Mental Health Act Annual Statement January 2010

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 Trust. All decisions must be lawful, informed by good practice and consistent with the Human rights Act 1998. Mental Health Act Commissioners expect these principles to underpin all decisions and clinicians and managers and all those involved in providing care 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 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 CQC’s assessments of organisations in relation to registration requirements, through evidencing ongoing compliance with the Mental Health Act and the Code of Practice

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

Background

The East London Mental Health Foundation Trust provides all specialist NHS Mental Health and Learning Disability care for the people in the boroughs of Newham, Tower Hamlets, the City and Hackney. It provides both community services, with specialist community teams for Assertive Outreach, Crisis Intervention and Early Intervention teams, and inpatient care mainly within three mental health centres in Newham Centre for Mental Health, Tower Hamlets Centre for Mental Health, the City and Hackney Centre for Mental Health, and a small number of out-laying wards in the community. Medium Secure care is also provided by this Trust from the John Howard Centre (JHC).

This Annual 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 CQC.

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 during this reporting period. The final Annual Report of the Mental Health Act Commission was received positively by the Board and an action plan was published. This has resulted in considerable progress in a number of areas. In particular Mental Health Act Commissioners are pleased to note an improvement in the occupancy levels on the wards, a matter that has been of concern over a number of years. There is a reduction in the use of Section 17 leave and other ‘sleeping out’ arrangements that were previously used to address the demand on beds on the wards.

In August 2009 the Named Commissioner for the Trust, attended a meeting with the Acute Care Forum at Homerton Hospital. During this meeting, a presentation was made of the audit of 10 agreed standards carried out by the user group on the wards in Hackney. Some short-comings identified were received positively by all the professionals present.

The Named Commissioner carried out a scrutiny of the use of Community Treatment Orders (CTOs) which has raised several issues. Many of these findings were described in the recent Serious Untoward Incident (SUI) report about a patient on Supervised Community Treatment (SCT). These include (a) lack of detention documents, (b) haphazard filing of documents, (c) lack of assessment of capacity and consent (d) lack of information regarding the availability of Independent Mental Health Act Advocacy (IMHAs) (e) no systematic evidence of Second Opinion Appointed Doctor (SOAD) request (f) no discussion about medication or the conditions of the SCT with the patient (g) lack of evidence of patient involvement in

their care and treatment and so on. The Trust sent a comprehensive response to the concerns raised which promised systematic and systemic changes to improve the administration of SCT to patients.

The Named Commissioner also attended a User Group forum within Hackney, when a number of concerning issues were raised by a group of more than 20 service users. Participants of this forum felt less confident that their issues were taken seriously by the Trust. They also had reservations about the complaints procedure that they needed to follow before they could raise their concerns with the Commission. These issues are being discussed with the Trust.

Although this Trust has initiated several innovative activities to involve service users in aspects of their care at corporate levels, such as the audit of standards on the ward, mentioned above, the CQC is concerned that the day to day experiences of individual patients on the ward may be lost from the focus of the service user involvement strategy.

Mental Health Act and Code of Practice

Over the last twelve months a number of concerns have been raised with the Trust. An overview of the concerns raised during the visits over the year, reveals that there were over twenty issues, each of which was found in at least four or more visits. Of these, six issues that featured more than 12 times in the visit reports, have been elaborated in the following sections of this Annual Statement. Some other issues are also highlighted both because they occurred frequently and also because of their serious nature. This does not mean that other concerns found by the visiting Commissioners were less important but they occurred less frequently across the Trust and were less emphasized by the other stake-holders who were seen over the year.

Following each visit, the detailed evidence to support the findings has already been shared with the Trust and is not rehearsed here. However, some examples are repeated here only to emphasize their nature and the fact that they are of particular concern to the CQC.

Statutory Documentation

Detailed scrutiny of patients' files revealed that there were over 20 occasions when visiting Mental Health Act Commissioners found issues with the detention documents. These included:

- Missing detention documents in the patient files such as on Crystal Ward.
- Detention documents which were found to have mistakes made in completing them.
- Missing Approved Mental Health Professionals (AMHP) reports of the social circumstances at the time of detention.

Many files also had several copies of the same reports making them unwieldy and chaotic. It is vital to ensure that accurate, up-to-date records in chronological order are maintained in patient files. This is especially important because a number of people seen during the visits had been in hospital over long periods of time, and had experienced a number of renewals of their detention orders. In order to ensure the

continuing lawfulness of their detention, it is essential that copies of the original detention documents are kept together and accessible for scrutiny within the patient's current file.

Section 17 Authorised Leave
With regard to Section 17, a number of issues were found, such as: inability to access escorted leave due to staff shortage; inability of patients to negotiate leave for particular activities such as attending the mosque for prayers; in many files there were several forms with overlapping dates creating confusion about the current leave status; and sometimes Section 17 leave documents could not be found in the files. These issues were raised at the time with each of the wards but have been raised here as they continued to occur on many other wards.

Section 58 Consent to Treatment
In the twelve months, visiting Mental Health Act Commissioners came across some good innovative practices such as making available a pharmacist on the ward for patients to discuss their medication. However, they also found a range of matters of non-compliance with the requirements under this Section of the Act. The most concerning issue found by visiting Mental Health Act Commissioners on some wards was a lack of attention to the views of individual patients, which were recorded on their files but there were no actions evidenced to address them.

Other concerns recorded by visiting Mental Health Act Commissioners included lack of evidence regarding the assessment of capacity or the obtaining of consent, both during and after the first three months of detention; a failure to record any discussion about medication and its side effects with patients; no records of communicating the Second Opinion Appointed Doctor (SOAD) decisions to patients or the statutory consultees' discussions with the SOAD. The CQC acknowledges that there have been delays in making SOADs available on occasions; however, there were several patients on wards such as Globe, for whom requests for SOADs had not been made over long periods of time.

Section 132 Patient Rights
Visiting Mental Health Act Commissioners heard from patients on several wards that they had not been explained their rights, although some said that they had been given a leaflet which they did not understand. A scrutiny of patient files also found that they did not evidence the discussion of patients' rights whilst they were detained, as there were no Section 132 forms nor were there records of discussions in the progress notes. Some files that did have the completed forms were dated on or soon after detention when the patients were likely to be too unwell to take in the information.

The last annual plan had identified a gap in patient participation in the development of their care plans. Despite the Trust's assurance that this would be addressed through training and change in policy, there has been no demonstrable improvement in the availability of care plans or in involving service users in constructing them. It is further concerning that in those wards where there was evidence of 1:1, these frequently did not record meaningful discussions which included issues of concern to the patients. The service user group also stated that they were not involved in drawing up their care plans and did not receive individual help focussed on helping

them get better and prepare for discharge. Plans were frequently not signed by the service users and their views on the care plan were frequently absent. The CQC has drawn the Trust's attention to paragraph 1.5 of the Code of Practice 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 as appropriate and effective for them as possible".

Environmental issues

The CQC acknowledges that this Trust has a range of purpose built facilities and that there are plans to renew and extend others. It is concerning that some of the new builds do not seem to be suitable for the purpose such as Millharbour Ward which has two groups of distinctly different patients. It accommodates highly disturbed patients needing intensive care and patients requiring low secure rehabilitation. This ward has short enclosed corridors between bedrooms that are impossible to observe either from the nursing station or the day areas. In addition, there were a number of other concerns found on the wards during this visiting period. These ranged from:

- Lack of facilities such as the missing door of a patient's bedroom which was occupied at that point and missing curtains and wardrobes in other wards.

- In one ward the cleaner was refusing to mop a flooded bathroom leaving the ward manager unable to have control over the environment.

- In Crystal and Ludgate Wards the Visiting Commissioner identified some ligature points. On a few occasions there were some issues found regarding inadequate provision of facilities for physically disabled patients.

Seclusion

Visiting Mental Health Act Commissioners found that sometimes when patients were confined to the seclusion room, there were no clear notes of the events leading up to the seclusion or during the seclusion. Patients on some wards also said that on occasions they were asked to go and remain in their bed rooms until a staff member could permit them to come out although patients saw this as a form of seclusion, staff did not seem to think it was. The CQC awaits the up-dating of the Trust's Seclusion Policy and expects that this will also result in the review of the procedures that staff should follow when a patient is put on seclusion.

Deprivation of Liberty Safeguards (DOLS)

Mental Health Act Commissioners have noted that staff on the elderly care wards had not all received training of the DOLS required under the Mental Capacity Act. Staff were not able to demonstrate a clear understanding of what assessments were needed, how to access them and were not able to specify if these assessments had been completed for their patients.

Recommendations for Action

- The East London Trust should as a matter of urgency institute effective governance arrangements to ensure that there is an improvement in

compliance with Section 58 of the Mental Health Act, especially with regard to capacity, consent and information to patients about their mediation.

- The East London Trust should review all its processes to consider how best to ensure compliance with the participation principle laid out in the Code of Practice. The audit of standards in the wards currently being undertaken by the local Service User Groups, could perhaps include a focus on care plans and treatment.

- An urgent programme should be put in place to ensure that SCT patients receive an effective service which is clearly recorded.

Forward Plan

- Mental Health Act Commissioners will continue to visit the East London Trust in the coming year to monitor the operation of the Mental Health Act and to meet with detained patients in private.

- Mental Health Act Commissioners will also have meetings with service user groups, advocacy services and particular professional groups such as the AMHPs to gain better insight into the effectiveness of the mental health services.

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

Appendix A

List of wards visited at East London NHS Foundation Trust

Date	Ward	Det. Pats. seen	Records checked
City and Hackney Centre for Mental Health			
30 Dec 2008	Joshua	6	6
2 Jul 2009	Colin Franklin Ward	2	4
20 Nov 2009	Bevan Ward	6	3
8 Dec 2009	Connolly Ward	5	5
Total for City and Hackney Centre For Mental Health		**19**	**18**
John Howard Centre			
16 Dec 2008	Broadgate Ward	5	6
18 Dec 2008	Limehouse	2	8
18 Feb 2009	West Ferry	4	4
17 Mar 2009	East India	3	3
20 May 2009	Aldgate Ward	4	7
	Ludgate Ward	5	4
4 Jul 2009	Moorgate Ward	3	5
9 Jul 2009	Tuke (At City and Hackney)	1	6
10 Jul 2009	Morrison	4	5
16 Jul 2009	Clerkenwell Ward	6	4
23 Jul 2009	Victoria	5	5
18 Aug 2009	Shoreditch	4	5
6 Oct 2009	Bow	6	3
7 Oct 2009	Broadgate Ward	4	4
15 Dec 2009	Bow	5	2
Total for John Howard Centre		**61**	**71**
The Lodges			
22 Jun 2009	Orchard Lodge	3	5
Total for The Lodges		**3**	**5**
Newham Centre			
24 Feb 2009	Jade Ward	2	6
16 Jun 2009	Coborn	1	0
	Ruby Ward	2	3
22 Jun 2009	Ivory Ward	4	3
22 Sep 2009	Emerald Ward	4	3
23 Sep 2009	Opal Ward	5	5
	Sapphire Ward	3	3
24 Sep 2009	Topaz Ward	5	3
25 Sep 2009	Crystal Ward	5	5
Total for Newham Centre		**31**	**31**

List of wards visited at East London NHS Foundation Trust

Date	Ward	Det. Pats. seen	Records checked
Tower Hamlets Centre for Mental Health			
7 Jan 2009	Roman	2	6
14 Jan 2009	Lea	4	6
23 Jan 2009	Brick Lane	0	6
1 Jun 2009	Rosebank	6	5
22 Jun 2009	Green	1	1
29 Jun 2009	Leadenhall Ward	1	1
11 Jul 2009	Millharbour	3	3
15 Sep 2009	Globe	2	5
Total for Tower Hamlets Centre for Mental Health		**19**	**33**

Total Number of Visits: 34

Total Number of Wards visited: 35
Total number of Patients seen: 133
Total Number of documents checked: 158