



**Mental Health Act Commission  
Annual Report**

**<sup>2</sup>Gether NHS Foundation Trust**

**July 2008**

Report prepared by: **Kate Brass**

## **Mental Health Act Commission**

*'Safeguarding the interests of all people detained under the Mental Health Act'*

### **Functions of the Commission**

- ◆ meet with detained patients during the course of visits by Commissioners to all hospitals caring for this group of patients;
- ◆ the appointment by the Commission of a panel of Second Opinion Appointed Doctors (SOADs) who visit and give a second opinion on certain treatments for patients who are unable or unwilling to give consent (Section 58);
- ◆ appointing multi-disciplinary panels to consider the authorisation of neurosurgery for mental disorder for consenting patients, whether or not they are detained (Section 57);
- ◆ advice on, monitoring and sometimes investigation of complaints by detained patients;
- ◆ monitoring of deaths of detained patients, including review of any enquiry reports and attendance at some inquests;
- ◆ considering appeals against the withholding of postal packets from (and, since the introduction of new Security Directions, internal mail from and telephone calls by) patients in the High Security Hospitals;
- ◆ giving advice on policy and practice, based on established views or where necessary following discussion amongst groups of Commissioners with relevant professional expertise.

**MENTAL HEALTH ACT COMMISSION  
ANNUAL REPORT  
<sup>2</sup>GETHER NHS FOUNDATION TRUST  
JULY 2008**

**EXECUTIVE SUMMARY**

**Statement of Purpose**

The Mental Health Act Commission (MHAC) works to safeguard the interests of all people detained under the Mental Health Act 1983. It has a statutory remit to keep under review the powers and duties of the Act relating to detained patients and to meet with detained patients in private. It may also examine any records relating to their detention or treatment. The primary aim of all visiting activity is to ensure that the work done by Commissioners makes a positive difference to the lives of detained patients. The Annual Report is a public document and provides feedback to the Trust Board and other interested parties on the key issues that have arisen and whether they have been addressed.

**Mental Health Act/Code of Practice Issues**

The Trust continues to demonstrate a conscientious approach to the administration of the Act and this is broadly reflected in the scrutiny processes that the Trust has in place, with exceptions, including the following, which the Trust needs to address.

*Section 17 Leave*

Last year's Annual Report recommended that the Trust should review its procedures for documenting leave. The MHAC found that such a review does not seem to have occurred. This issue was highlighted at a recent meeting with the Trust and several recommendations were discussed concerning how improvements might be made.

*Section 58 (Consent to Treatment)*

The requirements of Part IV of the Mental Health Act seem to have been met and there were only isolated incidents of lack of compliance, most of which were rectified at the time of the visit.

Commissioners were concerned that where patients appeared to be on long-term leave from a given ward, and their statutory documentation and medical records were not held on the ward, it was not possible for the MHAC to ascertain whether the appropriate actions had been taken to ensure that medical treatment was being administered in accordance with The Mental Health Act 1983 and the Code of Practice.

## **Environmental and Organisational Matters**

The Trust is to be commended for its implementation of the national Star Wards Activity programme at Wotton Lawn, which has been enthusiastically received by patients.

Wards were generally found to be in good decorative order and in some instances, of a particularly high standard. The MHAC is pleased to note that the hospital-wide replacement window programme at Wotton Lawn was finally started in April 2008 but there are ongoing maintenance issues at a number of sites including delay in providing smoking shelters.

The MHAC is still awaiting a copy of the Trust's Environmental Audit System, which was listed for action in the Trust's response to the 2007 Annual Report.

## **Social Services and Social Care**

The MHAC visited Gloucester Social Services Department to examine how the local authority is discharging its duties under the Act. While some concerns were raised by staff, there was a clear commitment to providing a responsive mental health service for Gloucestershire.

The Trust is to be commended for the inclusion of social care representation at Board level.

## **Forward Plan – the next 12 months**

During the next twelve months the MHAC will start monitoring compliance with the amended Mental Health Act and the new Code of Practice. Visiting feedback may therefore include specific comments relating to the Trusts implementation of the Mental Health Act 2007 and the impact of changes on detained patients. There may also be some developments in the way that Commissioners visit to enable them to consider new areas of legislation, such as Supervised Community Treatment.

In addition, during this period, the MHAC will be working to achieve a smooth transition of its statutory functions, including meeting with detained patients and providing the Second Opinion Appointed Doctor (SOAD) service, to the Care Quality Commission, the new health and social care regulator.

The MHAC will endeavour to visit all wards throughout the Trust to examine legal documents and notes relating to the care of detained patients.

Detained patients will have the opportunity to talk to a Commissioner in private should they so wish during the course of the visit.

Commissioners will also seek to ensure that they pay particular attention to those areas highlighted as recommendations for action by the Trust.

Commissioners will also:

- Make arrangements to meet patients on longer periods of Section 17 leave that may not normally have an opportunity to meet Commissioners, including those subject to Community Treatment Orders.
- Meet representatives of service user organisations and advocacy services that provide support for people detained under the Act.
- Seek to monitor delivery of the Mental Health Act 2007, and to ascertain that the necessary training programmes are in place for staff involved in administering the Act.

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**1. INTRODUCTION**

- 1.1 The Trust provides mental health and developmental disability services for over half a million people of all ages throughout the county of Gloucestershire. These services are provided in partnership with Gloucestershire County Council, and are managed in five different care groups viz: Child And Adolescent Mental Health Services; Mental Health Services for Adults of Working Age; Services for People with a Learning Disability; Substance Misuse Services and Services for Older Age Adults with Mental Illness.
- 1.2 During the period covered by this report, Gloucestershire Partnership NHS Foundation Trust has rebranded itself as <sup>2</sup>Gether NHS Foundation Trust with the aim of ensuring that it maintains a strong, easily recognisable identity which also reflects its commitment to partnership working.
- 1.3 The Healthcare Commission's annual health check (published 18 October 2007) has rated the quality of services provided by the Trust as "excellent", and confirmed that the Trust had met all the Healthcare Commission's core standards and each of the Government's national targets, including provision of crisis resolution services and a comprehensive child and adolescent mental health service.
- 1.4 The past year has seen the Trust moving towards the completion of a major reconfiguration of mental health services for Adults of Working Age and Older People's Mental Health Services. The Trust's Annual Report for 2007 states that changes are driven by the desire to modernize services in line with best practice and to achieve substantial savings as part of the Trust's financial strategy. In addition to changes in the delivery of community services, the main changes affecting patients detained under the Act are the reduction in acute mental health inpatient beds for working age adults and older mental health inpatients, and consolidation from four sites to the one site at Charlton Lane, Cheltenham. The MHAC has monitored the effects of these changes while carrying out its visiting programme and has found that in general a smooth transition seems to have taken place.
- 1.5 The MHAC visiting programme is well established with the Trust and a single Commissioner visits one or two wards on a day. Wherever possible issues are dealt with on the day of the visit. Following a visit, wards are rated according to several criteria, which contribute towards determining the frequency and focus of future visits. All wards which care for detained patients will normally be visited at least once during any 18 month period. A list of the wards visited within this Trust during his reporting period is provided at Appendix A.

1.6 To compile this Annual Report, information has been gathered from service users, ward staff, Social Service Department staff with duties under the Act and Commissioner observation, Trust responses to issues raised, and other statutory and voluntary organisation with an interest in the welfare of detained patients.

## **1.7 Visit Programme**

1.7.1 The MHAC visits all places where patients are detained under the Mental Health Act 1983. 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, smoking, 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.

1.7.2 The information recorded at each visit is collated and analysed centrally. This report will include reference to the aggregated data for this Trust. A list of the wards visited within this Trust is provided at Appendix A.

## **1.8 Other MHAC Activities**

1.8.1 In addition, other work undertaken by the MHAC, including visits in response to the notification of specific patient incidents, deaths of detained patients that have occurred, complaints monitored and Second Opinion Appointed Doctor (SOAD) activity is collated.

1.8.2 One death review was carried out during the monitoring period. The Trust acknowledged (in its response of 15 February 2008 to the findings of the MHAC) that the detailed Risk Assessment of ligature points, drawn up for the unit in which the death occurred, and a series of recommendations for future action, have not been strictly adhered to in the intervening months since the incident. The Trust further acknowledged that more staff training in risk assessment and observation procedures was required as a priority. The Commissioner's view on a recent visit to the Unit in question was that this training programme had not begun and that staff were not aware that revised procedures should be in place.

**Recommendation 1**

***The Trust is asked to ensure that the training programme on the implementation of risk assessment and observation procedures is instigated as soon as possible to ensure that the appropriate lessons are learnt from this incident.***

**1.9 Concordat**

1.9.1 The MHAC is signatory to a concordat between those bodies inspecting, regulating and auditing healthcare in England. A key aim of this agreement is to reduce the burden of inspection on service providers. This report may therefore refer to information or recommendations drawn from reports completed by other bodies and may in turn be used by others to avoid duplication of data collection. Further information about the Concordat can be obtained at the Concordat's website. ([www.concordat.org.uk](http://www.concordat.org.uk))

1.9.2 During the last year the Healthcare Commission has conducted a major review of NHS acute inpatient mental health services, including Psychiatric Intensive Care Units( PICUs). This review is the most comprehensive assessment of such services ever undertaken. The report based on its findings was published on the 23<sup>rd</sup> July 2008 and addresses many of the issues that the MHAC considers when carrying out its visiting programme. The MHAC's input into this review has been predominantly in helping to develop the methodology used and in providing data from our document scrutiny on Trusts' compliance with the requirements of section 58 and Section 132 of The Mental Health Act. Sixty nine Trusts were assessed, and The Gloucestershire Partnership NHS Foundation Trust received the rating of 'good', which was defined by the Healthcare Commission as 'performance [that] goes beyond the minimum requirements and the reasonable expectations of patients and the public'. The MHAC commends the Trust for this assessment, and we will be taking the opportunity during the next visiting cycle to monitor its continuing performance against the report's findings.

1.9.3 Further information can be found on the Healthcare Commission's website at the following link:

<http://www.healthcarecommission.org.uk/serviceproviderinformation/reviewsandstudies/servicereviews/improvementreviewmethodology/adultacuteinpatientmentalhealth.cfm>

**1.10 Links between the MHAC and the Trust**

1.10.1 The Trust continues to demonstrate a commitment to responding promptly to issues raised by the MHAC and these have been dealt with positively. There have been few occasions when there has been an unexpected delay in the MHAC receiving a response and a recent meeting between representatives of the Trust's Mental Health Act Managers and the MHAC looked at how communication between the Trust and MHAC could be improved. Although the responsibility lies with the ward manager/person in charge to ensure that

the feedback left at the end of a visit is copied to the office of the Director of Nursing, the MHAC is prepared to expedite the communication process by ensuring that the Trust is informed by telephone of the MHAC presence on a ward.

1.10.2 The MHAC found that the recent meeting between representatives of the Trust's Mental Health Act Managers and Commissioners was informative and helpful in addressing unresolved issues. The MHAC looks forward to the Trust's implementation of solutions discussed.

1.10.3 The MHAC's last Annual Report included seven recommendations which required a response from the Trust and the Trust's Action Plan specified how it would address the recommendations made. In the course of carrying out its visiting programme the MHAC found evidence that action had been taken in a number of areas but is still awaiting some of the requested documentation.

## **1.11 Service Changes and Developments**

1.11.1 Since the last Annual Report the Trust has undertaken a major reconfiguration of mental health services for Adults of Working Age and Older People's Mental Health Services. An important change has been the provision of inpatient services for older people on the site at Charlton Lane. The MHAC has monitored the effects of these changes while carrying out its visiting programme, and has found that in general, a smooth transition seems to have taken place. The MHAC will continue to monitor closely further effects of the reconfiguration process during the coming year.

1.11.2 To accommodate families having to travel longer distances as a result of the closure of some sites, The Trust has a Gloucestershire wide transport service available for families. The MHAC understands that, to date, there is little take-up of this service but that this could change when more services are relocated in the coming years.

## **2. FINDINGS AND RECOMMENDATIONS**

2.1 The MHAC is an organisation for whom the task of protecting the human rights of detained patients is central. People who are deprived of their liberty are also particularly vulnerable to human rights deprivations, and everyone involved in the care of detained patients should be aware of their responsibilities for safeguarding human rights, as set out in the Articles of the European Convention on Human Rights. The findings recorded below may make reference to the Articles as well as the sections of the Mental Health Act where these issues have been raised.

2.2 In this section of the report the main findings are summarised, any action taken or planned is noted and, where further attention is required, recommendations are identified.

## 2.3 Mental Health Act/Code of Practice Issues

### *Administration and Record Keeping*

2.3.1 The Trust continues to demonstrate a constructive approach to the administration of the Act, and has robust scrutiny procedures in place. The MHAC noted that anomalies and discrepancies identified during the course of a visit were rectified, where practical, during the visit or shortly afterwards. Those issues identified on visits which still need to be addressed, are detailed below.

### *Section 17 Leave*

2.3.2 Last year's Annual Report recommended that the Trust should review its procedures for documenting leave, and identified two areas of concern. The MHAC is disappointed to find that such a review does not seem to have occurred. The two main recommendations concerning Section 17 were discussed at a recent meeting with the Trust and positive proposals for improvement were explored.

2.3.3 The first recommendation raised in the 2007 report concerns practices for recording leave. On occasions the Commissioner found that some record keeping was inconsistent or absent and that there were instances where there was no link between the Section 17 form authorised by the Responsible Medical Officer (RMO) and the nursing care plan. The Commissioner noted that the conditions for leave on the Section 17 paperwork were identified as being 'as per care plan'. This could mean that a nurse, rather than the patient's own RMO, is determining the conditions of leave. This is at variance with the Code of Practice. Paragraph 20.6 of the Code of Practice suggests that the granting of leave and the conditions attached to it should be recorded in the patient's notes and a copy given to the patient. The MHAC found that this did not always happen. Paragraph 20.6 also states that hospitals should adopt a form on which the RMO can authorise leave and '*specify the conditions attached to it*'. The MHAC suggests that redesigning the form used by the Trust could help to resolve this anomaly.

2.3.4 The second recommendation concerns the Trust's practice of using 'extended leave'. The MHAC found that patients are still being allocated to a named ward but are often unknown to the ward staff and their statutory documentation authorizing detention, leave or treatment is retained by community mental health support staff and unavailable at the ward. The MHAC understands that ward staff can access patient information via the electronic 'Clinical Manager' but Commissioners are impeded in carrying out their statutory duties under the Act as the result of the unavailability of paperwork and so are not able to ensure that patients are lawfully detained or that medical treatment is being administered with proper lawful authority.

2.3.5 When the amended Act comes into force on 03/11/08, the MHAC's arrangements for the provision of SOADs and its Commissioner monitoring and visiting functions will extend to patients subject to Supervised Community

Treatment Orders. As part of the detailed guidance that is currently in the process of being prepared, the MHAC will be considering how best to engage effectively with people on long term Section 17 leave and to include them within the same practical arrangements and options as for those patients subject to Supervised Community Treatment Orders. The MHAC wishes to ensure that while guidance for SOADs and Commissioners covers all the MHAC's requirements for the discharge of its statutory duties, it also needs to allow for a flexible response to the diverse needs and circumstances of patients and the services that they use. To inform the development of this guidance, The MHAC has distributed questionnaires to Trusts, other organisations and interested parties for comment and a copy of this can be found on The MHAC website.

- 2.3.6 It was noted that, for some patients on Section 37/41, The Ministry of Justice leave authorisation was not with the Section 17 paperwork and there were some instances of no review dates on the Section 17 form. It is particularly important for both patient and public safety that restricted patients are not given leave to which they are not entitled. The MHAC would refer the Trust to paragraph 7.74 of the Twelfth Biennial Report concerning Section 17 Leave for restricted patients. Recommendation 41 of the report states:

*'A copy of Mental Health Unit authorisation of leave should be kept alongside local leave documentation for restricted patients. RMOs should be careful to define the parameters of leave for such patients where elements of that leave are at staff discretion.'*

**Recommendation 2**

***The Trust should satisfy itself that the rights of patients on long-term Section 17 leave are not breached***

**Recommendation 3**

***The Trust should review its practices in relation to Section 17 leave arrangements to ensure that it is fully compliant with The Act and the Code of Practice.***

*Section 58 Consent to Treatment*

- 2.3.7 The MHAC noted that on the whole, the requirements of Part IV of The Act seem to have been met and that there were only isolated incidents of lack of compliance, most of which were rectified at the time of the visit. An example of this is that on several wards Forms 38 and 39 were not always with the medicine cards so it was not possible to check that the medicine administered was covered by Section 58 of The Act.
- 2.3.8 As stated with regard to Section 17 leave, where patients appeared to be on long-term leave from a given ward and their statutory documentation and medical records were not held on the ward, making it impossible for Commissioners to ascertain whether the appropriate actions had been taken

to ensure that medical treatment was being administered in accordance with The Act and the Code of Practice.

### *Section 132 Patients' Rights*

- 2.3.9 Most patients interviewed, and who were able and willing to indicate that they had been informed of their rights, were aware of their rights. The Commissioner was also able to ascertain from patients' files that attempts had been made to inform patients of their rights and that most patients were given regular reminders at three-weekly intervals.
- 2.3.10 The form used by the Trust to record compliance with this section of the Act was considered by the MHAC to be a good example of this type of form. Similarly, the MHAC noted that the form used at Westridge to indicate consent to sharing information used symbols to make it accessible to learning disabled adults and was also an example of good practice.
- 2.3.11 The MHAC has drawn the Trust's attention to the practice at Hollybrook of inconsistent recording of Section 132 rights where the patient lacks capacity. The MHAC understands that a more patient-focussed approach has been adopted which is sensitive to individual needs in order to ensure that the patients' rights are not breached. The MHAC would welcome evidence of the effectiveness of this new practice.

#### ***Recommendation 4***

***The MHAC requests that the Trust monitors its revised practices concerning Section 132 and learning disabled adults and provides the MHAC with evidence of their effectiveness.***

### *Use of seclusion*

- 2.3.12 The seclusion of patients is carried out on some wards. Last year's Annual Report noted that the Trust's Seclusion Policy has been amended for use at Westridge and Hollybrook Units. The MHAC understands that the Trust's Psychology Service monitors the use of seclusion at these sites. The Trust has informed the MHAC that it is working on a new policy for its Learning Disability Units which it anticipates will be finalised in September. The MHAC looks forward to receiving a copy of the new policy.

## **2.4 Environmental and Organisational Matters**

### *Activities/Occupational Therapy*

- 2.4.1 The Trust is commended for the high level of activities at many of its sites, both on and off the wards. At Wotton Lawn, implementation of the nationally recognised user-led Star Wards programme is particularly appreciated by patients. An activities co-ordinator is allocated to each shift to ensure that activities happen every day, including evenings and weekends.

### *Bed occupancy/availability*

- 2.4.2 The Trust has made progress in this area during the past year and although occupancy levels were high on many wards, there was no evidence at the time of the visit that patients were being sent on leave to manage the situation.

### *Physical Environment*

- 2.4.3 Wards were generally found to be in good decorative order and in some of a particularly high standard. An example of this is The Honeybourne Unit, which was also commended in the 2007 Annual Report. The Commissioner noted that it had a warm and friendly feel. The reconfiguration of Priory Ward, Wotton Lawn, was also commended for providing a more open and relaxed environment for both patients and visitors.
- 2.4.4 The MHAC is pleased to note that the hospital-wide replacement window programme at Wotton Lawn was finally started in April 2008 but there is evidence that some maintenance schedules are not on target, resulting in delays in carrying out routine maintenance work and minor repairs at a number of sites, including the provision of locks for bedroom doors at Greyfriars Ward and soundproofing at Westridge. It is also felt by the MHAC that the therapeutic atmosphere provided at The Vron was undermined by the oppressive feeling given by the dark oak panelling lining most of the walls.
- 2.4.5 Last year's Annual Report recorded concerns about the delay in starting work on the new Section 136 suite and Psychiatric Intensive Care Unit (PICU) at Wotton Lawn. The Trust has informed the MHAC that work should now begin on the Section 136 suite project by the end of 2008 but no start date has been provided for the PICU.

#### ***Recommendation 5***

***The Trust is asked to keep the MHAC informed of progress on the building work for the Section 136 Suite and to notify the MHAC of the timetable for commencing work on the new PICU.***

### *Management of Smoking arrangements/access to fresh air*

- 2.4.6 Several units are still awaiting the provision of smoking shelters, some of which have been on order for a long time. The MHAC was pleased to observe, however, that the smoking shelters already provided are of a very high standard, particularly at The Vron and Wotton Lawn.
- 2.4.7 The MHAC is concerned that patients subject to escorted leave on the first floor wards at Wotton Lawn, are dependent on staff to access fresh air or to smoke. At busy times there can be no escort available. It also monopolises staff time. There were indications that as a result of this situation some patients were smoking in their rooms. The MHAC is aware that the situation at Wotton Lawn will not be fully resolved until the new PICU is built at ground

floor level. Commissioners were told that some patients at Laurel House also smoked in their rooms. These examples raise health and safety issues.

**Recommendation 6**

***The Trust is asked to investigate the situation concerning patients smoking in their rooms and explore the health and safety implications of this practice and to draw up a plan of action which the MHAC would be pleased to receive.***

## **2.5 Equality and Human Rights**

2.5.1 Further to the comments above regarding smoking and access to fresh air for patients on the first floor at Wotton Lawn, the MHAC observed that patients on the ground floor wards are not subject to the same restrictions, as those on the floor above, and this gives rise to inequalities in respect of Human Rights issues.

**Recommendation 7**

***The Trust is asked to review the situation regarding smoking arrangements and access to fresh air at Wotton Lawn and to devise a system for ensuring that all patients at Wotton Lawn can access their rights equally to fresh air and outside smoking areas, and to provide the MHAC with an outline of the proposed course of action.***

2.5.2 Patients' ethnicity and demographic information was found to be recorded consistently and accurately on most wards but there were exceptions, especially on some learning disability units. An understanding of a patient's ethnicity is important for a number of reasons, not least that it can properly inform care planning for the patient.

**Recommendation 8**

***The Trust is asked to ensure that the recording of ethnicity continues to improve over the coming year, especially in learning disability units, and that it is acknowledged to be an integral part of clinical assessment and care planning.***

### *Staff patient interaction/staff issues*

2.5.3 The MHAC observed during visits that staff patient interaction on wards was generally good. The MHAC commends staff on their attitude towards patients, who may often be extremely vulnerable or be challenging to nursing staff.

2.5.4 The Commissioner visiting Bourton Ward, Charlton Lane, observed that the staff seemed to have adjusted well to their new working arrangements and that patients did not appear to have been adversely affected by the reconfiguration of services for older people.

2.5.5 The MHAC observed that the use of volunteers at Honeybourne Unit, some of whom are former patients, is an example of good practice and works

extremely well. The MHAC will be monitoring the impact, if any, on staff and patients, of the Drug and Alcohol inpatient service moving to the Honeybourne site at a future date.

2.5.6 Staff at most sites reported that they had access to training in the provisions of The Mental Health Act 2007. The RMO and Ward Manager at Westridge have suggested to the Commissioner that joint training in the provisions of the amended Act would facilitate communication between health and social care staff. The MHAC would be pleased to receive an update on this initiative.

## **2.6 Monitoring Assessment and Admission – Contact with other Statutory Agencies**

2.6.1 The MHAC monitors those duties and responsibilities vested in local authorities, police and ambulance services, particularly the operation of the assessment and admission elements of the Act, to ensure that the rights of detained patients are being upheld and agencies are discharging their statutory duties correctly. During the period covered by this report the MHAC visited Gloucester Social Services Department and met social care staff in order to examine how the local authority is discharging its duties under The Mental Health Act 1983 . A copy of the Commissioner's report has being sent to the Trust and to Gloucester Social Services Department.

2.6.2 The report observed that, although some staff highlighted individual areas of concern, there was a clear commitment demonstrated to providing a responsive mental health service for Gloucestershire. The report also commended the Trust for its commitment to mental health partnership working, reflected in the inclusion of social care representation at Board level.

2.6.3 The report noted that Approved Social Workers (ASWs) enjoy good working relationships with the police in the course of carrying out the Mental Health Act assessment process, but sometimes experience long waiting times for the attendance of an ambulance. This problem is reflected in other Trust areas and the MHAC welcomes the current redraft of the joint protocol on conveying patients detained under the Act.

2.6.4 Some of the recommendations made in the report are as follows:

- The MHAC recommends that the Local Authority reviews its current arrangements for providing legal advice and representation for ASWs.
- The MHAC suggests that the Trust and The Local Authority move towards the use of compatible mental health care Information Technology systems.
- The MHAC suggests that The Local Authority should review its arrangements for providing adequate out-of-hours section 12(2) doctor cover, as part of its partnership working arrangement with the Trust.
- The MHAC was unable to examine the Trust's Absent Without Official Leave (AWOL) policy, but suggests that the policy ensures clarity of communication between hospital and community staff about the responsibility for returning a detained patient to hospital that had gone

absent without leave. The MHAC will monitor this matter through subsequent visits to acute wards.

- 2.6.5 The Trust has concurred with the main comments and recommendations in the report and further discussions have taken place with the MHAC concerning those areas of the report on which the Trust requested clarification.

**Recommendation 9**

***The MHAC suggests that the Trust prepare an action plan for implementing the recommendations made in the Social Service Department report and requests a copy of the plan.***

**2.7 The Patient Perspective**

2.7.1 Meeting detained patients is central to the remit of the MHAC. Detained patients are by definition, not in hospital by choice. If they dislike the services they are receiving, they are not free to leave. When Commissioners meet individual patients they may assist the patient by raising issues of concern or, if appropriate, to make a formal complaint. No help with formal complaints was requested during the period covered by this report. Commissioners may also talk more generally to patients about their detention, their rights, their care and treatment, and their care plan. At the end of a visit to a ward the Commissioner will usually leave a ward notice that provides feedback on general issues arising from the visit. Patients interviewed in private will normally be given a letter summarising the matters discussed, which can, with their permission, be copied to the ward manager.

2.7.2 The majority of patients spoken to, both in private and on the ward, made positive comments about their treatment and the care received, though some patients raised concerns about aspects of their care which fell outside the remit of the MHAC. Several patients praised the activities programme provided by the Trust.

**3. FORWARD PLAN – THE NEXT 12 MONTHS**

3.1 During the next twelve months the MHAC will start monitoring compliance with the amended Mental Health Act and the new Code of Practice. Visiting feedback may therefore include specific comments relating to the Trust's implementation of the Mental Health Act 2007 and the impact of changes on detained patients. There may also be some developments in the way that Commissioners visit to enable them to consider new areas of legislation, such as Supervised Community Treatment.

3.2 In addition, during this period, the MHAC will be working to achieve a smooth transition of its statutory functions, including meeting with detained patients and providing the SOAD service, to the Care Quality Commission, the new health and social care regulator.

3.3 In relation to the Trust visiting programme priority will be given to activity in the following areas:

- Commissioners will endeavour to visit all wards throughout the Trust to examine legal documents and notes relating to the care of detained patients.
- Detained patients will have the opportunity to talk to a Commissioner in private should they so wish, during the course of the visit.
- Commissioners will pay particular attention to those areas highlighted as recommendations for action by the Trust, while carrying out the MHAC visiting programme.
- Commissioners will endeavour to make arrangements to meet patients on longer periods of Section 17 leave, which may not normally have an opportunity to meet Commissioners, including those patients subject to Community Treatment Orders.
- The MHAC will meet representatives of service user organisations and advocacy services that provide support for people detained under the Act.
- Commissioners will continue to monitor closely the effects of service reconfiguration on patients at Charlton Lane and Wotton Lawn.

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**Appendix A**

**Commission Visit Information for <sup>2</sup>gether NHS Foundation Trust  
covering the period between 31 October 2007 and 1 July 2008**

<b>Date</b>	<b>Ward</b>	<b>Det. Pats. seen</b>	<b>Records checked</b>
<b>Charlton Lane</b>			
27 May 2008	Bourton Ward	2	4
<b>Total for Charlton Lane</b>		<b>2</b>	<b>4</b>
<b>Wotton Lawn</b>			
5 Jan 2008	Greyfriars Ward	1	3
9 Jan 2008	Abbey Ward	2	3
11 Jan 2008	Priory Ward	3	3
18 Feb 2008	Dean Ward	2	3
3 Mar 2008	Kingsholm Ward	1	4
19 Mar 2008	Montpellier	0	3
<b>Total for Wotton Lawn</b>		<b>9</b>	<b>19</b>
<b>Laurel House</b>			
1 Apr 2008	Laurel House	3	3
<b>Total for Laurel House</b>		<b>3</b>	<b>3</b>
<b>The Vron</b>			
20 Jun 2008	The Vron	1	1
<b>Total for The Vron</b>		<b>1</b>	<b>1</b>
<b>Holly House</b>			
7 Apr 2008	Assessment Ward	2	2
<b>Total for Holly House</b>		<b>2</b>	<b>2</b>
<b>Hollybrook</b>			
18 Apr 2008	Hollybrook	1	3
<b>Total for Hollybrook</b>		<b>1</b>	<b>3</b>
<b>Westridge</b>			
6 May 2008	Westridge	0	2
<b>Total for Westridge</b>		<b>0</b>	<b>2</b>
<b>Honeybourne Specialist Rehab and Recovery Centre</b>			
27 May 2008	Honeybourne	1	1
<b>Total for Honeybourne Specialist Rehab and</b>		<b>1</b>	<b>1</b>
<b>Total Number of Visits: 13</b>			
<b>Total Number of Wards visited: 13</b>			
<b>Total number of Patients seen: 19</b>			
<b>Total Number of documents checked: 35</b>			

**Mental Health Act Commission  
Annual Report**

**<sup>2</sup>Gether NHS Foundation Trust**

**Appendix B**

Action Plan prepared for <sup>2</sup>Gether NHS Foundation Trust  
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ISSUE IDENTIFIED	ACTION REQUIRED	RESPONSE	LEAD OFFICER	TARGET DATE FOR COMPLETION
Other MHAC Activities	The Trust is asked to ensure that the training programme on the implementation of risk assessment and observation procedures is instigated as soon as possible to ensure that the appropriate lessons are learnt from this incident.			
Section 17 Leave	The Trust should satisfy itself that the rights of patients on long-term Section 17 leave are not breached			
	The Trust should review its practices in relation to Section 17 leave arrangements to ensure that it is fully compliant with The Act and the Code of Practice.			

Action Plan prepared for <sup>2</sup>Gether NHS Foundation Trust  
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ISSUE IDENTIFIED	ACTION REQUIRED	RESPONSE	LEAD OFFICER	TARGET DATE FOR COMPLETION
Section 132 Patients' Rights	The MHAC requests that the Trust monitors its revised practices concerning Section 132 and learning disabled adults and provides the MHAC with evidence of their effectiveness.			
Physical Environment	The Trust is asked to keep the MHAC informed of progress on the building work for the Section 136 Suite and to notify the MHAC of the timetable for commencing work on the new PICU.			
Management of Smoking arrangements	The Trust is asked to investigate the situation concerning patients smoking in their rooms and explore the health and safety implications of this practice and to draw up a plan of action which the MHAC would be			

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ISSUE IDENTIFIED	ACTION REQUIRED	RESPONSE	LEAD OFFICER	TARGET DATE FOR COMPLETION
	pleased to receive.			
Access to fresh air	The Trust is asked to review the situation regarding smoking arrangements and access to fresh air at Wotton Lawn and to devise a system for ensuring that all patients at Wotton Lawn can access their rights equally to fresh air and outside smoking areas, and to provide the MHAC with an outline of the proposed course of action.			
Equality and Human Rights	The Trust is asked to ensure that the recording of ethnicity continues to improve over the coming year, especially in learning disability units, and that it is acknowledged to be an integral part of			

Action Plan prepared for <sup>2</sup>Gether NHS Foundation Trust  
Annual Report – July 2008

ISSUE IDENTIFIED	ACTION REQUIRED	RESPONSE	LEAD OFFICER	TARGET DATE FOR COMPLETION
	clinical assessment and care planning.			
Monitoring Assessment and Admission	The MHAC suggests that the Trust prepare an action plan for implementing the recommendations made in the Social Service Department report and requests a copy of the plan.			

**Mental Health Act Commission**  
**Maid Marian House**  
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**Nottingham**  
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*Headquarters based Visiting Services Manager with responsibility for visiting arrangements in the following geographical areas:*

- ◆ REGION 1 – The North, Yorkshire to Northumberland, Tyne & Wear
- ◆ REGION 2 – East Midlands, East Anglia & Thames Valley
- ◆ REGION 3 – Wales, West Midlands & The South West
- ◆ REGION 4 – London & The South East

VISITING SERVICES MANAGER		
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