic Services are all subject to a section(s) of the MHA -mostly Part lll as they are mentally disordered offenders - although some civil patients are accommodated. On a few occasions detention papers have not been accessible on patients' notes however the MHA office have originals and there have been no examples of unlawful detention during this period that Commissioners are aware of.

Leave – Section 17 and Absence without leave Section 18

Nursing staff appear to work hard at accommodating section 17 leave and even when staffing is short, it remains a priority. Frustrations aired by patients are usually in relation to time it takes to be considered for leave both by the clinical team and / or the Ministry of Justice. For patients without leave there is no access to the smoking

shelters and this causes difficulties within the patient group. For those with escorted leave who are smokers, leave seems to be exclusively devoted to smoking and therefore the range of rehabilitative activities that leave could be used for are limited for these patients. One of the concerns raised by the patients was that the authorised section 17 escorted leave was not always facilitated, quite frequently due to staff shortages. Patients on Rollo May, Brunel, Parkland, Aurora and Russet wards raised this concern.

Consent to Treatment

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcomes 2C and 9E

While the Chief Executive has attended directly to concerns raised about this issue there continue to be examples of unlawful treatment. Commissioners have found examples in this reporting period on Tagore Ward, Rollo May Ward, Glynn Ward, Melrose Ward and Derby 1.

There remains significant improvement to be made in the area of recording the patient's attitude to treatment and their capability at the time decisions are made. The Commissioners specifically scrutinise RiO for evidence of discussions with patients about their attitude to treatment and capacity assessments at admission and regular intervals thereafter. It is not appropriate to note "consent done" or "has capacity". While Commissioners do not expect a lengthy entry, something more meaningful than this is required. Please refer to the guidance set out in Chapter 23 of the MHA Code of Practice to assist in this improvement.

The nature of mental disorders experienced by patients in this service means that capacity to make treatment decisions may vary over time and therefore issues of capacity should be integral to any recording about treatment discussions.

Documenting Second Opinion Appoint Doctor (SOAD) visits in progress notes is rare and entries by Statutory Consultees remain variable and in general quite poor. The approach adopted by Barron 1 Ward to Wooder compliance, entries made by Statutory Consultees and the use of the consent to treatment proforma were exemplary and could usefully be cascaded to other wards in this trust.

Commissioners are pleased to note in the latter part of this period that medicine charts have finally been amended to reflect amendments in law enacted in November 2008. This is an area commented on many times in reports. The obsolete terms of Responsible Medical Officer (RMO) and Form 38/39 have been removed and Responsible Clinician (RC) and Form T2/T3 inserted. It would also be helpful if staff could make use of these charts fully so that the patient's status and authority to treat is clearly illustrated on the chart and available to those dispensing medicines.

Section 117 / Care Programme Approach (CPA)

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcome 4A and 4R

Patients are usually able to articulate what their care plans are and appear to have regular CPA meetings that they attend and find useful. However, on scrutiny of these

documents there appears an absence of entries that document the patient's view directly. CPA documents are top heavy with professional commentary and rarely include entries about the patient's view – it is not always apparent from the documentation that they have participated at all.

As far as the nursing care plans are concerned, in most cases they are of good standard and incorporate the risks identified in the risk assessment. The main short coming is that these care plans are not reviewed regularly, in some cases up to three or four months. Some of the ward managers and the nursing staff the Commissioners spoke to hold the view that the nursing care plans should be reviewed at least monthly.

Section 130A – Independent Mental Health Advocacy (IMHA)

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcome 1A

There have been notable improvements in information about and access to IMHAs during this period and patients seem to be making use of this service. There have been examples of the old rights leaflets still being given out. It has been a concern that the knowledge of the staff in relation to the requirements and provision of IMHA has been very poor and the visiting Commissioners have raised this concern on a number of occasions.

Section 132 – Information to Patients

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcome 1A

This continues to be an area that lacks consistent evidence of legal duties performed. The MHA Code of Practice contains guidance at chapter 2 that lays out the requirements and the service would benefit from a comprehensive review and training programme. Some wards cover some aspects well and not others, the timing of re-presentation varies and indicates a lack of protocol about when to carry out the duty to re-present information and to record that it has been done both orally and in writing. It is clear that many patients in this service are well appraised of their rights or the aspects of their experience that interest them. However, finding a way of regularly discussing rights with these patients and documenting the evidence of this remains an area for development. Reassurance on this subject has been forthcoming for a number of years so it is concerning that there remains a lack of consistency in approach to evidencing the performance of these legal duties.

Seclusion and the Management of Violence

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcomes 4Q, 7F and 7H

The nature of the patient group means there will be increased likelihood of incidents of violence and aggression that will necessitate the use of seclusion. While only getting a snapshot of this during visits it is not an area that has been brought to the attention of Commissioners in a way that raises concerns. The difficulties with staffing wards adequately raises anxieties in the staff and patient groups but the Commissioners are not aware of issues in this area that require attention. The

seclusion room on Tagore Ward highlighted in the last Annual Statement was found to be *"much improved in relation to climate control"*

Deaths of Detained Patients
A death by self strangulation occurring on Melrose Ward in this period was concerning as it appeared to be very similar to one that had occurred on the same ward the previous summer.

There are three other deaths of detained patients on Rollo May, BZ and Bevan that the Commissioners await confirmation of cause of death through the notification process.

Other Patient Issues

Physical Healthcare
Commissioners are pleased to note that access to GP and healthcare facilities is much improved. Patients routinely report a good service in relation to routine dental, eye and foot care as well as regular health checks and a swift response to health care problems. Though the trust policy expects each patient to have a physical examination prior to the CPA, the visiting Commissioners could not find any record in a number of patients' notes of a physical examination being carried out within twelve months prior to the visit.

Participation
Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcome 1

Participation in care planning and the CPA process has been mentioned above. All wards visited have regular in patient review systems that include the participation of the patient. Many wards have a plan of day meetings that patients are encouraged to attend and there are community meetings and patient representatives on each ward.

Environment
There has been an improvement in the ward environments generally and of particular note are some of the Tony Hillis Wing wards such as Avebury that are welcoming and pleasant despite being housed in an old Victorian building. No reports of rodents have come to the Commissioners' attention during this period and while it may not be possible to eradicate them completely there has clearly been an improvement as patients are not making complaints as they did previously.

An excellent addition to some of the wards has been the housekeeper role and it was noted as *"making a big difference to ward maintenance as well as relieving nursing staff from administrative duties related to the environment allowing them to focus on nursing tasks."*

It was disappointing to find that some areas had not been refurbished despite the need for this being raised previously – for example, the bathroom and toilet areas on Derby 1 Ward.

Access to fresh air seems to have improved and wards that don't have direct garden access have shown a willingness to take patients without leave out to the garden for fresh air.

Smoking Ban

The smoking ban continues to preoccupy and anger patients who would choose to smoke if they could. Wards often smell of smoke and there have been some smoking related fires on wards reported to Commissioners. The erection of three smoking shelters is welcome and alleviates some of the patient tension around this issue but causes problems between patients who have leave and those that do not.

It is of concern to Commissioners that patients reported their relationships with staff as having deteriorated due to the searches for tobacco. On Tom Main Ward "*one nurse said that therapeutic engagement has been replaced with policing the ward for cigarettes and lighters."*

On Tagore Ward a nurse said that the *"many confrontations about illicit cigarettes and lighters serve to impair the therapeutic relationship."*

There have been many accounts of patient vulnerability to exploitation in relation to smoking – those with leave being asked to bring tobacco in for those that haven't got leave and the high cost of one cigarette ranging from £5 upwards.

Some patients have of course benefited from the imposed ban and taken the opportunity to stop smoking, for those detained patients who wish to continue, the fact that prisoners have access to cigarettes and they do not continues to anger and frustrate them. It is noteworthy that despite the amount of searching that takes place cigarettes and lighters are routinely getting taken onto wards.

Privacy

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcome 1A, 10F, 10M

All patients have the privacy of their own rooms and some have en suite facilities. There appear to be enough facilities in those wards where they are shared. While subject to risk assessments, many patients are able to have equipment in their rooms enabling further privacy. Rooms are lockable and lockers are available. An exception to this was Derby 1 where patients complained that they did not have keys to their rooms unlike other patients on the unit.

The location of the patients' phone, while satisfactory on many wards, was found not to afford privacy on Pearl Ward and Blake Ward. The right to respect for private and family life is an European Court of Human Rights (ECHR) Article 8 right and unless there is evidence that the patient is causing harm or nuisance they should be afforded privacy to make phone calls.

Mental Capacity Act

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcome 7L

While patients in this service are all detained under the MHA, there may be times when decisions about issues other than those that are related to mental disorder may be necessary to make. For patients who at the material time are unable to make a decision for themselves it will be necessary that staff make a judgment about what will be in the best interest of the patient – for example physical healthcare needs that are not symptoms or manifestations of the mental disorder. It will be important in these circumstances that staff fully understand the legal authority relied on for their actions and record this.

Recommendations and Actions Required

1. West London Mental Health Trust should keep its smoking policy under review, mindful of similar policies in other London trusts and in the prison service.

2. West London Mental Health Trust should take action to ensure that all the clinicians comply with section 58, to ensure lawful treatment regimes, as required by the Act and Code of Practice.

3. West London Mental Health Trust should ensure that areas of good practice in one area are disseminated throughout so that high standards found in one area are replicated across the whole of the service.

4. West London Mental Health Trust should ensure that staff are fully informed and in receipt of training about the role and function of the Independent Mental Health Advocate.

5. Response times by the trust to the CQC should be more consistent and compliant with time scales set by Mental Health Act Commissioners. The general requirement is that the trusts has one calendar month from the issue of the report to respond to issues raised unless action is more urgent and this will be highlighted by the Commissioner at the end of the visit to the appropriate personnel.

Annex A

The quantitative data will only apply to visits completed from 1 April 2010 which is the time that the new data started to be captured uniformly

Date	Ward	Det. Pats seen	Pats in groups	Records checked
Ealing Forensic				
03/10/2009	Avebury (Forensic)	6	0	5
18/11/2009	Derby 1 (Forensic)	5	0	5
21/11/2009	Brunel Ward (Independently Owned Run/Managed By NHS)	5	0	5
12/12/2009	Mott House (Forensic)	2	0	5
15/12/2009	Rollo May (Forensic)	8	0	6
19/12/2009	Glynn (Forensic)	6	0	6
19/02/2010	Tagore (Forensic)	5	0	4
06/02/2010	Butler House (Forensic)	7	0	4
03/03/2010	Blake (Forensic)	4	0	5
15/03/2010	Pearl	6	0	3
20/03/2010	Bevan (Forensic)	5	0	5
08/05/2010	Wells Unit (Forensic)	3	0	4
21/04/2010	Tom Main (Forensic)	5	0	4
27/04/2010	Barron 1 (Forensic)	2	0	5
24/07/2010	Benjamin Zephaniah (Forensic)	6	0	5
07/09/2010	Avebury (Forensic)	5	0	3
Totals for Ealing Forensic		**80**	**0**	**74**
Orchard Unit (Ealing Forensic)				
14/11/2009	Melrose	4	0	4
09/01/2010	Garnet	4	0	5
27/03/2010	Parkland	5	0	5
01/05/2010	Aurora	4	0	4
12/06/2010	Melrose	5	0	4
11/08/2010	Russett	7	0	4
Totals for Orchard Unit (Ealing Forensic)		**29**	**0**	**26**

Total Number of Visits:	22
Total Number of Patients Seen:	109
Total Number of Documents Checked:	100
Total Number of Wards Visited:	20

Findings from Visits - Environment and Culture:	YES	NO	N\A
If the door is locked is there evidence that informal patients are informed of their right to leave the ward and given the means to do so?	0	1	8
Are you satisfied that there is evidence that informal patients are free to leave the ward in line with legal requirements?	0	1	8
Do patients have the ability to lock their rooms securely and the means to do so? [answer no if in dormitories]	7	2	0
Do patients have lockable space which they can control?	8	1	0
Are arrangements to cover viewing panels in bedroom doors adequate to protect patient privacy?	8	1	0
Are curtains or other window coverings in patient bedrooms adequate to protect privacy from people outside the ward?	9	0	0
Does the ward provide single gender sleeping areas, toilets, bathrooms and lounges?	4	1	4
Is there a ward phone for patients' use?	9	0	0
Is it placed in a location which provides privacy?	6	3	0
Are there any circumstances under which patients may have their mobile phones? [answer N/A if HSH]	2	7	0
Do patients have an opportunity to participate in influencing the ward they are on via such mechanisms as community meetings, patients' councils etc?	8	0	1

Findings From Document Checks	YES	NO	N\A
Were the detention papers available for inspection? Did the detention appear lawful	37	1	0
Was there either an interim or a full AMHP report on file?	6	2	30
If the NR was identified was s/he consulted, If there was no consultation, were reasons given?	2	3	33
Where appropriate was all psychotropic medication covered by a T2 and/or T3?	33	1	4
Was there evidence a capacity assessment at the time of first administration of medication following detention?	0	3	35
Was there evidence a discussion about consent at the time of first administration of medication following detention?	0	3	35
Was there a record of the patient's capacity to consent at 3 months?	8	4	26
Was there a record of a meaningful discussion about consent between the AC and the patient at 3 months?	22	7	9
Was there evidence that the RC had advised the patient of the outcome of the SOAD visit or an explanation why not?	10	2	26
Was there evidence of discussions about rights on first detention and an assessment of the patient's level of understanding?	16	4	18
Was there evidence of further attempts to explain rights where necessary?	26	1	11
Was there evidence of continuing explanations for longer stay patients?	28	7	3
Is there evidence that the patient was informed of his/her right to an IMHA?	16	18	4
Are the patient's own views recorded on a range of care planning tools?	13	23	2
Was there evidence that the patient was given a copy of their care plan?	37	0	0
Is there evidence that the patient signed / refused to sign their care plan	28	5	5
Was there evidence of care plans being individualised, holistic, regularly reviewed and evaluated?	28	9	1
Is there evidence of an up to date risk assessment and risk management plan?	35	1	2
Is there evidence that discharge planning is included in the care plan?	14	0	24
Were all superseded Section 17 leave forms struck through or removed?	10	20	8
Was there evidence that the patient had been given a copy of the section 17 leave form?	25	5	8
Are the timescales, frequency and conditions for the use of leave unambiguously specified?	26	0	12
For patients in hospital less than a year, is there evidence of a physical health check on admission?	3	3	32
For patients in hospital over than a year, is there evidence of a physical health check within the last 12 months?	23	9	6

	0	1	2	N\A
If the patient's medication was authorised on a T3, was there a record of the discussion between the SOAD and the statutory consultees [enter 0 for none, 1 for one consultee, 2 for both consultees, and n/a if no T3]?	4	1	6	27

Annex B – CQC Methodology

The Care Quality Commission 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. Since November 2008, Commissioners have also been meeting with patients who are subject to Community Treatment Orders. 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, ethnicity and gender of detained patients.

- Ward environment and culture, including physical environment, rights to leave, patient privacy and dignity, gender separation, choice/access to services/therapies, communication facilities, physical health checks, food, and staff/patient ratios, smoking facilities, staff patient engagement, diversity and cultural sensitivity, cleanliness and upkeep of the ward, fresh air and exercise, physical safety and environmental risks.

- 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 assessing the providers compliance with the Mental Health Act 1983 and the Code of Practice including scrutinising the supporting documentation, records, policies and systems. The Commissioner reviews the basis and evidence of detention, including compliance with Sections 132, 132a (information to the detained patient about their rights), Section 58 and 58A (consent to treatment), the provision of the Independent Mental Health Advocacy (IMHA) service, the use of the Mental Capacity Act Deprivation of Liberty safeguards, Section 17 and 17A (leave and Community Treatment Orders) and reviews the evidence of the patient's participation in their treatment by reference to the Care Programme Approach documentation. The patient's access to physical care and treatment is also assessed.

At the end of each visit a "feedback summary" is issued to the provider 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 provider 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 to inform the process of registration and on-going compliance with the outcomes and essential standards of safety and quality in accordance with the Health and Social Care Act 2008.