healthwatch Northamptonshire

Enter & View Report

St Andrew's Healthcare, Northampton

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Acknowledgements

We want to thank all the patients at St Andrew's who spent time talking to us during our visit about their experiences and views. We want to thank the staff at St Andrew's who spent time talking to us about the care provided and showing us round the hospital; the managers and staff who organised the visits for us at short notice and have commented on drafts of the reports and the staff who delivered the 2 day training session prior to our visits. We want to thank 'Together for mental wellbeing' who developed the questionnaire we used as the basis of our conversations with patients. We want to thank our team of Healthwatch Northamptonshire staff and volunteers who conducted the visits and have helped in the preparation of the reports.

1. Background

St Andrew's Healthcare, Northampton is a charity which provides in-patient secure mental health services and services for people with acquired brain injury, dementia or neurological conditions (conditions of the nervous system). Over 90% of patients at St Andrew's Healthcare, Northampton have been detained under sections of the Mental Health Act. Secure services include adolescent units for children aged 13 – 18, locked wards, low secure wards and medium secure wards.

Most of the funding for patient care for St Andrew's comes from the NHS. The main headquarters of the charity's services is Northampton and the charity also provides service in Birmingham, Nottinghamshire and Essex. The charity is a specialist, national service. A national body called NHS England plans and pays for (or "commissions") the patient care for patients who live in England. Patients at St Andrew's Healthcare, Northampton come from all over the UK and the Republic of Ireland. St Andrew's Healthcare, Northampton has just over 700 beds and is home to the largest secure adolescent unit in Europe. Only around 3% of patients at St Andrew's Healthcare, Northampton come from Northamptonshire.

Healthwatch Northamptonshire is the independent consumer champion for local people using health and social care. We are part of a network of 148 local Healthwatch in England. We are a statutory organisation and have a number of legal rights, including the right to go into health and social care services where care is paid for from public funds and assess the care provided from the perspective of patients and service users. This right is called "Enter and View".

Healthwatch Northamptonshire decided to exercise our legal rights and visit St Andrew's Healthcare, Northampton. We did this for a number of reasons:

- we have concerns about the quality of patient care at SAH
- we were aware that the independent regulator of health and adult social care in England – the Care Quality Commission (CQC) – had visited SAH and had a range of concerns about patient care at SAH. The CQC had issued an enforcement notice, now lifted, in relation to the adolescent service at SAH
- we had raised our concerns with SAH, the CQC and NHS England and have met with all three organisations together during 2014
- we became aware that the CQC was due to do an in-depth inspection of SAH during September 2014

2. Enter and View at St Andrew's Healthcare, Northampton

Healthwatch Northamptonshire visited St Andrew's Healthcare, Northampton (SAH) during August 2014. During a two day period, a team of 6 people – 4 from Healthwatch Northamptonshire and 2 people from the charity 'Together for mental wellbeing':

- visited 9 wards and observed the ward environment
- the wards ranged from men's medium secure, men's low secure and locked, women's medium secure and women's low secure and the adolescent secure units
- spoke to 44 patients from 13 different wards either individually or in small groups of between 4 – 6 patients
- spoke to staff and managers who work on the wards
- used a questionnaire with 29 questions developed by mental health service users working with the charity 'Together for mental wellbeing'. 39 patients responded to the questionnaire but for some patients, we did not use the questionnaire as it was not appropriate
- met with senior managers at the end of the two day period to share our initial findings in relation to what we had heard and seen during out two days

We were one of the first local Healthwatch, if not the first, to conduct Enter and View at medium secure mental health services, including secure adolescent services. We therefore needed to develop a plan for how we were going to conduct the visit and what tools we would use. The role of 'Together for mental wellbeing' in providing us with a framework for talking to patients individually and in groups was essential. We have met to review our visit and the approach we used, including with SAH, and we will improve our process for the next time we visit. We also plan to share our learning with the Healthwatch network as an approach for enter and view of secure mental health provision.

3. Our findings

Positive about care: Several patients talked to us **very positively about the care** they received at SAH. Some patients said that SAH had provided a structure to their life which they welcomed and several patients told us they felt they were getting better.

Staffing levels: Our questionnaire did not include a specific question about staffing levels. However, it was the biggest area of concern which patients raised with us spontaneously. Of the 44 patients we spoke to in total, 12 mentioned staffing issues without prompting. Comments about the impact of staffing levels from the patients who referred to their perceptions of low staffing levels included views that staffing levels are putting patient safety at risk. Patients who talked about low staffing levels said this has a knock on effect on the quality of care including the ability to increase their level of relative freedom, for example being able to go out in the grounds of St Andrew's with a staff member escorting them.

Patient safety: We formed a view that staffing levels impacted on some patients' sense of safety based on the responses to the questionnaire and the comments from around a quarter of the patients we spoke to who commented on staffing levels. While 79% always or often felt safe and secure, we would assume that the figure should be 100% of patients always feeling safe and secure. 13% of patients told us they rarely or never felt safe and secure.

> "I never had a good life, till I came here….I always feel safe and secure (at SAH)"…...."There is a lot of fighting and shouting on the ward "I never feel safe"

Staffing mix: We formed an impression, based on comments from some staff and some patients, that the mix of staff means there are a high proportion of relatively inexperienced and unqualified staff meaning that patients are not always receiving the clinical expertise and knowledge. St Andrew's advise that there is no national guidance on skill mix and that staffing levels are defined by the charity as informed by experienced clinical professionals which set out that there are at least two Registered Nurses per ward during the day. In addition, St Andrew's have made recruitment of more qualified nurses a priority which is to be welcomed.

Being treated with respect: 35 of the 39 people answered the question "Do people treat you with respect?" The majority of people - 74% who responded said they always (36%/14) or often (38%/15) felt treated with respect, 5% (2) said sometimes, 8% (3) said rarely and 3% (1) said they never felt treated with respect. 10% (4) did not respond to the question. 9 people made comments in relation to this question and comments included:

“Some people treat me with respect, some don’t”……..“A lot of staff do a very good job but some staff don’t……some make sarcastic comments”

Physical healthcare: 7 patients talked to us about how they felt their physical healthcare needs are being neglected. SAH has provided evidence of how they are meeting the physical healthcare needs of some of those patients we talked to. SAH provided information about complaints from patients about their physical healthcare complaint. Analysis of complaints from patients to SAH linked to physical healthcare in the last 12 months; 67 have a link to physical healthcare. 38% of complaints were either fully or partially upheld.

Quality of ward environment: Our impression from our observation of the ward environments in some areas is that more could be done to make the ward environment a better place for patients to live. Some of the older wards, such as Ferguson, are not in our opinion of good quality. We are aware that there is a significant programme of new building taking place, including the planned new adolescent unit and re-provision of wards such as Ferguson.

Individual care plans: Care plans are the basis of deciding on the care and treatment plan for patients and should take into account the views of patients. Based on the responses to the questionnaires and from comments some patients made to us, the majority of people said they were always, sometimes or often involved in their care planning. A quarter of the people who responded (8 out of 32) said they were rarely or never involved, although we would need further information to understand whether there were any reasons preventing involvement in care planning.

“Involved (in care plan) but not as much as I would like to be”……. “I have a choice over my care plan – what goes in and out”

Patient engagement: We noted that there is a high level of engagement in ward (known as community meetings). Most of the patients we spoke to attended community meetings (these are regular meetings held on the wards) – 75% told us they always attend community meetings. By contrast, only 13% (5) of the 39 people asked always thought decisions taken at patient meetings were implemented. St Andrew’s have set out in detail that they are working to improve patient engagement at all levels within the charity including a dedicated team of trained patients who are actively involved in clinical and senior non-clinical recruitment, including the appointment of their new CEO. SAH also advised that some patients will be unable to leave their wards because of the section under the Mental Health Act that they are detained under or because of Ministry of Justice restrictions.

4. Recommendations for action

1. We recommend that SAH and the commissioners should work together to deliver an environment and patient experience which aspires to all patients saying they **always** feel safe and secure. Patients should be involved in the development of the action plan.

2. We recommend that SAH regularly ask patients if they feel safe and secure. We recommend that the findings on perceptions of safety and security for individual wards are reviewed to assess how staffing levels impact on a sense of safety and security. We would welcome a conversation with SAH about how the methodology we used, could be developed.

3. We recommend that SAH regularly check care plans to determine whether care plans are being delivered in relation to the agreement with individual patients set out in care plans. This should include assessing whether staffing levels impact on the ability to deliver aspects of care plans such as escorted leave.

4. We recommend that SAH develops a clear process for facilitating patient choice of their care co-ordinator and records this information.

5. We recommend that NHS England includes in the review of physical healthcare, a review of the complaints which have been upheld (38% of 67 complaints) to determine underlying trends. Our expectation is that, as commissioners of the service, NHS England is robustly holding SAH to account for the quality of all aspects of service provision, including physical healthcare.

6. We recommend that SAH reviews the 7 unexpected deaths during 2013/14 to establish whether there were any actions that could have been taken by SAH to prevent the unexpected deaths. We further recommend that SAH commissions an independent review into the 7 unexpected deaths. A lay summary of the review should be published. We want to be assured that SAH has a culture of continuous review and learning from unexpected deaths.

7. We recommend that SAH invites the charity Rethink, to talk to the senior management team and the Board about Rethink's 2013 report "Lethal Discrimination" which calls for action to tackle premature morality in secure mental health settings.

8. We recommend that SAH works with patients to look at how the ward environments are rigorously maintained at a reasonable and comfortable level, which both protects patient safety and strives for a more homely atmosphere. This should include:

- improving the environment on the extra care units on the adolescent units prior to their closure

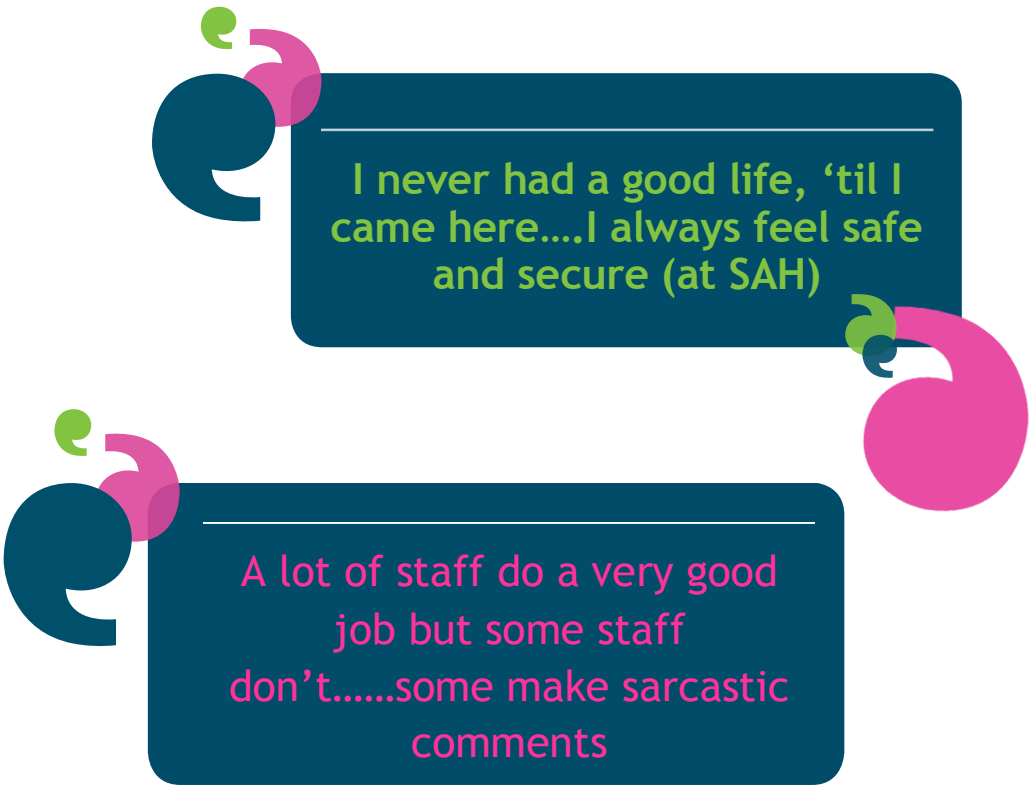
- ensuring that robust efforts are made to improve the environment of wards which are scheduled for closure, eg Ferguson ward, for as long as patients remain on those wards

- exploring the possibility of additional furniture items, other than just sofas and chairs on the medium secure units.

9. We recommend that SAH explores the possibility of enhanced peer support among patients, seeking advice from expert patient organisations about how this could be achieved.

10. We recommend that SAH extends the number of patients involved in patient engagement and leadership at different levels within the organisation.

11. We recommend that SAH develops a process to ensure that suggestions made by patients at community meetings are acted upon and if not, set out the reasons for non-implementation or delay for patients. We further recommend that this process should be regularly checked.



5. Responses to our report

Healthwatch Northamptonshire sent the full report to St Andrew's Healthcare, Northampton and NHS England Leicester and Lincolnshire which is the area team that commissions the service from SAH. Both organisations were invited to comment on drafts of the report and both organisations provided responses to the recommendations. We have gone back to both organisations to ask for a more detailed and a full response to the 11 recommendations contained in our report. To date the responses we have received are:

Response from Gil Baldwin, Chief Executive Officer, St Andrew's Healthcare: "As a Charity dedicated to treating the most complex and challenging areas of mental illness, our 4,000-strong team is committed to supporting those who are often the hardest to help, with the majority of our patients under section or equivalent. Caring for our patients is always our foremost concern and we are confident in the quality of the highly specialist services that we provide. We are proud of the impact that we have on many peoples' lives, with nine in ten St Andrew's patients discharged to more local or less secure environments.

It is, however, our approach to continuously look for new ways to provide ever better care and we welcome all views on how we might achieve this, whether from our patients, regulatory bodies or external organisations. As part of this process, we were pleased to facilitate Healthwatch Northamptonshire's first visit to a secure mental health facility such as ours. We are also grateful to Anne Beales of Together for mental wellbeing for her technical input into the development of their pilot questionnaire and processes.

With regards to the resulting recommendations, we were pleased to note that the report by Healthwatch Northamptonshire reinforces our existing plans in many areas, including patient security, staffing provision, care plans and complaint handling. Our plans and progress as a Charity are discussed in our regular meetings with both the NHS and the CQC. As an important statutory body we look forward to welcoming Healthwatch Northamptonshire to these meetings along with a broad range of other interested parties and learning further from them. Our charitable status means that any money we make is used to grow and improve our services for the benefit of our patients. This has enabled us to reinvest more than a quarter of a billion pounds in the last decade to help improve our ward environments.

As highlighted in the report, this is an ongoing process and we look forward to continuing these efforts with the development of a new state-of-the-art adolescent facility, on which we broke ground earlier this month. All of these plans have been developed in collaboration with the CQC and NHS (England). However, we welcome the suggestions that we might also involve the charity Rethink in our work, and we will continue to work with patient organisations to further develop enhanced peer support amongst patients. We are currently considering how this might be implemented in our operational plans.

With regard to recommendations for an independent review into any unexpected deaths for the period 2013/14, we are keen to reassure that St Andrew's has rigorous processes in place and has always taken responsible and proactive steps to report and fully investigate any incidents. We are committed to transparency and, in addition to our own initial investigations, sought advice from both the CQC and NHS (England), who were satisfied by the thoroughness and diligence of the existing review. As part of our commitment to transparency, we also publish a comprehensive quality review each year, detailing assessment and feedback on our current services and future plans for improvement. This report is distributed to a range of partners who have an interest in our work, and is publicly available on our website which we hope Healthwatch Northamptonshire will find helpful. **We will send a detailed response to Healthwatch Northamptonshire on the 11 recommendations once the report on the CQC inspection has been published.**

Response from Manjit Darby, Director of Nursing and Quality, NHS England Leicestershire and Lincolnshire (the commissioners): NHS England Area Team welcomes the Enter and View report on St Andrew's Healthcare in Northamptonshire in advance of the CQC inspection. NHS England would like to thank Healthwatch Northamptonshire for their continued efforts and focus on secure mental health services. We hope that Healthwatch Northamptonshire will follow this up periodically in order to examine trends that may be more informative than the single snapshot provided. NHS England recognises the challenges for Healthwatch Northamptonshire in their task given the particular challenges and complexity of the mental health secure hospital. NHS England is reassured regarding the areas of concern identified within the report as these are consistent with our local knowledge and intelligence. Currently NHS England are monitoring and gaining assurance in a number of areas identified within the recommendations of the report.

NHS England continues to work closely with St Andrew's Healthcare to ensure continuous improvements are made in relation to the services being provided. In respect to the recommendations, NHS England is grateful to Healthwatch Northamptonshire for focussing attention on specific indicators including wellbeing, and complaints. NHS England work with St Andrew's to achieve nationally recognised performance indicators and standards giving due priority to patient experience.

The Provider has reported to commissioners as part of the contract process on these indicators and we are aware that St Andrew's does continue to monitor how safe patients feel through our assurance processes with St Andrews Healthcare. Following this report by Healthwatch Northamptonshire NHS England will be liaising with St Andrews to discuss the recommendations from the report. "

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