Enter and View

Shrewsbury Court Independent Hospital, Redhill

December 2021

1 Summary

1.1 Why we visited

The purpose of the visit was to listen to the views and experiences of patients at Shrewsbury Court. The visit was prompted by discussions with the Joint Strategic Commissioning Convener- Learning Disability and Autism. We also had discussions with Surrey and Borders Partnership and the Care Quality Commission. The visit enabled us, as an independent organization, to get a broader range of experiences from patients and staff, from a lay perspective.

See the Appendix for more details on 'What is Enter and View', and 'What we did'.

1.2 Details of visit

Details of visit:	
Service Address	Shrewsbury Court Independent Hospital
Service Provider	Whitepost Health Care Group
Date and Time	6th December 2021 10am – 12pm
Authorised Representatives	Katharine Newman, Sarah Browne, Louise Daborn, Liz Sawyer.
Contact details	Healthwatch Surrey 01483 572790

1.3 Summary of key findings

- We have raised two safeguarding concerns, one regarding a staff member whose swipe card would not allow her to leave Shrewsbury Annexe, and the second regarding the experience which a female patient shared with us.
- We were concerned that many of the patients were in their rooms/asleep at 10.20 a.m. when we first entered Maple Ward. We only saw five patients who were up and about in communal areas/corridors. No meaningful activities were taking place.
- Regarding knowledge of leaving plans, we heard a mixture of views. Some patients were very clear about the next steps, and others were quite anxious and did not know what was going to happen.

1.4 Acknowledgements

Healthwatch Surrey would like to thank the service provider, service users, and staff for their contribution to the Enter and View programme.

1.5 Disclaimer

This report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

2 What we found

Description of service

Shrewsbury Court is a private mental health hospital, including patients with learning disabilities and autism.

Most of the patients are from out of Surrey, but there are currently two patients who are NHS Surrey and Borders patients. The average length of stay is 11 months (according to the website). On 11/11/21 CQC published a report which rated the facility as Inadequate. This rating related to the Learning Disability and Autism service and not the mental health rehabilitation service which retains its Good rating. The hospital had recently changed its model of care, to include inpatients with learning disabilities and autism. As a result of the CQC report, the owner (Whitepost Health Care Group), made the following statement:

We acknowledge the publication on Thursday 11th November 2021 of Shrewsbury Court Independent Hospital's CQC report relating to our Learning Disability & Autism services inspection on 10th & 11th August 2021.

We have been working collaboratively since August with our regulators and stakeholders to improve the safe delivery of care for our patients on the wards that were inspected, however, we have reached the difficult decision to close our hospital on 17th December 2021.

We've found that a combination of ever-increasing pressures within our sector, operational demands, the age of the building, and challenges with recruitment, means we're unable to fulfil CQC requirements or expectations.

The welfare of our patients and our staff is our primary concern and we will continue to work with our stakeholders as part of our managed closure programme in finding placements for our existing patients.

- Website: Shrewsbury Court Independent Hospital | Psychiatric Rehabilitation Services in Redhill (scihosp.co.uk)
- Provided by: Whitepost Health Care Group.
- Registered manager and Hospital Director Johnson Oshodi
- Capacity: number of patients. We were told on 2nd December that there were 27 patients (down from 34), but this number was changing on a daily basis as patients were moved on.
- All patients were deemed to have mental capacity to be able to speak to on the day.

Safety

We were concerned that while we were in Shrewsbury Annexe, a female member of staff tried repeatedly to swipe her card to open the door, which didn't work. As we left, we asked her what happened, and what would happen if there was a problem and she needed help. She said her card had been given to us so that we could move around the hospital. She said she would go into the office and ring from there. We raised this with the hospital director, who disputed that her card had been given to us, and that the card that she had at the time of our visit didn't work.

We were also concerned about the experience which a female patient on Maple Ward shared with us, she said that *"a nurse strangled me, …. staff had thrown cold water over me, they hit me with a belt and keys. They broke another patient's arms in two places. …..That nurse has left now".*

We raised both of these as concerns with the Joint Strategic Commissioning Convener- Learning Disability and Autism.

We were given safety alarms when we arrived at the male ward and were warned that the patients could be dangerous. We were also warned on Mulberry ward (female Learning Disability & Autism ward) that one of the patients could become unpredictable.

We were concerned that in the quiet room on Maple ward, the door was propped open by a café style chair (not a heavy chair). Our staff were concerned that if the chair was moved people could be locked in, as this room has a yale lock.

We were given no safety guidance by the provider; in hindsight we believe they should have given us more warning when we first arrived about which patients could have been potentially dangerous.

Covid measures

We were asked to show evidence of a negative LFT, and our temperatures were taken on arrival. We were not asked to sanitise our hands on arrival or to change our face coverings.

Environment

One of our Authorised representatives observed that it 'felt like a prison'. It felt like a rabbit warren with very narrow corridors.

There was a great variation in the size of the communal areas across the different wards. In some areas e.g. Shrewsbury Annexe, there was very little space, and one patient said *"there's no room to breathe"*.

The corridors appeared to be clean, we saw a cleaner at work. However, we observed that the 'back' stairs which were carpeted, were filthy, with clumps of fluff on them. One of the bedrooms on Mulberry ward which we went into was also dirty, with scribbles on the walls.

We observed a drain smell in the communal area in Maple Ward. We observed a strong smell of bleach on Aspen Ward. The entire building was not well ventilated and felt stale.

Only five patients were up and about in communal areas/ corridors. Others were brought to speak to us from their rooms.

Overall, we didn't feel like this was a place for people with a Learning Disability, it didn't feel like an environment designed for their needs, there was no constructive activity.

Facilities

The facilities in the OT area on Oakleaf were impressive; we saw arts and craft rooms, skills kitchens, a gym, and a tuck shop. However, none of these facilities were being used, and we were told that the tuck shop had been closed. When we asked a staff member whether the gym was used, she said "very rarely". We also heard that the OT wasn't in on the day of our visit; (however the service should not be dependent on the availability of one person). We noticed in Shrewsbury Annexe that two patients had OT activities written up on their activity planner, but this had not taken place on that day. We also saw the laundry room, we were told that there is one washing machine for five wards, and that patients are expected to do their laundry once per week.

3 What we heard

Leaving plans

We heard different knowledge levels amongst patients of leaving plans, and we acknowledge that information was changing on a daily basis. Some patients were very clear about the next steps, and others were quite anxious and did not know what was going to happen. One patient with a learning disability who we spoke to showed us his Easy Read document which detailed where he was going next and when. He had a very clear understanding of what was happening next.

One patient on Mulberry ward said *"I am going tomorrow, I am anxious about the move. I have not been informed of new keyworker."*

Another said *"I have had no information about my new placement – I've not even seen a picture, and I am anxious about the move".*

One person knew where they were going, but hadn't met anyone from the new place, which made them feel anxious. Another patient, who had a plan in place said *"It's a struggle getting to know people. I'm a bit worried about getting to know new people and settling in".*

Personal hygiene

We asked patients about access to bathrooms. Most people felt satisfied with this, although some said they were looking forward to not having to share facilities in their next accommodation.

One female patient had immediate hygiene concerns:

"I need toothpaste to clean my teeth and moisturiser for my face, I haven't cleaned my teeth in ages.

I have a shower, but I need to press the button down 20 times before getting hot water. No one helps to maintain personal hygiene -someone used to help but she doesn't anymore".

Medication

Four of the twelve people we spoke to appeared to be quite heavily medicated.

One person said *"the medication is making me sleepy"*. Another patient was fully aware of his medication, and that he was due to start a new treatment, but this would be delayed until he was in his new accommodation.

Food and nutrition

We heard mixed opinions about the food. We heard that some people said it was ok, and others said it was terrible, *"there's no choice"* some people went into town to get snacks, and one person ordered takeaways regularly to eat in the evening. We asked some people specifically if they had free access to water. Generally, they said that if they wanted a drink they could ask the staff and they would give it to them, however some people would prefer to help themselves. *"I would like to be able to get water myself- where I was before there was a water fountain – here I have to ask. I don't like to ask. The staff do always give it to me when I ask"*.

Activities

We heard that patients had the opportunity to plan their day with staff, however recently, staff shortages had meant that plans had to be cancelled, e.g. going on escorted leave. We heard about people doing colouring, karaoke, playing pool and cookery with OT, and that there was a walking group, fitness group, recovery group, coffee group and a psychology group.

However, one patient said "*I haven't bothered with any activities since I heard it's closing down"*.

Most patients told us that they just watch TV either in the communal areas or in their own rooms.

After we'd spoken to one patient, we saw him pacing up and down the corridor as if he had nothing to do.

We did not see any activities happening at the time of our visit.

Unescorted /escorted leave

We heard that some patients were able to leave the facility to go to the local town, either on their own or with staff, although some had not been able to leave due to staff shortages.

Family members

We asked the hospital director to share the details of how family members can share their experiences with us through our website. To date we haven't received any feedback from families.

Staff

We spoke to one member of staff and the patient advocate from Matrix.

The staff member told us *"Transition is difficult – it's not great not knowing where patients are going. I am also anxious about my job. I don't know where I'll be. It's a frustrating process – we don't know much more than the patients".*

Some staff seemed to have a good rapport with patients, others e.g. on Shrewsbury Annexe appeared to have very little interaction at the time of our visit.

In terms of staffing levels, in one room on Mulberry Ward, there were several staff present, however in other areas there were many staff working in offices, and we did not see many staff interacting with patients at the time of our visit.

Several patients said that the staff worked well together as a team.

4 Next steps

This report and the response from the service provider will be shared with commissioners and regulators of the service, and will be published on our website.

5 Service provider response

Service Name:	Shrewsbury Court Independent Hospital
Service Manager:	Johnson Oshodi
Visit date:	6th December 2021

Factual accuracy	
If you have any concerns about the *factual accuracy* of the report, please clearly identify the sections, content and corrections that are required in the space below:	
Service Provider's Response Service Name: Shrewsbury Court Independent Hospital Service Manager: Johnson Oshodi Visit date: 06.12.2021 Factual Accuracy Description of the Service: Report: On 11/11/21 CQC published a report which rated the facility as Inadequate. Fact: The Learning Disability and Autism service was rated inadequate by the CQC and not the mental health rehabilitation service which retains its Good rating. This has been amended on page 4 of this report.	

Organisation response to the report
Please provide your response here. This will be included in the final report. **(THIS RESPONSE WILL BE PUBLISHED IN FULL)**
What we found: **Safety** Report: We were also concerned about the experience which a female patient on Maple Ward shared with us, she said that "a nurse strangled me, …. staff had thrown cold water over me, they hit me with a belt and keys. They broke another patient's arms in two places. …..That nurse has left now". **Response: There was no known incident of this nature in the hospital. This type of incident would have triggered CQC notification, safeguarding, report**

to the police and NMC. It will be helpful to have the date and time that such incident was reported.

Report: We were given no safety guidance by the provider; in hindsight we believe they should have given us more warning when we first arrived about which patients could have been potentially dangerous.

Response: All the inspectors were told that staff will accompany them from one area of the hospital to another and were not expected to be left unsupervised. All the inspectors were taken to Maple ward and handed over to the Ward Manager. Maple ward did not have any patient that presented with risk of violence and aggression at the time of the inspection.

Covid Measures

No response

Environment

Report: One of our Authorised representatives observed that it 'felt like a prison'. It felt like a rabbit warren with very narrow corridors.

Response: There is no use of burglary proof on windows and doors as expected in Prisons. No metal doors in use throughout the hospital. The observation is subjective and we don't think it should be included in this report unless it can be benchmarked with rehabilitation hospitals nationally. The measurements for the width of the corridors are below: • Aspen - 2 meters • Oakleaf - 1.42 meters • Mulberry - 1.42 meters • Corridor linking Maple to Aspen, OT department and Oakleaf ward - 2.25 meters. The building is not purpose built but this is the first time that it has been described like a Prison.

Facilities

Report: We also saw the laundry room, we were told that there is one washing machine for five wards, and that patients are expected to do their laundry once per week.

Response: There were 2 washing machines and 2 driers available for use by patients who are able to do their own laundry. The hospital has a laundry department where laundry was done for patients who were unable to do their own laundry as part of their rehabilitation.

What we heard:

Leaving plans

Response: Most patients were anxious about leaving hospital, but information was shared on regular basis with them by the Multidisciplinary Team and the Clinical Commissioning Groups. They were also supported by the Host CCG.

All the patients have been successfully discharged as at 17.12.2021. The hospital was widely commended by the placing CCGs for supporting their patients during their placements and during discharge and transfer to other services. Please feel free to seek feedback from the placing Commissioners if necessary.

Personal Hygiene

Response: More specific information is required as staff usually support patients who need personal care.

Medication

No response

Food and Nutrition

Response: All the wards apart from Aspen have water fountains in the communal areas. The water fountain on Aspen was usually destroyed by some of the patients hence the reason why staff were regularly providing drinks to the patients.

Activities

Report: We heard that patients had the opportunity to plan their day with staff, however recently, staff shortages had meant that plans had to be cancelled, e.g. going on escorted leave. We heard about people doing colouring, karaoke, playing pool and cookery with OT, and that there was a walking group, fitness group, recovery group, coffee group and a psychology group.

Response: There were no staff shortages in the hospital. Staffing information was provided to the Host CCG and CQC on weekly basis. There was a decline in the uptake of activities as most of the patients were preoccupied with when they will be leaving the hospital.

Unescorted/escorted leave

Response: There were no staff shortages reported in the hospital.

Family members

Report: We asked the hospital director to share the details of how family members can share their experiences with us through our website. To date we haven't received any feedback from families.

Response: Information about the visit was shared with all the patients and family members as requested.

Respondent Name:	Johnson Oshodi 23.12.2021

Respondent Job Title:	Hospital Director

Feedback on the visit
If would like to provide some feedback to Healthwatch Surrey on the visit itself, please provide this in the space below:

RESPONSES MUST BE PROVIDED WITHIN 10 WORKING DAYS OF RECEIPT OF OUR REPORT TO ENSURE IT IS INCLUDED IN THE FINAL PUBLISHED REPORT

6 Appendix

6.1 What is Enter & View?

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch Authorised Representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit, they are reported in accordance with Healthwatch safeguarding policies. If at any time an Authorised Representative observes anything that they feel uncomfortable about they need to inform their lead who will inform the service manager, ending the visit.

In addition, if any member of staff wishes to raise a safeguarding issue about their employer, they will be directed to the CQC where they are protected by legislation if they raise a concern.

6.2 Purpose of Visit

The purpose of the visit was to listen to the views and experiences of people who live and work within the hospital. The visit was prompted by feedback that we had received and after discussions with the Care Quality Commission. The visit enabled us to get a broader range of experiences from patients and staff.

6.3 Strategic drivers

This was a reactive visit, conducted in response to feedback that we had received.

6.4 What we did

The visit to Shrewsbury Court was an announced visit. Four Authorised Representatives of Healthwatch Surrey conducted the visit. The Authorised Representatives were given swipe cards part way through their visit, and therefore had free access to all the wards, however they were mostly escorted from one ward to another by different members of staff. We observed the surroundings to gain an understanding of how the hospital works and how the patients engaged with staff members and the facilities, these findings were recorded on observation sheets We used open-ended experience sheets when talking to the patients.

On the day of the visit, we spoke to 12 patients, 1 members of staff, and the Mental Health Advocate.

We were told that all patients had mental capacity to speak to us. We explained to residents and staff that we were from Healthwatch Surrey and that we were gathering experiences of what it's like to be a patient at Shrewsbury Court. We had a brief conversation with Hospital Director to raise an issue which concerned us. We raised the same issue with the Convener.

We handed out one Healthwatch Surrey "Problem, Suggestion Praise leaflet" to one patient.

We asked the Hospital Director to share our details with patients' families so that they could share their views with us.