healthwatch Wolverhampton

ENTER AND VIEW VISIT

Penn Hospital: Mental Health Unit

Black Country Partnership NHS
NHS Foundation Trust

ENTER AND VIEW VISIT REPORT

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What is Healthwatch Wolverhampton?

Healthwatch Wolverhampton was established in April 2013 as the new independent consumer champion created to gather and represent the views of our community. Healthwatch plays a role at both national and local level and makes sure that the views of the public and people who use services are taken into account.

What we do?

Healthwatch Wolverhampton took over the role of Wolverhampton Local Involvement Network (LINk) and also represents the views of people who use services, carers and the public to the people who commission plan and provide services. Healthwatch provides a signposting service for people who are unsure where to go for help. Healthwatch can also report concerns about the quality of health care to Healthwatch England, and the Care Quality Commission so as to take action.

Our Mission

Our mission is to be the local independent consumer champion that enables individuals and community groups to influence the planning and provision of all local health and social care services Wolverhampton.

Our FREE Information and Signposting service can help you navigate Wolverhampton's complicated health and social care system to ensure you can find and access the services that are available for you. Call us Freephone 0800 470 1944 or email info@healthwatchwolverhampton.co.uk

Our Values

- We will be visible and accessible
- We will be credible, trusted and independent
- We will be inclusive and embrace diversity reflecting the diverse needs of local people
- We will work collaboratively
- Our work will be evidence based
- And we will be influential and bold

Enter & View

In order to enable Healthwatch Wolverhampton to gather the information it needs about services, there are times when it is appropriate for trained Healthwatch Volunteers to see and hear for themselves how those services are provided. That is why the Government has introduced duties on certain commissioners and providers of health and social care services (with some exceptions) to allow authorised Healthwatch representatives to enter premises that service providers own or control to observe the nature and quality of those services.

Healthwatch Enter and Views are not part of a formal inspection process, neither are they any form of audit. Rather, they are a way for Healthwatch Wolverhampton to gain a better understanding of local health and social care services by seeing them in operation.

Healthwatch Enter and View Authorised Representatives are not required to have any prior in-depth knowledge about a service before they enter and view it. Their role is simply to observe the service, talk to service users and staff if appropriate, and make comments and recommendations based on their subjective observations and impressions in the form of a report.

This Enter and View Report is aimed at outlining what they saw and making any suitable suggestions for improvement to the service concerned. The reports may also make recommendations for commissioners, regulators or for Healthwatch to explore particular issues in more detail. Unless stated otherwise, the visits are not designed to pursue the rectification of issues previously identified by other regulatory agencies. Any serious issues that are identified during a Healthwatch Enter and View visit are referred to the service provider and appropriate regulatory agencies for their rectification.

Legislation allows 'Enter and View' activity to be undertaken with regard to the following organisations or persons:

- NHS Trusts
- NHS Foundation Trusts
- Local Authorities
- a person providing primary medical services (e.g. GPs)
- a person providing primary dental services (i.e. dentists)
- a person providing primary ophthalmic services (i.e. opticians)
- a person providing pharmaceutical services (e.g. community pharmacists)
- a person who owns or controls premises where ophthalmic and pharmaceutical services are provided
- Bodies or institutions which are contracted by Local Authorities or the NHS to provide health or care services (e.g. adult social care homes and day-care centres).

Key Benefits of Enter & View

To encourage, support, recommend and influence service improvement by:

- Capturing and reflecting the views of service users who often go unheard, e.g. care home residents
- Offering service users an independent, trusted party (lay person) with whom they feel comfortable sharing experiences
- Engaging carers and relatives
- Identifying and sharing 'best practice', e.g. activities that work well
- Keeping 'quality of life' matters firmly on the agenda

- Encouraging providers to engage with local Healthwatch as a 'critical friend', outside of formal inspection
- Gathering evidence at the point of service delivery, to add to a wider understanding of how services are delivered to local people
- Supporting the local Healthwatch remit to help ensure that the views and feedback from service users and carers play an integral part in local commissioning
- Spreading-the-word about local Healthwatch.

Name and address of premises visited	Penn Hospital, Penn Road, Wolverhampton, WV4 5HN.
Name of service provider	Black Country Partnership NHS Foundation Trust
Purpose of the premises / service	Mental Health Unit
Lead contact	Mr Wayne Jasmin (Service Manager) Ms Maxine O' Brian (Matron) Ms Michelle Jones (Manager Meadow ward)
Date and time of visits	23 March 2016
Authorised representatives undertaking the visit	Navin Foolchand (Lead)
Healthwatch Support Team	Donald McIntosh

Disclaimer

This report relates only to the specific visit and does not claim to be representative of all service users, only of those who contributed within the restricted time available.

Purpose of the Visit to Penn Hospital Mental Health Unit

Healthwatch Wolverhampton (HWW) has been looking at mental health services as part of its programme of work for the year 2015/16. In May 2015 HWW conducted an unannounced 'enter and view visit' and it was agreed that there would be a follow up visit later in the year. After several attempts to contact the Trust a date was finally agreed for the visit to take place on the 23 March 2016.

Aim and objectives

The main aim of the visit was to get a better understanding of services delivered from the hospital particularly around discharge and support given post discharge. In addition a tour would take place of the ward for Adults over 65.

Method

Due to changes that have taken place at HWW, the team that conducted the first visit were not available and due to the nature of the visit it was decided to undertaken the visit with one authorised representative (who participated in the first visit) and a member of HWW staff team. The Enter and View team met prior to the visit to review the previous visit, and agreed areas to be covered and questions to prompt the discussion.

Upon arrival at Penn Hospital the team reported to the receptionist who informed the officers who would be participating in the visit

This report contains the outcomes from the discussions held and the observations made by the Enter and View team.

Background Information

The Black Country Partnership NHS Foundation Trust is a major provider of mental health, learning disability and community healthcare services for people of all ages in the Black Country.

They provide:

- mental health and specialist health learning disabilities services to people of all ages in Sandwell and Wolverhampton.
- specialist learning disability services in Walsall, Wolverhampton and Dudley
- community healthcare services for children, young people and families in Dudley

There are over 2000 staff working in the Trust. Staff carry out a wide range of roles, working together to provide integrated care and support to all those using services. Frontline staff working in the Trust include:

- mental health nurses
- psychiatrists
- social workers
- healthcare support workers
- health visitors
- school nurses
- allied health professionals (such as psychologists, occupational therapists, and speech and language therapists).

Penn Hospital provides inpatient services, the hospital has 3 wards catering for elderly and younger adults (18 – 65 plus) The Psychiatric Intensive Care Unit has now transferred to Sandwell. There are two wards for younger adults providing 16 and 20 beds respectively one for female and the other male.

The Trust have recently entered into a partnership with Birmingham Community Healthcare NHS Trust, and Dudley and Walsall Mental Health Partnership Trust with a view to transform the way acute mental health services are provided.

Our Findings

Introduction

Upon arrival at the hospital the team were greeted by Wayne Jasmin Service Manager and Maxine O'Brien Matron. We then moved to their offices and entered into a discussion around the services provided at Penn Hospital. The discussion commenced with HWW Team seeking to understand the structure within Penn Hospital, which includes lines of management and responsibilities for clinical and operational functions. Both staff explained their roles and lines of reporting. The team felt it would be useful for an organisational chart to be provided

A set of questions were asked around the following areas

- Discharge planning
- Bed Occupancy
- Urgent Care

Discharge Planning

Mr Jasmin explained that the Discharge Policy is explicit that carers/ family members and significant others are involved in the discharge process. On some occasions this is not possible when a patient request that some relatives' et al are not to be involved in their care process. Other departments of the Trust are involved in the supervision and provide support to patients who have been discharged, for example, the discharge team, Healthy Mind, Well-being team.

Other forms of support are determined by the severity of the patient condition (known as Care CLUSTERS as detailed in Appendix 1). This means that a care cluster 8 and above will require longer term support and treatment. In these cases patients are usually supported by Care Co-ordinators/ Case Manager, who will develop a care plan; this will be a Care Programme Approach (CPA) care plan by the Care Co-ordinator.

GPs are sent a discharge summary for all patients discharged from the Complex Care Service. Once Patients have been discharged some will attend the hospital for "Depot clinic" where their medication is administered. A physical health assessment check can

be carried out by the Complex Care Physical Health Team.

Concerning Care Co-ordinators or Lead Professionals individuals will be assigned one and this is dependent on which of the clusters they have been categorised in, generally these will be clusters 8 – 17 in Adult services and 18 - 21 in Older Adult Services. However, it was stated that when the Care Co-ordinator and cluster regime was introduced there was an expectation the number of patients under Complex Care Services would be in the region of 500, this figure now stands at approximately 1500 with no significant increase in care co-ordinators. On average the caseload should be between 20 and 30. The team was informed that the Home Treatment Team had increased its staffing establishment following the Clinical Commissioning Group (CCG) commissioning a change in the delivery of Urgent Care Services.

Bed Occupancy

On the day of the visit, the Unit had only 2 vacant beds in the female ward for under-65s. However when required, patients can be transferred to Hallam Street (Sandwell) and on occasion, to neighbouring areas like Walsall or Dudley. This has created significant travel implications for relatives and or carers. There is an acknowledgement that having 2 consultants per ward can lead to different ways of working, which can lead to differences in managing beds.

To manage this matter there is a weekly “Bed Management meeting”. This Multi-disciplinary team attempts to look at options for how to best manage the demands on beds including alternative accommodation and support for early discharge of some patients.

It was recognised that the availability of Recovery House assisted in discharging some patients under the proviso that these patients had an address. However, on some occasions patients who were sent to Recovery House were returned to Penn hospital due to the staffing levels not meeting the patients’ needs.

A fluctuating number of patients (around 60% at the day of visiting) at Penn hospital are detained under various Sections of the Mental Health Act 1983 (A) 2007. Some are

discharged under the Community Treatment Orders, but there is a general acceptance that there is a significant challenge in discharging some patients back to the community owing to complex presentations and funding their accommodation needs. This is not helped by the fact that there is no rehabilitation unit for patients to “step down” from acute wards.

Urgent Care Centre

The new Urgent Care Unit at New Cross Hospital has 2 rooms that are dedicated for the assessment of patient who are deemed to have a mental health concern. The Psychiatric Liaison Service (PLS) provides a 24 hour service and is staffed with Registered Nurses and Health Care Support Workers. Some input is provided by a psychiatrist. One of the Registered nurses carries a bleep and is easily contacted by the Urgent Care Centre.

In the event that a patient needs a more comprehensive mental health assessment then, they will be discharged in the care of Penn Hospital. Around 95% of patients will be transported to Penn Hospital by ambulance transport with the remaining 5% travelling to Penn Hospital with relatives. In some cases this can involve some delay. Prior to leaving New Cross Hospital the PLS will liaise with the bed manager to identify a bed at Penn Hospital, where there are capacity issues at Penn Hospital a bed would be sought at Hallam Street Hospital (Sandwell) and on the occasions where Hallam Street have no beds, a bed would be sought in an out of area hospital.

Meadow Ward

General

The Enter and View team visited Meadow ward. This is a 16 bedded unit that caters for male and female patients who are over 65 and have various forms of mental disorders, including Dementia.

On the day of the visit, 10 patients were detained under the Mental Health Act, some were subject to Deprivation of Liberty requirements (DoLs), 5 were informal and 1 bed was vacant. 2 patients were presenting with challenging behaviours and needed to be nursed on a 1 to 1 basis. Another was partially sighted and needed intensive support

to move around the unit.

Meadow ward has benefitted from extensive refurbishment and the environment is impressive. All patients have their own rooms with en-suite facilities. The rooms are of good size and patients have adequate storage space, a TV and safe for the storing personal items.

The unit has a variety of spaces to meet the needs of the patients these are

- Quiet areas
- Activity rooms
- Dining area
- Multi faith room
- Relatives/patients' visitor room
- Garden area

On admission all patients are subject to a full medical examination and particular attention is given to the physical health of patients. They are weighed on a weekly basis, subject to nutritional assessment and among others Body Mass index (BMI) measurements. All patients are seen by their Consultants on weekly basis and a dedicated Nurse is assigned to each consultant to maintain continuity of care.

Staffing

The ward is staffed by 4 consultants and they are supported by junior doctors and Registrars. Other staff includes Occupational Therapists (OT), OT Assistants, Physiotherapist (which are peripatetic), Speech Therapist, (weekly basis) and a Dietician.

With regards to nurses, the morning and afternoon shift is made up of 3 qualified nurses along with 2 Health Care Support Workers. The night shifts have 2 qualified and 2 Health Care Support Workers. There is regular use of Bank and Agency staff to support increased levels of patient observations and the ward is currently carrying 1 qualified nurse vacancy.

The ward has a Registered General Nurse as part of the clinical team, which provides an added level of expertise and support in relation to delivering the physical health agenda and enhancing the patient experience. It was noted that Ward Manager was

interim; however a new ward manager has been successfully appointed at interviews held on 21st March 2016. The HWW team were impressed with her commitment to the patients and to the work of the ward and displayed an empathy with patients. It is hoped that this situation is resolved as early as possible to remove uncertainty in the management of the ward.

Activities

The ward manager provided a tour of the activity rooms. They appeared well equipped and suitable for patient to be engaged. Unfortunately on the day of the visit we did not see any activity taking place.

Food

Patients have a variety of food available to them on a daily basis. Food is predominantly Cook- Chill and is regenerated directly on the ward in the ward kitchen. Patients dietary requirements are catered for and a separate menu to cover dietary needs (celiac, gluten intolerance, lactose free etc.) is also available, as well as food from the International menu. Food that is not available on our generic menus is purchased by the kitchens as required for patients. Fresh sandwiches, snacks, fruit, salad and jacket potatoes are also available daily. Some patients are able to cook some of their own meals in designated cookery groups at various times throughout the week. A selection of drinks are available 24 hours a day.

Engagement with Patients/Relatives

On the day the HWW team was not able to talk to any patients as it was nearing their meal times.

General Observations

It was noted that out of the 15 patients on the ward on the day of the visit there were two patients with Black and Ethnic Minority background one “Asian” and one “African-Caribbean”.

It was also highlighted that there are significant challenges in discharging some patients back into the community or Nursing Homes particularly when they need intensive intervention. The allocation of funding is a major obstacle in achieving this. Multi-Agency

discussions are held at the weekly Bed Management Meeting, (which includes Local authority representatives, Voluntary Sector and CCG commissioners) to identify patients who are delayed transfers of care or have the potential to be.

Conclusion

The overall impression of the HWW team was that the staff we met had considerable experience of working in mental health; they were motivated in caring for patients with dignity and compassion.

There are challenges in terms of bed management on the wards for Adults under 65, which result in Wolverhampton patients being placed out of the borough even though they may still remain within the Trust's catchment area.

More integration could take place with services / support provided once patients have been discharged from Penn Hospital.

The team feel further understanding is required in how the Care Co-ordinators and Case Managers operate especially in respect to case management once patients have been discharged.

With respect to Adults over 65 it was noted that the team have to deal with various complex conditions which can result in long stays, this in turn present challenges for staffing rotas due to nurse ratios where in some cases one to one care is needed.

The recent opening of the new Urgent Care Centre is an important development in supporting assessments into acute mental health services.

Recommendations

In light of the discussions held with the Staff at Penn Hospital, the following recommendations are made

- That an organisational chart for Penn Hospital and Mental health services delivered in Wolverhampton be provided to HWW
- That statistics are provided on the percentage of Wolverhampton placed in provision out of area including those placed within the Trust's catchment area
- That further details are provided in respect to Care Co-ordination and how this is managed in respect to the Care Clusters
- That a future Enter & View Visit is undertaken in respect to the new Urgent Care Centre
- That a timetable is produced for recruiting a substantive appointment for Manager on Meadow Ward

Response to Recommendations Received from Penn Hospital)

None received

SUPPLEMENTARY FEEDBACK FROM THE PROVIDER

In recognition of the work undertaken during an 'enter and view' we provide the opportunity and welcome any additional comments from the Provider post visit.

Supplementary information received in relation to Penn Hospital can be seen below:

At the CQRM held on 5 March 2016, Commissioners were given an update on the Meadow Ward improvement plan and were happy to close the plan following the work that has been achieved in raising the standards on the ward.

The improvement plan has continued to support staff development with a number of staff undertaking acting charge nurse roles to further improve their leadership/ organisation awareness.

A business case has been submitted to address the number of falls within the clinical area; this is looking at floor-beds that enable staff / patients to get on/off the bed from differing heights.

A quote has been submitted for wet pour rubber flooring in the internal court yard to help minimise the injuries caused from falls.

A full 7 day per week activity timetable

Protected Engagement Time has been re-established to ensure that as a minimum one hour per week the nursing team spend dedicated time engaged in therapeutic activity with patients. The Safewards initiative has been implemented

Key Priorities for 2016

- Physical health agenda to be strengthened by the team closely working with physical health Matron and mental health nurse leads.

- Development of a carer support team. The ward has started work on this project to develop a team on the ward to signpost and listen to carers in need during a patients stay on the ward whilst working collaboratively with Alzheimer's Society, Age UK and Wolverhampton Community Carer Support Team

- A research project exploring the use of technology to monitor physical health and releasing time to care led by the ward manager and one of the wards' Consultant psychiatrists.

After which,

- Healthwatch will submit the report to the Provider.
- Healthwatch will submit the report to CQC.
- Healthwatch will submit the report to the Health & Wellbeing Board.
- Healthwatch will publish the report on its website and submit to Healthwatch England in the public interest.

And where applicable a report will also be shared directly with:

- Local Authority
- Other Local Healthwatch
- Quality Surveillance Group (QSG)
- Health Overview and Scrutiny Committee (HOSC)
- Partners in the Third Sector

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Acknowledgements

Healthwatch Wolverhampton would like to Thank:

Black Country Partnership Trust

Wayne Jasmin, Service Manager

Maxine O'Brien, Matron

Michelle Jones Interim Ward Manager

Navin Foolchand our Authorised Representative

Appendix 1

IAPT services; Healthy Minds and Wellbeing

Care Cluster 1: Common Mental Health Problems (Low Severity) - This group of PATIENTS has definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any psychotic symptoms

Care Cluster 2: Common Mental Health Problems (Low Severity with Greater Need) - This group of PATIENTS has definite but minor problems of depressed mood, anxiety or other disorder, but not with any psychotic symptoms. They may have already received care associated with Care Cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms

Care Cluster 3: Non-Psychotic (Moderate Severity) - This group of PATIENTS have moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)

Care Cluster 4: Non-Psychotic (Severe) - This group of PATIENTS is characterised by severe depression and/or anxiety and/or other disorders, and increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

Care Cluster 5: Non-Psychotic Disorders (Very Severe) - This group of PATIENTS will be severely depressed and/or anxious and/or other. They will not present with hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for suicide and they may present safeguarding issues and have severe disruption to everyday living.

Care Cluster 6: Non-Psychotic Disorder of Over-Valued Ideas - This group of PATIENTS suffer from moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorders, Obsessive Compulsive Disorder etc, where extreme beliefs are strongly held, some personality disorders, and enduring depression.

Care Cluster 7: Enduring Non-Psychotic Disorders (High Disability) - This group of PATIENTS suffer from moderate to severe disorders that are very disabling. They will have received treatment for a number of years and although they may have an improvement in positive symptoms, considerable disability remains that is likely to affect role functioning in many ways.

Community MH; services Complex care / *Early intervention

Care Cluster 8: Non-Psychotic Chaotic and Challenging Disorders - This group of PATIENTS will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over-dependant engagement, and are often hostile with services.

***Care Cluster 10: First Episode Psychosis** - This group of PATIENTS will be presenting to the Mental Health service for the first time with mild to severe psychotic phenomena. They may also have depressed mood and/or anxiety and/or other behaviours. Drinking or drug taking may be present but *will not* be the only problem.

Care Cluster 11: Ongoing Recurrent Psychosis (Low Symptoms) - This group of PATIENTS have a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life.

Care Cluster 12: Ongoing or Recurrent Psychosis (High Disability) - This group of PATIENTS have a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation.

Care Cluster 13: Ongoing or Recurrent Psychosis (High Symptoms and Disability) - This group of PATIENTS will have a history of psychotic symptoms which are not controlled. They will present with moderate to severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.

Care Cluster 14: Psychotic Crisis - This group of PATIENTS will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.

Care Cluster 15: Severe Psychotic Depression - This group of PATIENTS will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present. It is likely that this group will present a risk of suicide and have disruption in many areas of their lives.

Care Cluster 16: Dual Diagnosis - This group of PATIENTS have enduring, moderate to severe psychotic of affective symptoms with unstable, chaotic lifestyles and *co-existing* substance misuse. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.

Care Cluster 17: Psychosis and Affective Disorder (Difficult to Engage) - This group of PATIENTS have moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non-concordance, are vulnerable, and engage poorly with services.

Older adult services: organic illness

Care Cluster 18: Cognitive Impairment (Low Need) - People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment, but who are still managing to cope reasonably well. Underlying reversible physical causes have been ruled out.

Care Cluster 19: Cognitive Impairment or Dementia Complicated (Moderate Need) - People who have problems with their memory, and/or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression.

Care Cluster 20: Cognitive Impairment or Dementia (High Need) - People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms, or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.

Care Cluster 21: Cognitive Impairment or Dementia (High Physical or Engagement) - People with cognitive impairment or dementia who are having significant problems in looking after

Care Cluster 9: - Note: This Mental Health Care Cluster should not be used.