healthwatch
Isle of Wight

Healthwatch Isle of Wight

Inpatient Mental Health Ward Visits

December 2019

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Contents Page

Background

Mental health is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

—The World Health Organisation

Historically, mental health care was provided in psychiatric institutions. Patients were unable to leave these institutions and many were made to undergo compulsory treatment.

Along with medical, psychiatric and technological advances came the desire and political will to transform mental health care practice. Institutions were increasingly being seen as morally wrong and a contravention of people's human rights.

In the 1980s institutions closed down and care in the community began. People would now be able to receive the mental health care they needed/wanted from community teams while being able to live in their own homes and remain active members of society.

The closure of institutions and the introduction of community care teams however does not mean that people can not be detained and treated with or without consent if deemed necessary. The Mental Health Act (1983) allows the detention and treatment of a person suffering from mental illness that need urgent help due to being a risk to themselves or others.

Most people receiving mental health care under a section of the Mental Health Act will be detained (unable to leave without permission or an escort) as an inpatient on a mental health ward. For others, there are certain conditions that must be met in order for people to live in their own homes.

It is important to recognise that many people receiving care as inpatients in mental health wards are not subject to sections of the Mental Health Act and are voluntary patients. This means that they can not be required to stay or receive treatment without their consent.

However, being a voluntary patient does not mean you can not become subject to the provisions of the Mental Health Act if your condition deteriorated and the risks to you or others increases.

The Isle of Wight has the highest rate of admission to mental health wards in England, with the shortest length of stay[1] (data from 2016/17). This suggests that there is a lack of community/crisis support available on the Island and that people are being discharged from inpatient wards to find themselves returning to the wards at a later date. The IW NHS Trust have described this as a "revolving door" care model as a result of a lack of suitable community provision.

The number of people on the Isle of Wight that were experiencing poor mental health during 2015/16 was significantly higher than the national average for the rest of England[2].

1 in 4 people will experience poor mental health in any given year.[3]

The National Institute for Health and Care Excellence (NICE) clinical guidance state that:

- When a service user enters hospital, greet them using the name and title they prefer, in an atmosphere of hope and optimism, with a clear focus on their emotional and psychological needs, and their preferences. Ensure that the service user feels safe and address any concerns about their safety.
- Health and social care providers should ensure that service users in hospital have access to the pharmacological, psychological and psychosocial treatments recommended in NICE guidance provided by competent health or social care professionals.
- Ensure that service users in hospital have access to a wide range of meaningful and culturally appropriate occupations and activities 7 days per week, and not restricted to 9am to 5pm. These should include creative and leisure activities, exercise, self▫care and community access activities (where appropriate).

Recent Care Quality Commission (CQC) Inspection History for Mental Health Services—Ratings

In 2014,CQC rated the Isle of Wight NHS Trust mental health service as 'good' in the safe, effective, caring, responsive domains and also 'good' overall. The well-led domain received the rating of 'requires improvement'.

A follow up inspection was undertaken during November 2016 and the report published in April 2017. In this report the service was found to have substantial issues that resulted in numerous enforcement notices being issued and with the exception of the caring domain, that maintained its 'good' rating, the remaining domains and the overall rating were downgraded significantly to 'inadequate'.

During this inspection, the IW NHS Trust as a whole (not just mental health services) received an overall 'inadequate' rating for all services and as a result was placed in special measures.

As a result of the significant concerns identified, the mental health services were revisited by the CQC in May 2017 to see if the improvements required had been undertaken. This visit found that while some progress occurred, there were still significant issues that meant that although some enforcement notices could be amended, the majority remained in place. The report was published in July 2017.

In January and February 2018, the mental health wards were again inspected by CQC and again rated overall as 'inadequate'. As with the previous visit, some improvements were noted but the commentary states;

We continue to have significant concerns about the safety of Shackleton ward

Due to the improvements to the physical safety of the overall environment in mental health inpatient units noted in 2018, the enforcement conditions were lifted.

Recent Care Quality Commission (CQC) Inspection History for Mental Health Services— Detailed findings

2014

Outstanding areas of practice

- The outside garden space on Afton Ward for older adults was funded and developed by staff. The garden was gender-specific, and had a quiet and restful area, as well as areas that encouraged activity and learning. It was described as inspirational by people and their families.
- On the acute, PICU and Rehabilitation wards (including S136 Place of Safety) there was effective debriefing for staff following incidents, and staff shared lessons learnt in team meetings. Reflective practice was provided to staff through a skilled psychologist.
- There was effective use of the wellness recovery action plan (WRAP) for patients on the acute, PICU and Rehabilitation wards (including S136 Place of Safety). Discharge planning started on admission and the discharge tree was used on the PICU. The wards had excellent relationships with housing and employment services.

2016

Key findings

- Since our last inspection in 2014, some services had seen deterioration in safety and quality, including care for patients with mental health conditions.
- Inpatient mental health wards were not safe.
- Staff awareness of the Mental Health Act (2005) and the Deprivation of Liberty Safeguards was variable and it was not always applied.
- Patients' privacy and dignity was not protected in mental health services wards. Staff did not always report incidents where mental health wards had people of both sexes sharing bathrooms, which is a breach of the regulations.
- Staff did not plan patient discharge effectively leading to extended length of stays across acute and mental health inpatients services.
- Staff did not always identify or report safeguarding incidents.
- IW NHS Trust is placed in special measures

CQC Enforcement Action.

The enforcement actions that were issued as a result of the 2016 inspection report for inpatient mental health services were related to the following:

- Serious environmental concerns
- Mixed sex breaches
- Lack of risk assessments
- Understaffing / untrained staff

The purpose of special measures:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or seek to take further action, for example to cancel their registration.

2017 Inspection: To ensure required improvements had been made

At this inspection the CQC found there remained a significant amount of work still to do for the conditions of the enforcement notice to be fully met including:

- further work on the ward environments to ensure they are fit for purpose
- addressing staffing levels
- addressing the quality of patient records;
- providing staff with access to supervision
- ensuring decisions are made about the future of some services
- Implementing good governance systems to ensure the board can effectively assure itself that the required improvements are being made in a timely manner.

Notable progress had been made, including:

- Work had been carried out and was progressing on the physical ward environments, in order to make them safer for patients.
- There was positivity and enthusiasm from the staff on the Sevenacres site at being fully involved in planned improvements to their wards.
- There was an increased awareness of staff about the potential risks on the inpatient wards.

2018 Inspection: Full inspection for the IW NHS Trust

The IW NHS Trust were rated 'inadequate' overall during this inspection and as a result remain in special measures. Mental health services, overall, also received an inadequate rating.

- The trust did not have sufficient clinical psychologists and other staff. This meant that patients under the care of community and inpatient services had little access to talking therapies recommended by the National Institute for Health and Care Excellence.
- The CQC continue to have significant concern about the safety of Shackleton ward, an inpatient ward for older people with mental health problems.

2019 Inspection:

- All requirements of previous enforcement action had been met and to date, there is no enforcement action relating to inpatient mental health services at the IOW NHS Trust.
- Significant quality and safety concerns were found on Shackleton ward leading to a temporary closure of the ward in Sept 2019
- Due to the nature of the inspection, the CQC were unable to change the rating of mental health services.

What Healthwatch did

In January 2019, the Healthwatch Isle of Wight Enter and View team visited all 5 inpatient mental health wards/facilities on the Island:

- **Seagrove ward—** a psychiatric intensive care unit.
- **Osbourne ward—** a mental health ward that primarily cares for people under 65.
- **Afton ward—** an acute admissions mental health unit for older people.
- **Shackleton ward—** specialist mental health dementia ward.
- **Woodlands—** a mental health rehabilitation unit.

Each of these visits followed the same format and focused on observing the following areas:

Environment **Activities** **Staff interaction** **General observation**

In addition to looking at these four areas, the team also concentrated on specific areas of concern raised by the Care Quality Commission within their inspection during January/February 2018.

The observations the enter and view panel were asked to make as a result of the concerns for each ward were as follows:

Osborne ward:

Is there unlimited access to the garden?

Do the bedrooms have en-suite bathrooms?

If there is a seclusion room, does this have a toilet in it?

Is access to Seagrove ward via this ward?

Afton ward:

Where is the nurses station situated?

Are there blinds/curtains in the communal rooms?

Are all bathrooms en-suite?

Do patients have access to the garden?

Woodlands:

Is there a female only lounge?

Is the garden accessible?

Do patients have unrestricted access to food and drink?

Shackleton ward:

Is there a sign on the female only lounge saying females only?

Are there signs above the basins to remind staff/patients to wash their hands?

Are patients bedrooms locked?

Are patients able to access food and drink without having to ask?

Does the environment feel clinical or homely?

Seagrove ward:

Where is the entrance to the ward located?

After the visits were undertaken, reports were written for all 5 of the wards visited.

This report has combined the findings from all 5 wards to give an overview of the inpatient mental health provision that is delivered by the Isle of Wight NHS Trust.

What Healthwatch found

Combined observation findings:

Osborne / Afton / Woodllands / Seagrove

Environment

- The environment on the wards was welcoming, but a little too clinical.
- The décor was bland and walls were a little bare, with few pictures or decorative furnishings.
- The furniture on the wards was in good condition and appeared to be appropriate and functional.

Activities

- Staff told the panel members that many activities were available. However, the only activities that were seen during the visits was an art-based activity or people watching television.
- Activities were not always person-centred.
- Access to outings was said to be available but this was dependent on staffing levels.
- Most patients had regular access to outside space (gardens).

Staff interaction

- When staff were seen to be engaging with patients they engaged well. There were long periods of time however that staff were not talking to patients and they were left alone.
- Staff were friendly and relaxed.
- Staff and patients seemed happy in the environment, however they were frustrated when outings or leave were cancelled.

General observation

- Staffing levels appeared reasonable during the time of the visits. However, when staffing levels dropped, this impacted on their ability to arrange patient leave and trips out.
- Overall, the wards were felt to be clean, tidy and orderly.
- Bed occupancy was a concern. If patients are on leave from the ward their bed can be allocated to someone else, resulting in an over 100% bed occupancy rate. It is unclear how this would be managed should the patient be recalled or return from leave unexpectedly.

During these visits Healthwatch representatives were alarmed at the serious failings that were found on Shackleton ward. As a result of these significant concerns, immediate contact was made with the IW NHS Trust to inform them of the findings and to make them aware that Healthwatch would be escalating the issues to the CQC, without delay.

As a result of the visit to Shackleton Ward, there was a delay in publishing the other ward reports. However, any issues identified were reported to the IW NHS Trust.

Due to the stark differences in the findings, Shackleton is reported on in a separate section of this report.

What Healthwatch Isle of Wight found relating to the CQC areas of concern

Osborne ward:

There was access to the garden.
The bedrooms have en-suite bathrooms.
There is no seclusion room on this ward. If seclusion is necessary, the patient would need to go to Seagrove ward.
Access to Seagrove ward is via this ward.

Afton ward:

The nurses station was in a communal area.
There were blinds/curtains in the communal rooms.
En-suites were toilet en-suites. There was 1 assisted and 1 assisted en-suite bathrooms.
There was access to the garden.

Woodlands:

There was no female only lounge.
There was access to the garden.
Unrestricted access to food and drink appeared available.

Seagrove:

The entrance to this ward is still through Osborne ward.

It is encouraging to see that the majority of the CQC concerns relating to the individual wards that Healthwatch looked at during these visits, have been addressed.

However, it is unfortunate to note that the entrance to Seagrove ward has not been addressed and continues to present a risk to the safe management of patients on each ward and compromises privacy and dignity.

Shackleton ward

Shackleton ward is described on the Isle of Wight NHS Trust`s website as follows:

Shackleton Ward is a 4 bedded unit which provides specialist inpatient assessment and care for those suffering with dementia. The unit is able to offer assessment and advice to relatives/ carers and residential homes on the management of people who present challenging problems in the care that they require. The unit is also able to offer advice to/for individuals who are not receiving inpatient care. There are plans to develop an outreach service from the unit to enable people to be assessed in their own living environment.

Recent history

Shackleton ward has been an area of significant concern for some time. The CQC have high-lighted numerous issues within their inspection reports, many repeatedly.

Healthwatch staff members visited the ward in Dec 2014 for a brief walk around tour of the ward and wrote to the IW NHS Trust at this time regarding environmental concerns.

It is important to note that Shackleton ward was designed to be a short term assessment ward although in practice this has often not been the case. As a result, the ward became 'home' for many individuals over the past few years, for significant periods of time ranging from days or months to in some instances, years.

During the visit to Shackleton ward, our enter and view representatives found significant concerns relating to all of the topics of focus, specifically with regards to the environment and to levels of proactive staff interaction.

Of particular concern was the level of restrictions placed on people. Toilet and bathroom doors were locked and patients had to request help from staff if they needed to use the toilets. The general décor was bare and unwelcoming and there were no light switches in the bedrooms, meaning that patients were unable to control the lighting once in their own room. Although staff were very welcoming and caring in their approach, there was a lack of understanding of positive risk taking and proactive support methods observed during the visits.

Following the visit to Shackleton ward, we contacted the IOW NHS Trust to inform them that due to the serious and significant nature of the concerns we would be escalating the issues they discovered to the Care Quality Commission and to NHS England. As a result of the findings contained in the report we made 5 recommendations to improve the experience of people with dementia on Shackleton ward. A report of the visit was sent to the IOW NHS Trust and they were asked for a response.

Recommendations made

1. The immediate environment should be enhanced to provide a more homely, welcoming feel, with input from patients and their families/carers.
2. Patients should be able to access toilet facilities at all times.
3. Individualised therapies and therapeutic activities should be provided on a daily basis.
4. Light switches should be moved immediately to ensure patients can control the lighting in their bedrooms.
5. Staff should implement a proactive approach to supporting people, in order to minimise the risk of patients becoming anxious and agitated.

IOW NHS Trust response to the report

"We are grateful to Healthwatch for their Enter and View report about Shackleton ward, and fully agree with the assessment. Shackleton ward is a 4 bedded mental health Dementia ward that cares for people who have specialist mental health needs. The environment was not appropriate for this type of specialist service, and we have therefore worked with staff, carers and partners, including Healthwatch, to develop plans to refurbish the ward and create a dementia-friendly environment. The works began at the beginning of April, and the ward is due to reopen in June 2019. We accept all of the recommendations in the report, and are fully implementing all of them. We look forward to welcoming Healthwatch to carry out a follow up review of Shackleton ward once it is reopened to see the improvements made." - Isle of Wight NHS Trust.

The IOW NHS Trust accepted all 5 recommendations and began to improve the immediate environment by refurbishing the ward before the report was published. Their renovation plans included making the environment more dementia friendly and improving the bathroom facilities. Rooms were also refurbished to provide a more homely feel.

Ward closed for refurbishment

The Isle of Wight NHS Trust closed Shackleton ward at the beginning of April 2019 in order to refurbish the ward. All patients who were on the ward at the time were discharged and If new admissions were required, these were referred to mainland hospitals.

Although necessary, it is important to remember that moving patients off Island was incredibly difficult for not only the patients affected but also their family members and/or carers.

Healthwatch revisited the ward

On the 12th June 2019, shortly before the ward was due to reopen, Healthwatch revisited Shackleton ward to look at the new environment. During this visit we were informed that the staff from the wards had undertaken numerous training courses and shadowing days during the closure period. It was pleasing to see the improvements that had been made to the environment and to hear of the new proactive approach that would be taken by staff.

Healthwatch informed the trust it was looking forward to working closely with them to ensure that improvements on the ward are sustained.

Ward temporarily reopens

Nearing the end of June 2019 the ward was reopened. Arrangements were made to transfer patients that were in mainland wards back to Shackleton.

In August 2019 Shackleton ward was closed to new admissions, with low/ not suitable trained staffing levels cited as the reason for this. Any patients needing this service would again be transferred to mainland wards.

In September 2019, it was announced that the Isle of Wight NHS Trust board had decided not to reopen the ward, and would be looking at options for the future care of people with dementia who have complex needs. It has been reported that this ward may be replaced with a community service instead. Anyone needing inpatient care is now being transferred off Island or admitted to another ward at the IOW NHS Trust.

Duty to consult

It is unclear what the future is for this service but Healthwatch would expect to see consultation surrounding the decision to close the ward in the near future, as this is a legal requirement when a substantial variation of service occurs.

Planning, assuring and delivering service change for patients - NHS England

What is service change and when is consultation with the local authority and public consultation required?

The National Health Service Act 2006 sets out the legislative framework for public involvement (Sections 13Q (NHS England), 14Z2 (CCGs) and 242 (NHS Trusts and FTs)). Consultation with local authorities is provided for in the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the s.244 Regulations") made under section 244 (2)(c) of the NHS Act 2006. Broadly speaking, service change is any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered. There is no legal definition of 'substantial development or variation' and for any particular proposed service change commissioners and providers should work with the local authority or local authorities Overview and Scrutiny Committee (OSC) to determine whether the change proposed is substantial. If the change is substantial it will trigger the duty to consult with the local authority under the s.244 Regulations. It is this that can trigger a referral to the Secretary of State and the Independent Reconfiguration Panel. Public consultation, by commissioners and providers, is usually required when the requirement to consult a local authority is triggered under the s.244 Regulations because the proposal under consideration would involve a substantial change to NHS services. Change of site from which services are delivered, with its consequent impact on patient, relative and visitor travel times, even with no changes to the services provided, would normally be a substantial change and would therefore trigger the duty to consult the local authority and would be likely to require public consultation. Decommissioning a service could also be a substantial change. Tendering a service by itself is unlikely to be a significant change unless the new service specification will provide a substantial change in service.

*Changes can be made temporarily under regulation 23(2) of the s.244 Regulations because of a risk to safety or welfare of patients or staff. In these circumstances it may not be possible to undertake any public involvement or consultation with the Local Authority. The local NHS should try to undertake as much engagement as possible in the time available and discuss with NHS England and NHS Improvement how this can be assured. However, when a decision is proposed to make a temporary change permanent, the full process set out in this guidance must be followed.

Conclusion and recommendations

Conclusion

Overall, the environment on the inpatient mental health wards, with the exception of Shackleton ward, was found to be comfortable. There was a recurrent theme throughout the wards that decoration was sparse and not particularly homely. However, the general state of repair was found to be good, wards were found to be clean and tidy and other than some personal touches, the only thing that was perhaps needed was a new layer of paint.

It is difficult to comment on the activity provision. Staff said various activities were available but none of these were witnessed during the visits. Of those that were available but not witnessed, it was felt by the Enter and View panel and some patients that most of the activities were not person-centred.

Staffing levels was a contentious issue for both staff and patients. When staffing levels are low activities are minimised, outside trips may not go ahead and home leave can be cancelled.

Bed occupancy rates are also a concern. It is worrying that staff were not able to articulate a clear plan of action that could be taken in the event of someone needing to return to the wards from home leave when their bed had been reallocated to someone else.

It was positive to see that the serious concerns that we raised with the trust regarding the environment and staff attitudes on Shackleton were finally being addressed. It is extremely disappointing that so many CQC warnings and concerns raised by Healthwatch had not been acted upon sooner.

Recommendations

Individual wards received their own recommendations in their Enter and View reports.
To summarise, these were as follows:

Afton ward, Woodlands, Osborne ward, Seagrove ward:

- Wards would benefit from a new layer of paint and some homely items such as cushions or wall hangings.
- Activities should be person centred.
- Staffing levels should be maintained to reduce the activity and leave cancellations.
- Clear risk management protocols must be available to staff in the event of a patient needing to return to the ward during their leave, when occupancy rates are over 100%.
- A private entrance to Seagrove ward should be created.

Shackleton ward:

The original recommendations made for Shackleton ward are listed on page 13.

- In addition to these, it is recommended that due process is followed and a full public consultation takes place as soon as possible regarding the future of Shackleton ward and what an alternative service, if this is indeed the preferred option, may look like.

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