

Mental Health Act Annual Statement January 2010

Local Services – Ealing, Hounslow, Hammersmith & Fulham West London Mental Health NHS 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.

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 Healthcheck 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

A list of the wards visited within this Trust is provided at Appendix A.

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.

Main findings

Relations between Mental Health Act Commissioners and senior managers of the Trust have remained constructive throughout the reporting period. This period has been one of considerable activity between the Trust and the Care Quality Commission. Much, but not all, of this has been triggered by the publication of the CQC report into West London Mental Health Trust.

During the period, the Named Commissioner met with the Director of Ealing services in July and the Director of Hammersmith and Fulham in August. In September constructive meetings took place between the CQC Mental Health Operations Manager and the Director for Hammersmith and Fulham, and both he and the named Commissioner had constructive discussions with the Service Manager of the Lakeside Unit in August. In October the CQC shared a platform with the Trust at the Hounslow Local Involvement Network meeting (LINKs) to discuss mental health services

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 author of this report via the Care Quality Commission at the Nottingham office.

Detention

Commissioners generally found statutory documentation in order and on the occasions where errors have been found, they have quickly been corrected. The Commission has reported concerns however about whether the Trust is adequately staffing this service to cope with the increasing demands placed upon it. While it is impressed with the dedication, skill and commitment of individual Mental Health Act Administrators, 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 Mental Health Act issues raised in one part of local services continue on other sites indicating a lack of overall action to address issues across the entire service at a strategic level.

Recommendation for Action

The Trust's Mental Health Act Manager should review current Mental Health Act Administration services to confirm whether they are able to cope with increased demands generated by Supervised Community Treatment, the Mental Capacity Act, and the Deprivation of Liberty Safeguards and still fulfil existing core administration and audit requirements.

Section 58

Responsible Clinicians continue to fail to record assessments of capacity when negotiating consent to treatment. They also do not regularly demonstrate the nature of discussions for consent or the information provided to patients. The compliance of Responsible Clinicians with their requirement to record the conversation they have

with a detained patient following the visit of a Second Opinion Appointed Doctor (SOAD) remains patchy as does the requirement that the other consultees also record their meetings.

These issues, were addressed in the response to the 2008 MHAC Annual Report where the Trust wrote:

“It is agreed that we have more work to do to improve our performance and documentation. In relation to documentation following second opinion visits, a letter has gone out to all relevant staff from our Medical Director formally reminding them of the requirements of both the RMO and the statutory consultees. In our forensic wards where there is greatest use of Part IV of the Act, each one has now identified a person to check consent to treatment documentation on a regular basis. In addition there is a Trust-wide quarterly audit on consent to treatment for detained patients, the findings of which go to the Divisional Clinical & Research Governance Groups for action and to the Trust Clinical & Research Governance Executive for monitoring. We will also be sending the audit reports to the Commission. The West London Forensic Service proforma for documenting statutory duties in respect of Form 38 and Form 39 has been updated for use across the service. This has been widely consulted on across the services and will be rolled out for use shortly. The new proforma aims to ensure consistent practice and comprehensive compliance. In addition, completion of the proforma will be made subject to a rolling audit programme. The audit process will be introduced in the Induction programme for Junior Doctors and form part of their routine job plan.

Local services are considering the appropriateness of adopting this proforma for use in acute wards in London. A number of other local initiatives to monitor and improve compliance are underway Trust-wide. We believe that training which will inevitably be rolled out to clinical staff in the run up to the Amended Mental Health Act will provide an excellent opportunity to formally update knowledge on compliance with consent to treatment and second opinion requirements.”

The findings of Commissioners in this regard are supported by the findings of the recently published Acute Inpatient Survey where West London scored in the lowest 20% on two key questions:

- Did the hospital staff explain the purpose of this medication in a way you could understand?
- Did the hospital staff explain the possible side effects of this medication in a way you could understand?

Recommendation for Action

The Medical Director is asked to address Consent to Treatment issues with medical staff and instigate effective audit systems to address this matter across all services.

Section 132

Commissioners found deficiencies in this area on a regular basis. This has included poor evidence of compliance to inform patients of their rights. Patients have also

shown little understanding of their rights leading to questions as to the effectiveness of current methods taken to discuss rights with those who are detained.

Recommendation for Action

The Director of Nursing is asked to address with ward managers the requirements of Section 132 of the Act and ensure effective understanding of both the underlying ethic and the administrative requirements.

Other Issues Raised

Mental Capacity Act

The lack of use of the Mental Capacity Act remains a recurring issue. Staff often said they had received training but there was little evidence of its use by medical, nursing or other health staff on wards. This is important when a patient is detained and is a statutory requirement when patients who lack capacity are staying on wards and are not detained under the Act.

Recommendation for Action

The Trust reviews its implementation of the Act and develops a system to audit the current lack of use across wards to ensure compliance with this legislation.

Coordination between services

The Commission is aware of raising a number of issues on different wards on a regular basis over time and finding that they recur both on other wards in a local area or on wards in other local areas. It appears that coordination between wards and all local services is not clear enough to ensure strategic action is taken to tackle an issue uniformly across all local services.

Recommendation for Action

The Trust and local service directors should consider how issues raised by the CQC in one area are benchmarked across other areas.

Nursing staff

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 nursing staff. From being too busy to talk to them to more negative comments, this issue is central to the patient experience of care.

This feedback is confirmed by the results of the Acute inpatient survey where the Trust scored in the lowest 20% of all Trusts on the questions:

- Did the nurses listen carefully to you?
- Were you given enough time to discuss your condition and treatment with the nurses?
- Did you have confidence and trust in the nurses?
- Did the nurses treat you with respect and dignity?

Indeed it would appear that the Trust's score on 'Did the nurses treat you with respect and dignity' at 57% is close to the lowest score in the country

Recommendation for Action

The Director of Nursing takes action to address poor patient experience. The Commission is aware of the Time to Care initiative and hopes the Trust will effectively audit its implementation to ensure ongoing improvements.

Informal patients

Ensuring informal patients understand their rights to leave wards etc has been raised on a number of occasions. The Trust should consider a uniform approach across all three boroughs to address this matter including an informal rights leaflet and signs by exit doors explaining rights. The issue also connects to assessment of patients in terms of capacity to consent to their admission or continued stay on a ward and potential Deprivation of Liberty indicators.

Recommendation for Action

The Trust develops measures to address the rights of informal patients across all local services.

The Physical Environment

Concern over ward environments was raised on a number of visits from lack of cleanliness, mice and cold bedrooms to general repair issues. The Commission is aware of the involvement of the Healthcare Associated Infection Team of the Care Quality Commission and hopes that after many years of campaigning about the issue of vermin on the Ealing site, progress is beginning to occur. The Commission is also aware that many sites are undergoing considerable physical changes at present or in the near future and hopes that this will resolve many of these issues.

Recommendation for Action

The Trust ensures that environmental issues raised during visits are tackled promptly.

Police

The Commission is concerned about police not taking action to charge patients with offences such as serious assault (resulting in forensic MHA detention) and instead using civil admission (Section 2 or 3). This can remove patients from the oversight of forensic services that are better equipped to provide assessment and treatment and also places undue pressures on local services potentially increasing risk levels in areas less able to deal with this. The Commission welcomes the Designated Police Officer project at Ealing that has started resulting with an officer (Andy Fox) being on site and hopes this project will address our concerns.

Recommendation for Action

The Trust takes forward this issue with the police and monitors cases where action is not taken.

Phones

The Code of Practice states:

“16.3 Hospitals should make every effort to support the patient in making and maintaining contact with family and friends by telephone and to enable such calls to be made with appropriate privacy. Most wards contain coin-operated and card-

operated telephones. Hospital managers should ensure that patients can use them without being overheard. Installing booths or hoods around them may help to provide the necessary level of privacy.

16.4 The principle that should underpin hospital or ward policies on all telephone use is that detained patients are not, of course, free to leave the premises and that individual freedom to communicate with family and friends should therefore be maintained as far as is possible. Any restrictions imposed should be the minimum necessary, so as to ensure that this principle is adhered to.”

This issue was raised across the service and unfortunately remains unresolved.

Recommendation for Action

The Trust reviews all wards to quickly address this matter in local services.

Smoking

The Commission is aware of proposed changes to the Trust’s smoking policy but it notes that many visits have contained negative comments on the impact of the existing policy of not allowing any smoking on the hospital sites. This evidently creates considerable patient frustration and annoyance which impacts on staff. The Commission looks forward to monitoring future developments in this area.

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 they plan to meet members of the Mental Health Law committee to review progress on the issues raised in this report.

Appendix A

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

Date	Ward	Det. Pats. seen	Records checked
Lakeside Unit			
25 Nov 2008	Kingfisher Ward	3	4
1 Dec 2008	Dove Ward	3	2
	Grosvenor Ward	4	2
25 Jun 2009	Finch Ward	5	4
19 Aug 2009	Kingfisher Ward	3	4
25 Aug 2009	Kestrel Ward	5	5
27 Oct 2009	Dove Ward	4	3
Total for Lakeside Unit		27	24

Hammersmith & Fulham Mental Health Unit

10 Nov 2008	Avonmore Ward (Was Area 2)	6	3
26 Nov 2008	Lilly Ward (Was Area 4)	5	5
6 Feb 2009	Askew Ward (Was PICU)	4	3
13 May 2009	Meridian Ward (Was Area 3)	10	3
15 Jul 2009	Ravenscourt Ward (Was Area 1)	6	5
26 Oct 2009	Lilly Ward (Was Area 4)	8	5
13 Jan 2010	Meridian Ward (Was Area 3)	0	0
Total for Hammersmith & Fulham Mental Health Unit		39	24

Ealing Local (Non Forensic)

27 Jan 2009	Beverley Ward (Non Forensic)	4	3
7 Feb 2009	Coniston (Non Forensic)	2	3
	Windermere (Non Forensic)	3	4
15 Feb 2009	Windermere (Non Forensic)	4	2
31 Mar 2009	Campion Ward (Non Forensic)	1	5
30 Jun 2009	William Sargent	2	4
1 Jul 2009	Blair (Non Forensic)	6	5
18 Jul 2009	Mary Seacole (Non Forensic)	4	4
31 Oct 2009	Conway (Non Forensic)	3	4
5 Dec 2009	Beverley Ward (Non Forensic)	7	7
11 Dec 2009	Coniston (Non Forensic)	6	4
Total for Ealing Local (Non Forensic)		42	45

Total Number of Visits: 23

Total Number of Wards visited: 25

Total number of Patients seen: 98

Total Number of documents checked: 93