Mental Health Act Annual Statement January 2011

East London NHS Foundation 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 The East London NHS Foundation Trust on 42 occasions, visiting, 39 wards, interviewing 162 patients in private and scrutinising 159 sets of records.

As in previous years, the main focus of the Commission's work continues to be on the day-to-day experience of patients on the wards, although essential corporate issues also feature significantly in this statement with regard to their impact on detained patients.

It is noted by the Commission that the Trust had to develop and implement several policies and practices following the four serious incidents that occurred during the twelve months covered by this statement.

Trust staff continue to work closely with the Commission to address issues found during visits and to improve the care of patients. A number of wards have changed their usage to improve single gender provisions and also to address occupancy issues found in the previous years.

In general the MHA Commissioner found that there is evidence of a gradual improvement in several areas of patient care. These improvements are acknowledged in the main body of this statement which also outlines several areas which need to be better managed. Four areas of particular concern are emphasized for urgent attention through a set of recommendations. These consist of:

- Recording of and facilitating section 17 authorised leave for detained patients.
- Several issues with regard to section 58, the care and treatment of detained patients.
- Giving information about their rights and facilitating choice for detained patients under section 132 information to patients.
- Creating an atmosphere and ethos within the trust to enhance patient involvement in their treatment and care under participation.

Main findings

The East London NHS Foundation Trust provides all specialist NHS Mental Health and Learning Disability care for people in the four London Boroughs of City of London, Hackney, Newham and Tower Hamlets. It provides both inpatient care and community services, with specialist community teams for Assertive Outreach, Crisis

Intervention, Substance Misuse and a Child and Adolescent Mental Health Service. The inpatient units are locally based in each borough with City and Hackney sharing one facility. Medium secure care is provided at the John Howard Centre. A number of beds in the mother and baby unit are also offered to other NHS trusts. The services in one ward which is operated in partnership with an independent provider, Care UK, are described separately under that provider.

All the wards were visited at least once except for two wards which were visited on two occasions. A number of new wards which opened during this reporting period such as Strauss Ward (the regional mother and baby unit) and Mermaid Ward (male only acute ward, opened due to over occupancy issues raised during previous years) were also visited. This statement is based on findings during 12 months of visits to wards on all these sites.

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.

Most issues that related to individual patients on a particular ward were usually resolved soon after the trust was notified following the visit to that ward. However those issues of staff practice that affected patient care and the lawfulness of their treatment, which continued to be found on subsequent visits, are highlighted here as a matter of trust-wide concern, even if they were addressed on those particular wards. The trust strategy to address these does not appear to be uniformly implemented across all the wards. A few wards have been named to illustrate the Commission's concerns, although there were other wards where these issues continued to be found. The Commission acknowledges that the trust has had to deal with a number of serious incidents involving severe injuries and deaths in the last 12 months and urges the trust to urgently review the relevant policies and comply with the recommendations made herein, especially within the section on participation

For further discussion about the findings of this Annual Statement please contact the author via the Care Quality Commission's Mental Health Operations Office located at The Belgrave Centre, Nottingham.

Relationship with the provider in the reporting period

The previous Annual Statement was received positively by the trust board and an action plan published. 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 documented below.

Within the 12 month period of this statement, the Named Commissioner has had a number of constructive meetings with the Chief Executive, the Nursing Director and other senior managers of the trust. At these meetings the action plans for the previous Annual Statement and other serious incidents that occurred during this period were discussed. During these meetings findings from the recent visits were raised with the trust managers who informed the Commission of the new policies and

systems that were introduced to address the issues raised. As a result some improvements were found during subsequent visits to some wards and these are noted under the relevant paragraphs below. There have also been meetings with Service User Groups and the Independent Mental Health Advocacy (IMHA) workers.

Mental Health Act and Code of Practice Issues

Detention

During the period covered by this report, the introduction of a new filing system resulted in a considerable improvement in the filing of patients' notes on the wards. In most cases, visiting Commissioners found all the relevant documents to evidence patients' detention, however on a few occasions there were no detention forms on patients' files. The Commission was informed that these were available but archived elsewhere by the administrators. The trust is reminded it is a legal requirement that detention documents must be easily available for scrutiny at all times. On some wards where the detention documents were in place, the social circumstance reports written by Approved Mental Health Professional (AMHP) were missing from the files. In addition to being a requirement, it is the Commission's view that this report, written at the time of detention, is an important source of information for understanding the patient's situation in the community and should inform patient care on the ward. Their omission is especially important because of the concerns regarding patient care plans described below.

De Facto 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

Although there was evidence on many wards that the rights of informal patients were being attended to, there were isolated issues of concern on a few wards. These included lack of basic information, both in the form of posters and verbal communication to informal patients, about their rights and how they could leave the ward should they wish to do so. Some patients reported that there were inappropriate restrictions placed on them. Visiting Commissioners also found notes such as 'Not allowed to leave the ward' and the use of inappropriate terms like 'Absent Without Leave', in their files, suggesting staff are either confused about patients' status or about the legal rights of informal patients. The Commission acknowledges the significant progress that has been made on this issue across many of the trust's wards and urges the trust to take further steps to eradicate such isolated breaches of the rights of informal patients.

Leave – Section 17 and Absence without leave Section 18

With regard to section 17 leave for patients, there has been a gradual improvement in the documentation, with more Responsible Clinicians completing leave details on the forms. On a few wards, such as Coborn and Globe, patients continued to report to visiting Commissioners that they were not clear about their leave conditions as they had not received a copy of the form. Recently the trust modified their forms by adding a tick box to indicate that the patient had received a copy of the completed section 17 form. However, not all the wards had these new forms. Where they were located, the tick box was not completed on two occasions.

It is acknowledged that Responsible Clinicians make increasingly difficult decisions about authorising leave for patients whose mental state may be unpredictable. The Commission has repeatedly advised staff to strike through old section 17 leave forms to minimise confusion regarding the current leave status of patients and has noted a broad improvement in associated practice. However, visiting Commissioners continued to find a minority of section 17 forms with different dates on patient files, making it difficult to comprehend the current leave authorisation for patients.

Another major concern for the Commission is that, on several wards, including Bow, Roman and Limehouse, patients complained that they were not able to take their escorted section 17 leave due to staff shortages. File entries on wards such as Limehouse confirmed this. The Commission recognises that there are difficult balances to be struck between the decisions of Responsible Clinicians on the clinical basis for leave and the challenges for ward managers and staff of administering and facilitating all authorised leave. Where such issues arise, the Mental Health Act Commission has previously recommended that they should be discussed openly within multi-disciplinary teams.[1]

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

Consent to treatment under section 58 covers a range of issues and constitutes the largest number of concerns raised by visiting Commissioners in this reporting period. Many of these issues were also raised in the last Annual Statement. Those issues which continue to be found by visiting Commissioners are listed below along with examples of wards, although it should be noted that these findings were not limited to these wards alone.

The Responsible Clinician is required to assess the capacity of patients to consent to treatment and keep it under review. Although it is lawful to treat patients without consent during the first three months of detention, the Code of Practice is clear that good practice demands such an assessment from the beginning of a detention period. At the end of the first three months of compulsory treatment, the issue becomes a matter of law. Visiting Commissioners did not find satisfactory records of assessments of patients' capacity to consent during their visits to wards during most of this reporting period. However, during a scrutiny of the Compulsory Treatment Orders in Hackney and a visit to Victoria Ward, which were both carried out towards the end of this reporting period, some comprehensive assessments of capacity were found. It is hoped that this is a sign of the beginning of an improvement and that it will also occur in all the other wards across the trust.

The Code of Practice, paragraph 24.62 advises that the decision made by the Second Opinion Approved Doctor (SOAD) about treatment should be discussed with the patient by the Responsible Clinician in person. On a majority of the wards there were no records that this occurred.

[1] Mental Health Act Commission Thirteenth Biennial Report 2007-2009 p97

The Code of Practice, paragraph 24.54 also states that staff who are consulted by the SOAD to aid his decision should make a record of their discussions in the patient's file. There were examples of either one or both consultees having recorded their discussions with the SOAD on wards such as Millharbour and Clerkenwell.

A range of issues regarding medication were found during the visits to the wards. Although many wards have introduced an arrangement with the pharmacist to be regularly available to discuss patients' medicines with them, there were no records of these discussions in the patient files. Patients on many wards reported that they did not understand the effects and side effects of medicines they were given. This is especially concerning when it is recorded that a patient has expressed misgivings about taking the treatment and there is no record of a SOAD request or evidence of any discussions by the RC or the primary nurse with the patient about their concerns.

There were also issues with regard to the administration of medication, an example being Joshua Ward where PRN medication was given without prior authorisation. On Shoreditch Ward two patients were prescribed very high dose medication contrary to SOAD advice that the combined dosage should be within BNF limits. On Mermaid ward, where high dose medication was being given to one patient, the Commissioner was unable to find records of any reviews of their medication nor evidence that the potentially detrimental effects of high dose medication on the physical health of this patient were being monitored.

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

Mind provides the Independent Mental Health Advocacy service for the three mental health sites and the Forensic Medium Secure Unit. At the beginning of this reporting period visiting Commissioners found that patients were not being given information about the IMHA service – over the following months there has been a gradual improvement in that files now contained copies of letters informing patients of their detention and their right to access the IMHA service. It was also found that leaflets are displayed on the board and ward staff said that advocacy workers are invited to attend patient community meetings and sometimes ward rounds. However, some patients continued to report that they did not know of the existence of the service or understand its nature or how to access it. The visiting Commissioner met with the IMHA service, who said that they were aware of this issue and were in the process of addressing it with the trust.

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

The MHA requires that detained patients should be informed of their rights whilst being detained. This should be done verbally and in writing both at the time of detention and also repeated thereafter at intervals

At the beginning of this reporting period, some visits found no evidence of patients being told about their rights. During the reporting period there has been some improvement on most wards in respect of this issue. Commissioners have started to find records of patients being read their rights at the time of detention. However, on a minority of wards there is no evidence that this is repeated at later intervals to ensure that patients have understood their rights. It is especially concerning that there was no evidence that patients' rights were repeated to them despite recordings that they had not understood them on the first occasion. A number of patients also said they did not know their rights and could not remember being told about them. Some of those patients who said that they had been given the rights leaflet stated that the content was too difficult and that they wanted help to fully understand it.

Other Patient Issues

Physical health

During this reporting period visiting Commissioners have found evidence of routine regular weekly physical health checks of patients. However, on several wards, some patients who needed external care, such as appointments with dentists, expressed difficulties in accessing help with these needs. Another concern was a patient who refused to co-operate with the weekly physical checks, and an accompanying lack of documentation about how his care was being managed. As a consequence it appeared to the Commissioner that this patient was denied the physical health care which he urgently needed.

During the visit to inspect Community Treatment Orders (CTOs) in Hackney, it was found that a number of patients with serious physical conditions did not appear to be accessing relevant physical health care. It is essential that all clinicians are encouraged to take a holistic approach to healthcare that incorporates an understanding of the interaction of mental and physical health, in line with the Royal College of Psychiatrists' Fair Deal manifesto. However the Commission recognises that, particularly in the case of CTO patients, this concern also raises issues about access to good quality primary care services and appropriate levels of communication between all clinicians involved in a patient's care across primary and secondary services.

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

Over the 12 months covered by this statement, there was a noticeable improvement in patient care plans. This seemed to be an evolving process, as visits during the later months of the reporting period found extensive care plans. However, many had statements which appeared to be staff views written in the space for 'Patient Views'. In interviews with the visiting Commissioner, some patients also said that their involvement was limited to being informed by their key nurses of the existence of their care plans, the themes of which had only been decided by their clinical teams. Care plans in some files were not personalised as they focussed on standard themes such as medication, detention under the Act, risk assessment, and so on. Although this is gradually changing, the evidencing of patient involvement is still at a

somewhat nascent stage in many of the trust's wards. On the evidence of Commissioner interviews, patients' experience is not always consistent with the documentation of participation in care plans.

A more recent and commendable improvement in eliciting patient views is the introduction of a form for patients themselves to record their needs and the areas of help they require. These were filled in by patients or staff on their behalf. However, the valuable information obtained still did not feature in the care plans, confirming the patients' views that care plans were merely task lists solely used by staff to organise their responsibilities rather than a technique to help patients with their problems and thus to aid their recovery. Many patients also said that they were not given copies of their care plans.

Social circumstance reports, which form an important source of information for formulating patient care, were missing in many files (this is elaborated above). Another important source of information is the 1:1 keywork sessions between patients and their primary nurses. Following a trust audit of these, visiting Commissioners found a marked improvement in the reporting of 1:1 sessions on the files of patients. However, visiting Commissioners continued to be informed by a number of patients that 1:1 sessions were not occurring. Closer scrutiny of the reported sessions found that routine observations were frequently marked as 1:1 sessions 'Complied with medication and slept well', indicating that there was no discussion taking place that could be viewed as being meaningful to patients. At the same time, there were remarkable descriptions of very good sessions occasionally found in some patient files. In a few cases these discussions had even been converted into care plans with clearly illustrated action points.

As a general duty of care and also to ensure the safety of patients and others, it is important to complete and regularly review patients' risk assessments. In the last 12 months there has been some inconsistencies observed by the Commission in how these are completed, recorded and risk managed. Although there is a section in the patient file for keeping risk assessments, the Commission is not always able to find recent assessments in these sections. Visiting Commissioners were told that risk assessments now formed an integral part of the Care Programme Approach (CPA) documents. Files on a number of wards did not have this part of the CPA record. In some files risks were addressed through a care plan. In some cases there were old documents with no evidence that any risk assessment had been completed following detention, or within the last year.

In a number of files, risks identified in the patients historical information and records of observations on the wards were neither included in the assessment details nor in the risk management plans. The Commission is concerned about the seeming lack of consistency in how risk assessments are made, how and when they are reviewed and updated, what is included and how they are addressed.

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

During this reporting period a number of issues relating to patient privacy were found. Although most of these pertained to the building and structure of the wards, these impacted on staff practice and consequently patient experiences on the ward. For instance, on wards such as Crystal, Victoria and Aldgate, the patient phones were placed in the lounge/dining area affording little privacy for patients to have personal conversations. In some wards the viewing panels of patient rooms consisted of plain glass panels covered by fabric on the exterior, so that anyone could lift them and look inside the bedrooms, thus encroaching on patient privacy. Some wards had no locks on the doors and no lockable facilities in their rooms for valuables. Patients in longer term wards found this especially unhelpful as they had to bother busy staff for assistance with locking and unlocking their rooms and gaining access to essential day-to-day articles. While it may not be possible to address some of these issues without changing the structure of the wards, other issues can be addressed with small changes in staff practice and minor building alterations.

Ethnicity and Culture

On a number of occasions, visiting Commissioners found that patient details such as ethnicity were not available on their files. In a few wards, there was no adequate provision to facilitate ongoing discussions with patients who had little or no English. Whilst acknowledging that the trust covers a population with a large number of first languages, the Commission urges the trust and its partner Primary Care Trusts to improve resources such as the communication facilities for these patients to enhance their day-to-day participation. In order to do this effectively, it is vital that demographic data, such as the ethnicity and languages understood by patients, must be diligently completed.

Gender Separation

Over the visiting period of this statement, there have been a number of reorganisations of wards aimed at enhancing the gender separation, both in terms of allocating separate wards for male and female patients and also making arrangements for separating the facilities within existing mixed gender wards to enable effective privacy.

Recommendations and Actions Required

1. Section 17. The trust should review its practice under section 17 to ensure that all old style forms are replaced with the new form, that staff fully complete those forms and ensure all patients receive a copy and that all superseded section 17 leave forms have end dates, signatures and are struck through leaving only the current form on file. Open discussions about authorisation and facilitation of leave should be encouraged in multidisciplinary team meetings to reduce the tensions caused when staff resources are not sufficient to facilitate authorised leave for individual patients.

2. Consent to treatment. The trust should make renewed efforts to ensure that its medical staff are fully aware of their responsibilities to review and record patients' capacity and consent and of other duties of communication with patients under section 58. Effective universal appraisal and audit systems should be established

to monitor compliance with the trust's own policies, such as high dose medication. The trust is reminded that this has been an ongoing concern for the Commission in recent years and is now an issue linked to registration requirements.

3. Section 132. The trust should establish systems overseen by ward managers such that giving patients information about their rights forms a regular item in the keywork sessions with patients. This should be followed up routinely by interviews with patients to find out if they understand their rights and by regular audit of patient files.

4. Risk management. The trust should develop a consistent and effective approach to Risk Assessment and Management, and find a strategy to ensure that it is uniformly implemented in all the wards across all the sites.

5. Care Planning. The trust should renew efforts to emphasise the central ethos of patient participation in all care planning related staff training. The inclusion of essential issues identified in information gathered from patients, their carers and relevant documents, in care plans should be emphasized in the ongoing staff supervision and the evaluation of care plans.

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	Pats seen	Pats in groups	Records checked
City and Hackney Centre For Mental Health				
20/11/2009	Bevan Ward	6	0	3
08/12/2009	Connolly Ward	5	0	5
29/01/2010	Strauss Ward (Mother and Baby)	2	0	3
24/02/2010	Gardner	6	0	3
27/02/2010	Joshua	5	0	5
19/03/2010	Brett Ward	3	0	4
26/08/2010	Connolly Ward	4	0	4
27/08/2010	Colin Franklin Ward	4	0	5
18/09/2010	Ruth Seifert (Formally Mermaid)	4	0	5
Totals for City and Hackney Centre For Mental Health		**39**	**0**	**37**
John Howard Centre				
06/10/2009	Bow	6	0	3
07/10/2009	Broadgate Ward	4	0	4
15/12/2009	Bow	5	0	2
12/03/2010	West Ferry	4	0	3
08/05/2010	Limehouse	3	0	3
23/07/2010	Shoreditch	4	0	3
11/05/2010	East India	5	0	2
12/06/2010	Aldgate Ward	5	0	2
18/06/2010	Ludgate Ward	6	0	3
09/07/2010	Moorgate Ward	4	0	3
16/07/2010	Morrison	3	0	5
25/08/2010	Victoria	5	0	4
26/08/2010	Clerkenwell Ward	5	0	4
21/09/2010	Tuke (At City and Hackney Centre For Mental Health)	1	0	6
Totals for John Howard Centre		**60**	**0**	**47**
Newham Centre				
01/06/2010	Ruby Ward	0	0	1
16/07/2010	Topaz Ward	1	0	3
09/08/2010	Emerald Ward	2	5	4
28/05/2010	Jade Ward	2	0	4
28/07/2010	Crystal Ward	4	0	5
12/06/2010	Coborn	2	0	4
10/09/2010	Opal Ward	3	0	5
22/09/2010	Sapphire Ward	5	0	5
Totals for Newham Centre		**19**	**5**	**31**
The Lodges				
10/05/2010	Orchard Lodge	3	0	3
Totals for The Lodges		**3**	**0**	**3**

Date	Ward	Pats seen	Pats in groups	Records checked
Tower Hamlets Centre For Mental Health				
22/01/2010	Roman	5	0	3
26/01/2010	Lea	0	0	0
04/02/2010	Lea	4	0	4
17/02/2010	Brick Lane	7	0	4
15/06/2010	Rosebank	4	0	3
29/07/2010	Millharbour	7	0	4
30/07/2010	Globe	7	0	7
27/08/2010	Green	1	20	1
08/09/2010	Cto (No Detained Patients)	5	0	13
24/09/2010	Leadenhall Ward	1	0	2
Totals for Tower Hamlets Centre For Mental Health		**41**	**20**	**41**

Total Number of Visits:	42
Total Number of Patients Seen:	162
Total Number of Documents Checked:	159
Total Number of Wards Visited:	39

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?	11	4	15
Are you satisfied that there is evidence that informal patients are free to leave the ward in line with legal requirements?	10	5	15
Do patients have the ability to lock their rooms securely and the means to do so? [answer no if in dormitories]	17	11	2
Do patients have lockable space which they can control?	18	9	3
Are arrangements to cover viewing panels in bedroom doors adequate to protect patient privacy?	21	7	2
Are curtains or other window coverings in patient bedrooms adequate to protect privacy from people outside the ward?	28	1	1
Does the ward provide single gender sleeping areas, toilets, bathrooms and lounges?	28	0	2
Is there a ward phone for patients' use?	27	1	2
Is it placed in a location which provides privacy?	18	10	2
Are there any circumstances under which patients may have their mobile phones? [answer N/A if HSH]	16	11	3
Do patients have an opportunity to participate in influencing the ward they are on via such mechanisms as community meetings, patients' councils etc?	21	0	9

Findings From Document Checks	YES	NO	N\A
Were the detention papers available for inspection? Did the detention appear lawful	94	5	21
Was there either an interim or a full AMHP report on file?	59	18	43
If the NR was identified was s/he consulted, If there was no consultation, were reasons given?	57	12	51
Where appropriate was all psychotropic medication covered by a T2 and/or T3?	54	8	58
Was there evidence a capacity assessment at the time of first administration of medication following detention?	27	35	53
Was there evidence a discussion about consent at the time of first administration of medication following detention?	26	35	59
Was there a record of the patient's capacity to consent at 3 months?	22	22	76
Was there a record of a meaningful discussion about consent between the AC and the patient at 3 months?	23	18	79
Was there evidence that the RC had advised the patient of the outcome of the SOAD visit or an explanation why not?	5	27	88
Was there evidence of discussions about rights on first detention and an assessment of the patient's level of understanding?	75	16	29
Was there evidence of further attempts to explain rights where necessary?	80	16	24
Was there evidence of continuing explanations for longer stay patients?	61	17	42
Is there evidence that the patient was informed of his/her right to an IMHA?	37	65	18
Are the patient's own views recorded on a range of care planning tools?	76	23	21
Was there evidence that the patient was given a copy of their care plan?	32	34	19
Is there evidence that the patient signed / refused to sign their care plan	65	21	34
Was there evidence of care plans being individualised, holistic, regularly reviewed and evaluated?	81	16	23
Is there evidence of an up to date risk assessment and risk management plan?	83	17	20
Is there evidence that discharge planning is included in the care plan?	60	34	26
Were all superseded Section 17 leave forms struck through or removed?	57	15	48
Was there evidence that the patient had been given a copy of the section 17 leave form?	15	64	41
Are the timescales, frequency and conditions for the use of leave unambiguously specified?	74	6	40
For patients in hospital less than a year, is there evidence of a physical health check on admission?	77	4	39
For patients in hospital over than a year, is there evidence of a physical health check within the last 12 months?	40	6	74

	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]?	9	8	4	98

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 ongoing compliance with the outcomes and essential standards of safety and quality in accordance with the Health and Social Care Act 2008.