healthwatch Enfield

healthwatch Haringey

Healthwatch Enfield and Healthwatch Haringey

Enter & View Report

Downhills Ward, St Ann's Hospital, March/April 2015

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Enter and View Report

Premises name	Downhills Ward, St Ann's Hospital
Provider name	Barnet, Enfield and Haringey Mental Health NHS Trust
Premises address	St Ann's Road, Tottenham, N15 3TH
Dates of visits	Thursday 19 March and Wednesday 29 April 2015

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Enter & View visit to Downhills Ward, St Ann's Hospital,

Purpose of the visit

Authorised Representatives from local Healthwatch have statutory powers to 'Enter and View' health and social care premises to observe and assess the nature and quality of services and obtain the views of the people using those services.

Healthwatch Enfield and Healthwatch Haringey undertook this visit jointly, as residents from both boroughs may be treated at St Ann's Hospital. This was an announced Enter and View visit as part of a planned strategy to look at several acute mental health wards provided by the Barnet Enfield and Haringey Mental Health Trust, to obtain a good idea of the quality of care provided. Healthwatch Enfield took the lead on this visit.

We were aware that the CQC had found serious problems when they visited the mental health wards at St Ann's Hospital on two occasions in 2013 and had required enforcement action after their visit in November of that year; we had heard concerns from local people about the environment and standard of care provided at St Ann's; we had also received reports that some female patients have experienced harassment while staying in wards on other sites within the BEH Trust. We therefore decided to visit an acute adult female mental health ward at St Ann's Hospital to see for ourselves whether female residents of Enfield and Haringey are receiving good care from this service.

Executive Summary

The overall impression we gained from our visits to Downhills Ward was that the manager and staff work hard to provide skilled support to the patients in their care, but that their ability to provide an excellent service is limited, largely by circumstances beyond their immediate control.

The ward operates in a very challenging physical environment in old premises which urgently need to be replaced. There appears to be severe pressure on beds, which is apparently exacerbated by the shortage of suitable accommodation locally for patients to move into when they are ready to be discharged, such as recovery houses. In addition, we know both from this visit and from the Trust chief executive that, as the mix of patients has changed over time, there is now a much higher proportion of severely ill patients on the wards than five years ago.

We found that patient experience is compromised by the poor environment, with some patients having to share four-bedded dormitories, and with limited access to secure outdoor space. We also gained the impression that staff are over-stretched, and do not have enough time to deliver person-centred care on a consistent basis to all the patients. Some patients told us that they did not always feel listened to, and we heard several examples where patients told us they had not felt safe. One of the patients, however, told us, "St Ann's Hospital has saved my life."

We have made a number of recommendations for the management of Downhills Ward, and we have also made four recommendations for consideration by Barnet Enfield and Haringey Mental Health Trust (BEH MHT) and Enfield Clinical Commissioning Group (CCG), the lead commissioners.

A draft of this report was sent to the manager of Downhills Ward to be checked for factual accuracy and for an opportunity to respond to the recommendations prior to publishing. He responded to each recommendation individually, and stated "We are in the process of putting together a formal action plan." We have included his response to each recommendation below, and are pleased to learn that many of our recommendations have been accepted by the management, and are being acted upon. We appreciate that it may not be possible to make all the suggested changes to the environment immediately, but there are two cases (recommendations 6 and 11) where we believe action is needed now, and therefore we add a further comment.

Recommendations

Recommendations for the management of Downhills Ward, with response

1. ***Cleaning staff should be reminded to keep cleaning products out of reach of patients. (p.12)***

Response from Downhills management: The Support and Hotel services manager had directed the domestic staff to ensure that cleaning materials are not left unsupervised during their cleaning schedules. This also is been monitored by the domestic supervisor and ward staff for compliance.

2. ***Staff should respond promptly to any signs that a patient is trying to harm herself, including reports from other patients who have witnessed such incidents. (p.13)***

Response from Downhills management: I understand that you were informed by two separate service users in relation to the responsiveness of staff to reports that a patient tried to self- harm or observed by another patient to be attempting to self-harm. The ward management team has discussed this extensively in Clinical Governance meeting and in individual staff supervision. Staff had been asked to respond in a timely manner to patients concerns. They have also completed staff observation competency forms and are aware of the expected standard of care/practice. On every shift, staff are delegated on rotational basis to be based in communal area to enhance observation of patients at all times.

3. ***We recommend that staff undertake a joint review of the systems and practices in place in the ward, including daily routines, staffing arrangements, and opportunities for interaction between staff and***

patients, to see whether or not these arrangements are person-centred. Patients should be encouraged to participate in this review. (p.14)

Response from Downhills management: Every patient on admission is allocated a named nurse and associate nurse. There is a weekly audit to ensure that the care plan reflects the needs and aspirations of the patents. The charge nurse is to monitor all completed care plans and a signed copy given to the patient. It has also been discussed at the clinical governance meeting and for staff to ensure that all care plans are individualised and patient-centred with patient's views written in the first person. The responsible staff is indicated on each care plan.

4. ***Personal safes and lockable drawers for patients should be checked regularly and maintained in good working order, so that patients can keep their clothes and valuables safe. (p.15)***

Response from Downhills management: All staff are aware of how to reset the combination numbers or can override it with a key on patients request. Unfortunately all wardrobes are not lockable due to ligature issues. Patients are reminded that all valuables should be handed in for safekeeping and not to bring excessive clothing on admission. We have responsibility to balance the needs of the patients with the risks that such needs may bring.

5. ***The Activities schedule should be reviewed to plan and provide a full programme of activities seven days a week, including during the evenings. Patients should be invited to suggest activities which they would enjoy. (p.17)***

Response from Downhills management: There is a new activity schedule covering seven days in a week which was designed with the patients input. All shift leads have been instructed that it is their responsibility to ensure that these activities are carried out as scheduled. There is also occupational therapy programme which complements the ward led activities. A designated occupational therapist had been assigned to the ward and there is also a support worker who is involved in supporting patients with activities.

6. ***We recommend that immediate steps are taken to make reliable wifi available throughout St Ann's Hospital. (p.17)***

Response from Downhills management: This has been escalated to senior management to liaise with the IT department for Wi-Fi facilities on the wards at St Ann's hospital. We hope that this will be incorporated into the new build. All patients on the ward can access their personal e-mails accounts and internet in a designated room on the ward under staff supervision.

Further comment from Healthwatch: we believe that this improvement should not have to wait until the redevelopment of the site.

7. ***Staff should ensure that they listen to patients and check with them regularly to find out if they feel safe, secure and comfortable on the ward. Appropriate action should be taken to ensure that harassment and bullying are prevented and tackled. It is not clear whether this can be achieved with existing staffing levels. (p.19)***

Response from Downhills management: This had been discussed at the clinical governance meeting about patients concerns. The Trust has zero tolerance policy for abuse of both staff and patients. Having staff in strategic places on the ward would help in identification and resolution of any issue of bullying, harassment and abuse. Staff to ensure that feedback is taken from patients during the community meetings and regular environmental checks. Both patients and staff have been reminded that bullying and harassment is not acceptable on the ward. The current staffing establishment meets safe staffing levels expected on mental health wards.

8. ***The patients' information pack should be revised and corrected, regularly updated, and reprinted to a reasonable standard. Patients could be invited to suggest ways in which the pack could be improved. (p.21)***

Response from Downhills management: Updated and reprinted patients' information pack is in place on the ward. The ward manager is working with the patients in incorporating their suggestions into the information pack.

9. ***Efforts should be made to make the décor and furnishings in the communal areas more cheerful and homely. Marks and blemishes on walls and notice-boards should be removed as soon as possible to prevent an air of neglect and out of order vending machines should be either repaired or removed. (p.23)***

Response from Downhills management: The vending is owned by the catering services and they have been informed to replace it with another machine in good working condition or remove it. The decorations on Downhills ward communal area had been included as part of the Trust renovation projects. In the interim the ward manager has ordered some pictures to enhance the environment.

10. ***Efforts should be made to reduce or prevent unnecessary noise at all times but particularly at night when patients may be finding it hard to sleep. Ear plugs are provided on some other wards. (p.24)***

Response from Downhills management: Every patient on admission is provided with a wellness and welcome pack which has ear plugs. However the manager had bought additional earplugs to be given to patients on request. All patient s have been informed to asked for ear plugs if required.

11. ***Patients should have access to a functioning emergency call bell at all times. (p.24)***

Response: We have been reassured that this will be incorporated to the proposed new build of St. Ann's Hospital.

Further comment from Healthwatch: we stand by this recommendation and believe it should be implemented immediately without waiting for the redevelopment of the site.

12. ***Toilets, shower rooms and bathrooms should be regularly checked and maintained. Consideration could be given to installing electric hand dryers. (p.25)***

Response from Downhills management: Toilets, shower rooms and bathrooms are part of the environmental checks. Staff have been reminded to report any damages to estate and Facilities for immediate repair. The electric hand dryer is been discuss at the Trust Infection Control Committee.

13. ***Any unpleasant smell should be dealt with as soon as it becomes apparent. (p.26)***

Response from Downhills management: Battery control air fresheners have been fixed at different areas of the ward. Any unpleasant smell is immediate address by the nursing staff.

14. ***Patients should have access to a pleasant outdoor space which is secure enough not to require staff escorts. (p.26)***

Response from Downhills management: This is part of the designed for the proposed new build of St. Ann's Hospital.

15. ***Robust measures should be put in place to ensure that the ward is properly managed in the absence of the manager, so that patient care and efficient administration are not compromised. This may require a review of the adequacy of staffing levels. (p.27)***

Response from Downhills management: The ward have recruited to all the vacant posts and recently appointed a Band 6 acting up position. There is a daily return of safe staffing levels to the nursing directorate. All the Band 6 have designated role in the absence of the manager.

16. ***We recommend that staff shifts are reviewed to assess whether the current shift patterns are capable of providing adequate support for patients. (p.28)***

Response from Downhills management: The assistant clinical director for Haringey is liaising with HR to revert to the three shifts pattern. This is expected to happen within the next three months.

Recommendations for Barnet Enfield and Haringey Mental Health NHS Trust (BEH MHT) and Enfield Clinical Commissioning Group (lead commissioners), with response

1. ***Consideration should be given to extending the opening hours of the hospital café, so that it is open during visiting hours. (p.22)***

Response: The catering services have reported that this is not in the service level agreement with the Trust. However, they are considering installing food vending machines in the key areas within the Mental Health Unit.

2. ***The Trust should make every effort to provide single rooms for all patients at the earliest opportunity. (p.23)***

Response: The proposed plan for the rebuild of St Ann's Hospital has wards that are fit for purpose and in compliant with current registration/policy.

3. ***We recommend that a review be undertaken of the adequacy of the number of acute adult mental health beds available, in conjunction with a review of the availability of alternative intensive support in the community to individuals who are experiencing an acute mental health episode. (p.24)***

Response: The demand and capacity for in-patient beds is constantly under review and as a borough Haringey is looking into ascertain accurate in-patient bed needs that will be commensurate with the demand.

4. ***We recommend that a review be undertaken as to whether current staff allocations for acute mental health wards can adequately ensure that the prevailing mix of patients consistently receive high quality person-centred care. (p.28)***

Response: The staffing level review was done over a year ago and benchmarked with other Trusts and was considered adequate. However, it has been recognised that the compressed hours have not been beneficial as expected to the service users. It has recently been agreed that the shift patterns be reversed back to three shorter shifts per day. This will enhance the staffing level as well as therapeutic milieu.

Good practice recommendation for other local inpatient or residential facilities

We were impressed by the way the manager of Downhills ward had provided training for staff, which had led to significantly reduced numbers of complaints from patients about the attitude of some members of staff, and believe that other inpatient and residential services could benefit from the same approach:

Good practice recommendation

Complaints from patients or residents about "staff attitude" should always be taken seriously. It should be recognised that cultural differences may lead to misunderstandings. Staff may benefit from cultural awareness, communication skills and customer service training. (p.18)

The Enter & View Team

The Authorised Representatives who took part in the visit were Audrey Lucas and Lucy Whitman (team leader) from Healthwatch Enfield, and Mable Kong-Rawlinson and Sally Kirkpatrick from Healthwatch Haringey.

General information

Downhills Ward is one of three acute adult mental health wards on the St Ann's hospital site, and is the treatment ward for female patients. The treatment ward for male patients is Finsbury Ward; Haringey Ward is a mixed assessment ward.

The manager of Downhills Ward is Mr Ben Ejeka. The Acting Team Leader with overall responsibility for the three acute adult wards when we visited in March was Ms Bessie Laryea; the Team Leader from April onwards is Mr Kerby Francis.

There are acute mental health wards in each of the three boroughs served by Barnet Enfield and Haringey Mental Health Trust (BEHMHT), at St Ann's Hospital (Haringey), Chase Farm Hospital (Enfield) and Edgware Hospital (Barnet). We have been informed that although they try to treat patients in their home borough, patients from any of the three boroughs may be admitted to any of the acute wards within the Trust, depending on availability of beds. However if someone has been admitted to a ward far from home and/or family they usually try to transfer them to the ward in their own borough at the first opportunity.

Downhills Ward has 19 beds; there are 11 single rooms and two dormitories containing 4 beds each. There are two seclusion rooms available for the patients of Downhills Ward which are shared with the other acute wards on the site. There is also a '136 suite' ("place of safety") available for any patient who arrives in a very disturbed state (often someone who has been brought in by the police) who is waiting to be assessed and admitted to one of the acute mental health wards at St Ann's site.

Downhills Ward has patients of all ages between 18 and 70, and when we visited on 19 March they appeared to come from a mixture of ethnic and social backgrounds. The Nurse in Charge told us that they don't make any special arrangements for the younger patients, and that the condition of the younger patients is usually stress-related eg pressure at college, or because they are unemployed; or else it may be drug-related. The manager told us that although in theory adult wards are for those aged under 65, in practice some older patients with a long-term history of mental illness are placed in adult wards rather than elderly mental health wards.

The Nurse in Charge told us that the majority of patients have been formally detained under Section 2 of the Mental Health Act (can be detained for up to 28

days) or Section 3 (can be detained for up to 6 months). Only a small number are informal (voluntary) patients. Patients may stay any length of time in the ward. Some stay only a few days. Others may stay for many months. A significant number have been inpatients in this ward before, in some cases multiple times.

When we visited on 19 March, all beds were occupied and we were told that the ward is almost always full.

Methodology

A team of four Enter and View Authorised Representatives (two from Healthwatch Enfield and two from Healthwatch Haringey) visited the ward with the intention of making observations and engaging in conversation with residents, relatives and staff focusing on the following five key areas:

1. Physical and mental health care
2. Personal choice and control
3. Communication and relationships
4. The environment
5. Staffing and management

Unfortunately when the team visited on 19 March, we were disappointed to find that the manager and both deputy managers were all on leave at the same time.

We had sent detailed information about our visit by post addressed to the manager a fortnight before the visit, including letters announcing the visit to be distributed to patients and their relatives; the Acting Team Leader for St Ann's had also been informed of the planned visit by email. However we discovered when we phoned up two days before our visit that postal correspondence addressed to the manager had not been opened in his absence – he was on planned leave for the whole of March – and no one on the ward knew that we were coming. Following our phone call, hurried arrangements were made to let the patients and staff know about the imminent visit.

When we arrived on 19 March, we were greeted by the Nurse in Charge for that day who tried to be as helpful as possible, but it soon became clear that she had not been fully briefed about our visit, had not prepared copies of the documents requested, and was not in a position to answer many of our questions about the management and overall organisation of the ward. She suggested that we should return in April, when the manager would be back from leave. We took up this suggestion and two of us (Lucy Whitman and Audrey Lucas) returned on 29 April, when we had a long meeting with the manager (but did not attempt to speak to any patients, relatives or other staff).

During our first visit, seven patients engaged with us and gave us their feedback. Three other patients who we approached did not wish to engage with us. A further two patients contacted us in writing after our second visit.

Some patients have been admitted to Downhills Ward and spent time there on several occasions. From certain comments made by some patients, it appears that some of them were commenting on previous admissions as well as their current experience.

It was not possible to talk to any relatives during our first visit, as although we were there during "visiting hours" most relatives did not arrive until we were about to leave.

In the report that follows, statements attributed to "the Nurse in Charge" were made during our first visit on 19 March; statements attributed to the manager were made on our second visit on 29 April. With the exception of one Bank staff member and two students on placements, we were not able to talk to other staff on the ward as they could not be freed from their other duties to talk to us during our first visit.

This report has been compiled from the notes made by team members during the two visits, and the conclusions and recommendations agreed amongst the team afterwards. The recommendations also appear at the appropriate point in the report, close to the relevant pieces of evidence.

The report will be sent to interested parties including Barnet Enfield and Haringey Mental Health NHS Trust, the Care Quality Commission, the Clinical Commissioning Groups for Enfield, Haringey and Barnet, and the London Boroughs of Haringey, Enfield and Barnet. The report will be published on the websites of Healthwatch Enfield, Healthwatch Haringey and Healthwatch Barnet.

Acknowledgements

Healthwatch Enfield and Healthwatch Haringey would like to thank the people we met at Downhills Ward, including the manager, staff and patients, who welcomed us and whose contributions have been very valuable.

Disclaimer

This report relates to the service viewed on the dates of the visits only, and is intended to be representative of the views of the patients and staff who met members of the Enter & View team on those dates or sent us comments in writing.

Key area 1: physical and mental health care

Admission, care planning and review

The manager told us that the Crisis Resolution and Home Treatment (CRHT) team act as gatekeepers for the acute wards, so most patients are admitted via this team. Informal and Section 2 patients are normally admitted to Haringey ward for assessment. Within 72 hours there has to be a "formulation meeting" which identifies presenting problems, current mental state, any physical health issues and any likely barriers to discharge. A primary nurse is assigned and a care plan is drawn up, also capturing the patient's views. Family members/carers are usually involved in drawing up the care plan. The person's care coordinator or key worker from the community attends the initial assessment. The patient should see the consultant the same day or the next day but consultants are not available at the weekend, so if the patient is admitted on Friday night or over the weekend they will be seen on the Monday; it must be within the 72 hours. If a female patient is admitted under Section 3 they will be admitted direct to Downhills ward; these patients are usually known to the staff as most of them have previously been inpatients on the ward.

One patient told us that she had been admitted at the weekend and was told she had to wait till Monday to see the consultant. This was then postponed till Tuesday. She seemed quite upset by this delay.

The manager told us that: there is a team meeting every morning with all staff present (doctors, nurses, therapists, OTs, healthcare assistants and admin staff) and each patient is discussed in detail; patients receive a minimum of one hour engagement per week to review their care with their primary nurse, and will usually have some other short slots with this nurse as well; if the named nurse is not on duty they will receive this engagement with another nurse. See also "Person-centred care" on p.13 below.

Treatments available

The Nurse in Charge told us that the consultant sees each patient twice a week. She said that patients may receive drug treatment and/or psychological therapies. Not all patients are given medication. She said that a patient who is presenting psychotic symptoms for the first time in their life will always be observed for a period of time and given some calming medication instead of automatically being prescribed antipsychotic drugs.

Access to psychological and creative therapies

We were told that every ward at St Ann's has a psychologist, and that talking therapies are available to all patients. The manager showed us where they are building a new room for individual therapy sessions. There are group therapy sessions every week. The Nurse in Charge told us that patients may take part in art or music therapy, cooking etc. None of the patients we spoke to mentioned any art or music therapy, but some mentioned the cooking activities.

Access to regular exercise and fresh air

We were told that some exercise activities take place in the lounge. Yoga is available, but we did not see evidence that there is much access to more energetic exercise. The Nurse in Charge told us that in good weather the patients could play badminton in the garden but only if staff were available to supervise them as the garden is not secure. However there is a small paved outdoor area which is secure and patients told us they could pop out there if they wanted some fresh air.

Access to physical healthcare

All patients have a physical check-up when they arrive. We spoke to one of the consultants who said that most minor conditions could be treated by the medical team on site (junior doctors on site who are apparently trainee GPs); patients who wanted to visit their own registered GP might be allowed to go there under escort; if they need a dentist there are dentists on the main hospital site; long term conditions such as diabetes are managed in the usual way.

Access to mental health advocates

We were assured that all patients are made aware of their rights and those who have been formally detained are given access to the Independent Mental Health Advocates (IMHAs) who are provided by Voiceability. The Nurse in Charge told us that if patients want to see an IMHA the nurses will phone on their behalf to make an appointment for the IMHA to come in to see them. Informal patients have access to the Community Mental Health Advocates who are provided by MIND. We saw leaflets for these advocacy services in the leaflet racks in the corridor. We understand that a member of the Patient Experience team at the Trust also visits the ward but that recently these visits have not been so frequent.

Precautions against self-harm and suicide
Care has been taken to remove all ligature points.

We noticed that while one of the bathrooms was being cleaned, a cleaning trolley containing bleach and other cleaning products was left unattended in the corridor. A patient commented on this and said that patients who are suicidal could "easily get access to bleach."

Recommendation 1 for the management of Downhills Ward
Cleaning staff should be reminded to keep cleaning products out of reach of patients.

One person we spoke to claimed that she had tried to strangle herself as the doctor had made her upset and she heard voices telling her to do it. She said that no one came or noticed for a long time. She also said that the next day the doctor told her off by saying she had upset the other patients by doing this, and she didn't receive any sympathy or help to deal with her feelings. Another patient we spoke to told us that she had seen a patient trying to strangle herself with a handbag, and that when she ran for help it took a long time for the staff to react. This appears to corroborate the first patient's account.

Recommendation 2 for the management of Downhills Ward

Staff should respond promptly to any signs that a patient is trying to harm herself, including reports from other patients who have witnessed such incidents.

See also Recommendation 7 on p.19.

Precautions against patients absconding

The manager told us that staff have to be careful to ensure that patients do not abscond, as there are several possible exits which all have to be carefully monitored, especially at times such as meal times when patients access a different part of the building.

Discharge arrangements

The manager told us that the lack of suitable housing locally is the biggest challenge when patients are being discharged. Some patients cannot return to the place where they were formerly living as it is not safe. For this reason housing issues are flagged up during the admission process and an action plan is drawn up well before the patient is ready to be discharged. There is a weekly meeting attended by the local authority housing/social issues commissioner to deal with housing issues.

There is a recovery house in each borough, which is intended for patients who no longer need to be in hospital but still need some additional support. The manager told us that on the whole the recovery houses tend to be used for patients who are ready for discharge but do not have suitable housing to go to.

After discharge, each patient is referred to the Crisis Resolution and Home Treatment team who check up on them for seven days.

Key area 2: personal choice and control

Person-centred care

Care plans and reviews are recorded on a secure online system. On each visit we were able to look at a printout of an anonymised extract from a care plan. In each case, we did not see a full record of personal and medical information, but just saw what had been recorded after one of the weekly review meetings, where the named nurse talks through with the patient how they are getting on, including seeing whether they have met any agreed objectives. The comments recorded from both staff and patient were so brief that these records could not be said to demonstrate a person-centred approach to care. We noted in both cases that in the "staff responsible" column no staff member was named, and the manager told us this is because of the shift system, which means that different staff would be conducting the review at different times. This makes care less personalised. However, the manager said that because every patient is discussed every morning at the team meeting, all staff are aware of how each patient is getting on.

A disadvantage of electronic record-keeping is that a staff-member may only see the "current" pages of the file and may not read the background information about the patient which would tell them more about this person as an individual. The records which we saw did not give any personal information about the patient eg their background, family connections, what precipitated their admission, physical health needs, dietary preferences, cultural requirements etc. We did not see enough of the content of the care plans to judge whether or not they reflected the needs and wishes of the individual patients, and because we did not get the opportunity to talk to most of the staff, we could not tell how well the staff know the patients as individuals.

The comments we heard from patients who felt that their concerns were not always listened to (which are scattered throughout this report), the brevity of the records that we saw, and the manager's comments on the shift system, left us unconvinced that person-centred care is adequately implemented on the ward.

Recommendation 3 for the management of Downhills Ward

We recommend that staff undertake a joint review of the systems and practices in place in the ward, including daily routines, staffing arrangements, and opportunities for interaction between staff and patients, to see whether or not these arrangements are person-centred. Patients should be encouraged to participate in this review.

Safety and security

We asked patients if they felt safe in the ward at night. One person said she could lock her bedroom door. Several of the patients said they don't feel safe at night and it keeps them awake. One patient said she could lock her door but didn't lock it at night because she thought if there was a fire she would be trapped. But she said that one night someone came into her room twice so she had to lock the door. She said that this other patient was disturbed, and took her clothes. She said the next day she found the other person wearing her clothes.

We were told there were lots of complaints about people's things going missing on the ward, and the manager acknowledged that patients sometimes steal or borrow other patients' clothes or personal items.

We saw that all patients have a small safe and lockable drawers with keypads so that they can lock their things up, but several patients told us that they can't lock up their possessions because the staff have lost or forgotten the combinations. One person said that her freedom pass had been taken while she was staying on the ward. The woman who brings in the travelling tuck shop told us that patients often tell her they can't buy things because they say they have had their money stolen.

We raised the issue of the "lost combinations" for the personal safes when we met the manager on our second visit. He said there was no excuse for this, and that he would see to it that the combinations were re-set so that patients could keep their personal possessions secure.

Recommendation 4 for the management of Downhills Ward

Personal safes and lockable drawers for patients should be checked regularly and maintained in good working order, so that patients can keep their clothes and valuables safe.

Quality and choice of food and drink

On our first visit, none of the patients we spoke to said they liked the food, and several patients said there was not enough food. Patients told us that there was not enough choice, and vegetarian and culturally appropriate options were very limited. We were told that there were not enough vegetables and fruit on offer.

When we returned to meet the manager on 29 April, however, he told us that since our first visit, the food contract had been changed and meals are now being supplied by Steamplicity who also supply food to other local hospitals. We did not have the chance to find out from patients whether they are happier with the new arrangements. We hope that management will seek and act on patient feedback on the new food providers.

When reviewing the new contract, management may find it useful to test with patients whether the appointment of Steamplicity as the new meal provider has removed some strongly-held and quite specific concerns that had been raised with us by some patients about the *previous* food provider. For example, one patient had said that there was a salad option but "there is not enough vegetables in the salad," so if you chose it then you did not get a main meal so you would be hungry. One patient had said she felt you could not "eat five of your fruit and vegetables a day." She had said there was not enough food and "there is always a missing item from the menu because they run out." Another patient had said she needed Halal food, and had said that because of this she had to have the vegetarian option. That day she had had cauliflower cheese and potatoes which wasn't what she was used to and was not healthy. Management will want to test that these previous concerns are addressed by the new contract.

We noted that the evening meal is served very early (at 5pm) and asked whether snacks were available if patients got hungry later on. The manager told us that patients are offered an evening snack with a choice of crackers, toast with butter and/or jam, and biscuits, with a hot drink. Patients told us that toast and butter is available, but not jam. We also observed while we were there (late afternoon) that a woman with a mobile snack shop was in the lounge selling chocolate and sweets.

Patients told us that fruit was not normally available between meals, but when we met the manager he assured us that there was always a plentiful supply of fresh fruit, and he pointed out a fruit bowl containing fruit which was in the lounge. However, according to the manager, some patients sometimes hoard fruit which means there is not enough for everyone else.

On our first visit some patients told us they had to ask for a drink of water and that it was served in very small plastic cups. However, on our second visit the manager told us that patients can always help themselves to as much water as they like; he said water is always available and pointed out the water dispenser.

He also showed us that patients were helping themselves to hot water from an insulated jug, to make themselves tea and coffee.

Arrangements for patients who smoke
Patients can go outside to the small enclosed garden when they want to smoke, and we observed some patients doing so. They pointed out that they now have a lighter in the wall outside which is good as it means patients don't need their own lighters any more.

Availability of planned activities and meaningful occupation
The Nurse in Charge told us that there were plenty of activities including "movie night", nails and grooming, physical exercise etc and the patients enjoyed them. We saw the Activities programme but the Nurse in Charge said it was not up to date. According to the programme there is a "community meeting" for all the patients and staff every weekday morning at 9am, followed by a "healthy living" session. After that there is an exercise session on two days and a discussion on the other mornings. After lunch there is "protected engagement time" for staff and patients to converse with each other. The last session of the day (before the evening meal) could be "board games", "makeup" etc. The programme at the weekend is different and includes "bed dressing and clearing" on Saturday mornings and the "cooked breakfast group" on Sunday mornings.

However, the patients we spoke to felt that there should be more activities for them to get involved in and said that not all the planned activities took place. They were not particularly enthusiastic about the activities on offer and told us there was nothing to do at the weekends.

When we asked patients about activities and about how they spent their time, replies included:

- One person said that the activities that are displayed on the wall do not always happen. She said that cooking and yoga did take place this week.
- One person said that there is a yoga group and women's therapy session. She said that she has not attended any activities yet.
- Two said they had been for a walk.
- One person said, "Having a rest."
- One said there was a day when they can help to cook breakfast but it was much too early for her.
- One person said, "I went to the yoga group."
- Another said there were not enough activities.
- One person commented, "I can't do anything on the weekends."
- One person said, "I can keep fit."

We understand that some patients are allowed out (escorted) in the hospital grounds and can go to a gym on the hospital site.

Recommendation 5 for the management of Downhills Ward

The Activities schedule should be reviewed to plan and provide a full programme of activities seven days a week, including during the evenings. Patients should be invited to suggest activities which they would enjoy.

The ward does not have wifi, although there had apparently been limited availability in the past. Several patients said they could do more if they had access to the internet and that they really miss it. The Nurse in Charge said most patients could access the internet on their phones, but this is only possible if they have sufficient credit.

A patient who is a student said that if there was internet access she could use her iPad properly and do some college work and stay in touch with friends while she was there. Having the internet would help her feel happier.

We mentioned to the manager that both North Middlesex and Whittington Hospitals now have wifi access throughout the whole hospital sites, and he agreed that it would be good if wifi was available throughout St Ann's Hospital.

Recommendation 6 for the management of Downhills Ward

We recommend that immediate steps are taken to make reliable wifi available throughout St Ann's Hospital.

One patient who wrote to us commented that in her opinion patients should be encouraged to take more responsibility for their own recovery. "You have to work towards recovery!" She went on to say: "The need to learn to REFLECT properly cannot be understated… Patients on arrival should be given a pen and notebook and should be encouraged to write their thoughts and feelings. From time to time, a named nurse/keyworker should make time with this individual to discuss this tool."

Key area 3: Communication and relationships

Relationships between staff and patients

One patient said, "St Ann's Hospital has saved my life." However, another patient said, "It is very bad here."

We asked patients what they thought of the staff. Their comments include the following:

- "The staff are very good."
- "Some staff are patient and some staff are not."
- "The nurses did not give the time of day to a patient who was upset."

One patient complained of the "negative" attitude of one of the doctors and said she felt the hospital "covers up complaints".

One patient was frustrated by poor communication between clinicians on the different wards. She said that while she had been in Haringey Assessment Ward, it had been agreed and signed for that she could go out for walks in the hospital grounds. However, when she was transferred to Downhills Ward, she said she had to wait for a whole week before she was allowed to go out for a walk. She said nothing had been actioned as the clinician had not read her notes.

The manager told us that patients all attend the "patients committee meeting" every day from 9 – 9.30 where they can express their views and make suggestions.

The manager told us that in previous years there had been frequent complaints from patients about the attitude of some of the staff. He had come to the conclusion that there might have been some misunderstandings due to cultural differences between staff and patients, who tended to come from different backgrounds. He had set up some training for all staff on customer care and communication skills, asking staff to consider how their manner of communicating – including tone of voice, body language etc - might come across to someone from a different cultural background. He also instituted a system whereby patients vote for the "Nurse of the week" each week, which had also had a positive impact on relationships between staff and patients. He said that as a result of these two initiatives, communication between staff and patients has improved and complaints against staff have dropped dramatically.

Good practice recommendation for other local inpatient or residential facilities
Complaints from patients or residents about "staff attitude" should always be taken seriously. It should be recognised that cultural differences may lead to misunderstandings. Staff may benefit from cultural awareness, communication skills and customer service training.

The Nurse in Charge told us that many patients express their gratitude to the staff of the ward and they receive many thank you cards. We did not see these cards displayed. However, the manager showed us a large lever-arch file containing complaints and compliments. We did not find out what period of time was covered in this folder. We noticed that there were quite a lot of thank you cards in the folder and asked why they were not displayed. The manager replied that when they displayed them on a notice board, patients tended to pull them down. He has bought some lockable display cabinets but has found patients can still pull things out of them as they are not securely sealed.

Relationships between patients
The nurse in charge told us that on the whole patients get on well with each other and try to help each other. However, this is not always the case and patients may need to be supported or protected from other patients who pick on them.

After our second visit, we received a written account from a patient who had recently spent a couple of days in Downhills Ward. This patient has given permission for us to quote her in full:

I've had a horrendous stay in St Ann's. I was admitted voluntarily by the home treatment team. Initially I was meant to go to a recovery house, but they had no beds.

I was intimidated by another patient who entered my room and demanded money and my toiletries. (The lock on my door was not working.) I complained to staff and was ignored. I requested medication for my panic and anxiety – again ignored.

The ward was extremely noisy – staff shouting to each other from one end of ward to the other. They stayed in the office constantly.

I called my family to help to discharge me as I felt unsafe from the patient and felt no duty of care was being shown by the staff. A duty doctor saw me and sectioned me 5.2. I was horrified as I was not a danger to myself or others.

The next morning the same patient came back on ward. She pushed me in the queue for lunch. I packed and demanded to leave. Saw consultant who agreed I should not be sectioned and discharged me.

We are not in a position to comment on clinical decisions. However this patient's account of her experience concerned us because the picture that emerges is of a ward where some patients do not feel safe and do not feel that staff take good care of them. (This account also shows up the adverse effects on people living with mental health conditions of the shortage of beds in the local recovery house.)

We are not suggesting that this patient's experience is typical but, combined with the alleged "strangling" incident noted above on p.12, it does seem to confirm our general impression that staff are overstretched, and do not have enough time to give patients the individual attention they need. (This applies both to patients who feel intimidated, and to those who are behaving in an intimidating way.)

During our visits, we heard a number of examples of patients behaving in a way that is detrimental to the comfort, morale and overall experience of other patients; patients deliberately blocking the toilets by putting paper towels down them, pulling down or destroying pictures on the walls or other homely touches, pulling the thank you cards out of the display cabinets. It may be that this sort of behaviour is inevitable in an acute mental health ward, and that these actions are symptomatic of the mental state of some patients. They could also be expressions of frustration from patients who are bored and feel they need more attention. If staff had more time to spend with patients, and patients had more opportunity to spend their time constructively in absorbing activities, it is possible that there might be a reduction in this type of challenging behaviour.

Recommendation 7 for the management of Downhills Ward

Staff should ensure that they listen to patients and check with them regularly to find out if they feel safe, secure and comfortable on the ward. Appropriate action

should be taken to ensure that harassment and bullying are prevented and tackled. It is not clear whether this can be achieved with existing staffing levels.

Response to "challenging behaviour"
We asked what happens if any patients get upset and cause a disturbance. The Nurse in Charge said they try to de-escalate the situation, and separate the patients if necessary. At any time, one nurse within the three acute wards at St Ann's is the designated "bleep holder", and if there is an emergency, that person is bleeped and will immediately attend the incident. We were told that a patient who has become very disturbed or is behaving in an aggressive way will first be offered a drug to calm her down – a "rapid tranquilliser". This could take the form of a tablet or an injection. If they do not respond to this, they may be placed in seclusion.

The Nurse in Charge said they have two seclusion rooms which are used from time to time but they have not secluded anyone in the past month. We were told that: only a doctor, the bleep-holder or a Nurse in Charge can decide that someone should be put in the seclusion room. All staff have been trained in the correct procedures. There is an observation panel in the door, and a patient in seclusion must be observed all the time. She will be reviewed by the nurse every 2 hours to see if she needs to stay in seclusion or may be allowed out. On our second visit the manager showed us the seclusion unit.

We asked whether staff at St Ann's ever call the police to assist when staff cannot control an unruly or aggressive patient. The Nurse in Charge said they do sometimes call the police eg if a patient tries to escape from the 136 suite. The manager told us that the police would only be called if a patient was behaving very violently. He said the mental health team would work closely with the police in this situation, and said they have regular meetings with the police.

Information provided to patients and relatives
There are two racks on the walls of the corridor containing a variety of information leaflets.

We were given a copy of the welcome pack which patients are given on arrival in the ward. The pack we received contains a "Patients Information leaflet", a sheet showing the "Downhills Ward Daily Routine", and a sheet headed "Your rights as an informal patient". (Presumably a different sheet is inserted for patients who have been detained under the Mental Health Act.) It also contained some basic toiletries which we handed back.

The "Patients Information leaflet" is very messy to look at, poorly photocopied and contains quite a few errors. On the cover, Tippex has been used to white out the name of the ward, the ward phone number and the manager's name, and these details have been written in by hand. The opening words inside the leaflet are "Finsbury ward is a 19 bedded male acute admission ward…" and throughout the leaflet, the ward is frequently referred to as "Finsbury ward". It is clear that some pages of the leaflet were originally printed for Finsbury ward and that although the

details on the cover have been changed, the text inside has not been corrected. There are other errors – for example, the Care Quality Commission is described as "an independent organisation set up by the Government to help people who are detained under the Mental Health Act", which is misleading, and also gives an out of date phone number for the CQC. The leaflet also refers to "your patient advice and liaison person" ie PALS, although this function has now been taken over by the Patient Experience Team in the Trust. There are discrepancies between the timings for meals etc which are shown in the patient Information leaflet and the "Daily routine" leaflet.

These information leaflets have not been produced or updated with care and attention to detail, and are not of a standard which patients deserve. Other information provided for patients was also out of date. We were told that the laminated Activities programme which we were shown was out of date. Again, under the catering system in operation at the time of our first visit, the meals menu was on a four-week cycle, but the wall chart showing the menus stopped at 9 February 2015 (our visit was on 19 March); the menus for lunch and dinner which were displayed were for "Tuesday" although we visited on a Thursday.

Combined with the run-down appearance of the hospital site, the poor quality leaflets and out of date information give patients a strong sense of neglect and lack of care which must be very demoralising and could affect recovery.

Recommendation 8 for the management of Downhills Ward

The patients' information pack should be revised and corrected, regularly updated, and reprinted to a reasonable standard. Patients could be invited to suggest ways in which the pack could be improved.

Protected engagement time

All patients are entitled to have "protected engagement time" (the opportunity for a patient to spend some uninterrupted time for conversation with their named nurse). Protected engagement time appears on the activity programme every afternoon. The manager told us that it does not always take place at the same time every day as this depends on the other duties staff have to carry out in the course of the day.

Key area 4: the environment

The whole of the St Ann's Hospital site is very run down and the buildings and grounds have become neglected during long-running planning consultations and disputes which have gone on for many years. Some buildings on the site are used for mental health wards and the BEH Mental Health Trust headquarters, while other buildings are used for community health services such as physiotherapy and podiatry.

A large number of people work on the site and many more use the inpatient and outpatient facilities. However, the buildings are very old and accommodation and facilities do not meet modern standards. We appreciate the fact that the Trust wishes to redevelop the whole site and that its rebuilding and improvement

programme has been repeatedly delayed, and we understand that the Trust would not want to spend money on temporary improvements when a full refurbishment is due.

However, we feel that some immediate improvements could be made without incurring very high costs. For example, when we arrived at St Ann's at 2.45pm, we found that the café at the centre of the hospital site was shut, as it shuts at 2pm each day. This adds to the generally gloomy and unwelcoming atmosphere on the site. Any relative visiting a patient in one of the mental health wards, possibly coming straight from work, would not even be able to get a cup of tea or a snack before or after the visit. Staff and patients from all services on the site could also benefit if a lively and welcoming café was available throughout the day and in the early part of the evening.

Recommendation 1 for BEH MHT and Enfield CCG

Consideration should be given to extending the opening hours of the hospital café, so that it is open during visiting hours.

Communal areas

The communal spaces appeared to be well-used by the patients while we were there.

Décor in the communal areas is very plain, with bare walls and no personal touches such as coffee tables, plants or pictures. This means the atmosphere is not very homely. The television was on for the duration of our first visit. No one was watching it, but patient was snoozing on the sofa directly in front of it. We did not see a remote control for the television. There are a number of sofas in the lounge which are quite comfortable but they are all arranged with their backs to the wall, so there are no "cosy nooks" for more intimate conversations.

A member of staff we spoke to said that whenever they tried to put up pictures or add homely touches to the communal areas, patients who were feeling upset would always pull them down or damage them. However, when we returned for our second visit we noticed that some pictures had been put up on the walls of the lounge, which was very welcome.

We met the Nurse in Charge in a very small room which she said was sometimes used for activities. We presume she meant one to one conversations as this room is not much bigger than a cupboard. She said it was also used for patients to talk privately to their visitors. It was a very cheerless room with bare walls and without any pleasant touches. There was a noticeboard covered in blue felt which had white smudges and looked very unappealing.

As we approached Downhills ward, down a long internal corridor, we saw a lobby with three drinks vending machines. Two of these were labelled "Out of order" and the third was empty. This adds to the dispiriting atmosphere within the mental health premises.

Recommendation 9 for the management of Downhills Ward

Efforts should be made to make the décor and furnishings in the communal areas more cheerful and homely. Marks and blemishes on walls and notice-boards should be removed as soon as possible to prevent an air of neglect and out of order vending machines should be either repaired or removed.

We asked if there was anywhere quiet for people to sit and were told that patients tend to go to their bedrooms if they want quiet time. However, this is a problem for those patients in shared bedrooms.

Bedrooms

Sleeping accommodation for patients is poor. Eight of the nineteen patients have to share two four-bedded dormitories, with curtains that can be pulled round each bed. These shared bedrooms compromise patient privacy, security and comfort, and do not provide an appropriate healing environment for people who are experiencing mental or emotional distress or instability. The manager told us that he was not happy with this arrangement and regards it as a risk to patient safety; he records this on the risk register.

Recommendation 2 for BEH MHT and Enfield CCG

The Trust should make every effort to provide single rooms for all patients at the earliest opportunity.

When we visited on 19 March, all beds were occupied and we were told that the ward is almost always full. We learned that there was one patient waiting for a bed, and she was due to be transferred to Edgware Hospital during the evening. This is far from ideal as it is difficult to settle in a new patient who arrives at night.

In fact, there is a history of overcrowding in the acute wards at St Ann's hospital. On two inspection visits in 2013 the CQC found that the shortage of beds meant that patients were sometimes asked to sleep in the seclusion units, although there was no clinical reason for them to be in seclusion. This led to the CQC putting the hospital under enforcement measures because this practice is deemed totally unacceptable. We heard from patients about the traumatic experiences that some of them had experienced when having to stay in completely inadequate rooms, such as the Lordship Room (the upstairs activities room), but these seemed to be earlier experiences. Since the CQC report, the Trust has since taken steps to deal with this issue, and this has been verified by the CQC.

The manager told us that since the Enforcement action was imposed by the CQC after their inspection in November 2013, neither the activities room nor the seclusion rooms had been used as bedrooms and that since then, if necessary, the Trust had paid for any additional patients who required urgent hospitalisation to be admitted to private facilities. It is, of course, welcome that spaces within the Trust are no longer being used inappropriately, but the use of external facilities suggests an excess demand for mental health beds.

The manager also said that Downhills ward consistently operates at between 98% and 102% capacity, which means in practice that all beds are constantly in use. It appears that there is a need for more acute beds than are currently provided. The manager told us that there used to be many more wards at St Ann's but they have been closed over time as part of changing professional practice and the shift towards care in the community.

One patient told us she was better now and was ready to be discharged but they couldn't find her a safe place to go (women's refuge or Recovery house) so she had to stay on the ward "taking up a bed that was needed for a sick person". This emphasises the challenges the staff face in managing the beds when the ward itself is at full capacity and there appears to be a chronic shortage of suitable accommodation in the local community.

Recommendation 3 for BEH MHT and Enfield CCG

We recommend that a review be undertaken of the adequacy of the number of acute adult mental health beds available, in conjunction with a review of the availability of alternative intensive support in the community to individuals who are experiencing an acute mental health episode.

Patient comments on sleeping accommodation

One patient said, "My room is okay."

Another said, "Sometimes it is freezing and they don't have extra blankets." However, the manager contested this, and showed us spare blankets in the linen cupboard.

Some people said it was noisy at night time and they never got much sleep. One said the clothes dryer kept beeping all night even though she had asked four times for it to be switched off. One person said she had got some earplugs in the welcome pack on the Haringey Assessment ward but none were available in Downhills ward. She said earplugs would help a lot.

Recommendation 10 for the management of Downhills Ward

Efforts should be made to reduce or prevent unnecessary noise at all times but particularly at night when patients may be finding it hard to sleep. Ear plugs are provided on some other wards.

Call bell system

We did not see a call bell system on our visit, although it may be available. The patients who were asked if there was one said they didn't think so, they had to shout for help.

Recommendation 11 for the management of Downhills Ward

Patients should have access to a functioning emergency call bell at all times.

Seclusion rooms
On our second visit, we were shown the two seclusion rooms which are shared with the other acute wards on the site.

These rooms are completely bare, containing only a foam mattress. There is a heavy reinforced steel door which is kept locked when the room is occupied and can only be opened from the outside, with observation panels, and CCTV cameras placed strategically to show all parts of the room. The walls are an unappealing shade of brown, and we thought they could have been painted a lighter colour so that they were not so grim. The windows have smoked glass, and in order to avoid ligature points, there are no blinds or curtains. This means the patient cannot see out of the windows, but the manager pointed out that light gets in early in the morning and often wakes up the patient. The toilet is reached through an adjoining door which is locked, and carefully controlled by staff, so the patient has to ask to use it. There is an intercom for communication between the patient and the staff outside.

Toilets, bathrooms and washing facilities

There are no en suite facilities in Downhills Ward, but there is a basin in each bedroom. Almost all the patients complained that the toilets are frequently blocked; apparently some patients keep putting hand towels down the toilets. We were told that earlier in the week, four toilets were blocked and they had to use the toilets in the Finsbury Ward with the male patients. Some said that as the toilets are in the shower rooms and bathrooms this makes it more difficult to be able to find a working toilet. Comments include:

- "The toilets are always blocked and not hygienic and sometimes not checked."
- "There are three showers and only two work and the toilets are blocked regularly. They could do with more showers as one doesn't work."
- "In the bath there is not a plug as they are worried about patients drowning so we have to use tissue to plug up the bath."
-

Recommendation 12 for the management of Downhills Ward

Toilets, shower rooms and bathrooms should be regularly checked and maintained. Consideration could be given to installing electric hand dryers.

Laundry facilities

We were shown the laundry room where patients can wash and dry their clothes. Two of the patients mentioned this facility.

Cleanliness

What we saw of the ward was clean, although there was a slight smell of urine coming from the bathrooms as we entered the ward and in parts of the communal areas. During our visit we saw a cleaner going round to clean.

Recommendation 13 for the management of Downhills Ward

Any unpleasant smell should be dealt with as soon as it becomes apparent.

Access to outdoor space

There are two outdoor spaces, a small enclosed area where patients can go out unsupervised and can smoke if they want to, and a larger area with a lawn where they can play games but cannot go out unsupervised as the fence is not very high and they could climb over. It is a shame that patients do not have more frequent access to this very pleasant outdoor space. We suggest that more effort could be made to make this grassed area secure: for example, making the fence higher and planting thorny shrubs round the periphery, which would deter attempts to climb over. It would also be beneficial to create some flower beds or vegetable patches where patients could do some gardening, with appropriate supervision (similar to the opportunities offered to some mental health patients at the Trust's Chase Farm Hospital site).

Recommendation 14 for the management of Downhills Ward

Patients should have access to a pleasant outdoor space which is secure enough not to require staff escorts.

Key area 5: staffing and management

During our first visit, it was not possible for us to talk to any staff other than the Nurse in Charge, with the exception of one member of bank staff and two students on placement. The Nurse in Charge said that the other members of staff were either on their break or were attending to patients. This was unfortunate as we were not able to hear directly from staff about their experiences and views. It also reinforced our impression that staff are over-stretched and have no time to spare. Our second visit was specifically to meet the manager and we did not ask to speak to other staff; however we did have a brief conversation with one of the consultants.

Management

When we met the manager of the ward we were impressed by his commitment and kindness, and it was clear that he was very knowledgeable and experienced in working in the mental health field. He spoke to us very openly about the challenges of running an acute mental health ward in a deprived part of London, and told us that in his opinion these challenges had increased in recent years for a number of reasons. He said he thought that there is more mental distress these days, perhaps partly because of the economic climate, and that many of the patients in Haringey have drug problems.

We expressed our concern that no managers had been on duty on the day of our first visit, and that the ward staff had not been properly prepared for the visit.

We learned that the two envelopes addressed to the manager, one containing the announcement of our visit, and one containing the letters and leaflets for distribution to patients and relatives, which were posted 2 weeks before our visit, had not been opened until we phoned up two days before the visit. The manager said that ward staff did not open the envelopes because they were addressed to him by name. He has since given instructions for all mail addressed to him to be opened in his absence. Although the Acting Team Leader (for the three acute wards) had also been notified in advance of our visit, it appears that she did not check up to ensure that staff on the ward were prepared for the visit.

We said we were surprised that all managers had been permitted to go on leave at the same time. The manager replied that they normally try to spread staff leave out across the year and that some unfortunate coincidences had led to there being no managers on duty that day: his own leave, for the whole of March, had been booked a year in advance; one deputy manager was on bereavement leave, and the second deputy was on sick leave. Although this explained why none of them had been there on the day of our first visit, it did not explain why adequate cover arrangements had not been appeared to be in place, and we were not convinced that there are adequate arrangements in place to ensure the efficient management of the ward at *all* times, which gave us cause for concern in terms of patient safety and continuity of care, and staff supervision and support.

Recommendation 15 for the management of Downhills Ward

Robust measures should be put in place to ensure that the ward is properly managed in the absence of the manager, so that patient care and efficient administration are not compromised. This may require a review of the adequacy of staffing levels.

Staffing

The manager told us that there are 25 staff members, 13 qualified nurses (including the manager) and 12 healthcare assistants. Staffing allocation during the day is 3 qualified nurses and 2 healthcare assistants, and at night 2 nurses and 2 healthcare assistants. The manager works 9 – 5, Monday to Friday, and is supernumerary. The two deputy managers work 8am to 8pm three days per week, alternating their shifts to cover Saturdays. There is also a 'bleep-holder' shared between the 3 acute wards on the site, and a team leader for the three wards who is supernumerary. Staff work 12 hour shifts, with one hour (unpaid) break, plus a paid half-hour handover. This means they are on duty for 3 or 4 days or nights each week, followed by 3 or 4 days off. No manager is on duty at night, but one of the nurses from the three acute wards is designated the "night coordinator". The Nurse in Charge told us that night and day staff are rotated on a regular basis.

The manager commented that in his opinion the 12 hour shifts are "counter-productive" as staff get very tired; staff often miss clinical governance meetings as they are not on duty on the days when they are held; and this system damages

continuity of care: a staff member may work at the beginning of one week and then towards the end of the following week. This means that although each patient has a named nurse, they do not see them every day.

We note that in the Trust's Oaks ward at Chase Farm Hospital site (an elderly care ward), having experimented with 12 hour shifts, they have recently reverted to 8 hour shifts, as they have found that staff are better able to care for patients under this system. It may well be that other wards, such as Downhills, could learn from this experience.

Recommendation 16 for the management of Downhills Ward

We recommend that staff shifts are reviewed to assess whether the current shift patterns are capable of providing adequate support for patients.

The Nurse in Charge told us that there is a high level of long-term sickness, sometimes because staff have been injured in the course of their duties. They do not use any agency staff in Downhills Ward. Temporary cover is provided by bank staff, and they tend to have regular people who know the ward and the patients very well, which is good for continuity of care.

When we asked if the manager thought that staffing numbers were adequate, he commented that he thought the staff ratios had been decided long ago when the client mix was rather different. He said that in the past there would have been more of a mixture of people with different levels of need. He said that now, after a lot of wards have been closed down, and with an emphasis on providing care in the community, only those who are most seriously ill tend to be admitted, and perhaps staff numbers are not fully adequate for this more needy group of inpatients. He also said there is a very wide age range in the ward – the oldest patient is about 70 while some are in early 20s, and in his opinion it would make sense to group patients in smaller age groups as the issues and life experiences are so different for young people, those in middle age, and those who are a lot older.

Recommendation 4 for BEH MHT and Enfield CCG

We recommend that a review be undertaken as to whether current staff allocations for acute mental health wards can adequately ensure that the prevailing mix of patients consistently receive high quality person-centred care.

We did not see the staff training matrix, but the manager told us he encourages and funds all staff to attend external training courses in addition to all the mandatory courses. We did see the list of mandatory training courses which are not specific to mental health but include things like manual handling, health and safety, equality and diversity.

Supervision arrangements
The manager told us that all staff receive supervision at least once a month.

There appears to be a good system of support for managers. We were told that ward managers of the three acute wards at St Ann's all attend fortnightly meetings with the team leader to share current issues, and there are quarterly "deep dive"

meetings for managers across the Trust where they review such issues as staff training, supervision and sickness management. We would welcome it if these meetings also looked at patient feedback and what could be learned from it, if they do not do so already.

Conclusion

The overall impression we gained from our visits to Downhills Ward was that the manager and staff work hard to provide skilled support to the patients in their care, but that their ability to provide an excellent service is limited, largely by circumstances beyond their immediate control.

The ward operates in a very challenging physical environment in old premises which urgently need to be replaced. There appears to be severe pressure on beds, exacerbated by the shortage of suitable accommodation locally for patients to move into when they are ready to be discharged. We found that patient experience is compromised by the poor environment, with some patients having to share four-bedded dormitories, and with limited access to secure outdoor space. We also gained the strong impression that staff are over-stretched, and do not have enough time to deliver person-centred care on a consistent basis to all the patients.

We hope that some of the recommendations we have made can be implemented quite swiftly and at no great cost. We recognise that other recommendations may be more difficult to implement and may take more time.

What is Healthwatch?

Every local authority in England has a Healthwatch, which is an independent watchdog, set up to collect information and represent the views of the public on health and social care. Our job is to make sure local people's voices are heard by those who design and deliver services. We are part of a national network of Healthwatch organisations.

What does local Healthwatch do?

- Local Healthwatch exists to help secure improvements to services such as GP practices, dentists, opticians, pharmacies, hospitals, care homes and day centres.
- We work on behalf of the local community, children, young people and adults.
- We provide information about the health and social care system.
- We collect the views and experiences of local people about health and care services; what works well and what needs to be improved.
- We have formal powers called 'Enter and View' so we can go and see for ourselves how adult health and social care services are working.
- We have a place on bodies like the Health and Wellbeing Board and we attend the Clinical Commissioning Group. This enables us to influence the way services are planned, commissioned and delivered.
- We pass on information and recommendations to Healthwatch England, to the local Council and the Care Quality Commission.

Further information can be found on our websites:
www.healthwatchenfield.co.uk www.healthwatchharingey.org.uk

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Healthwatch Enfield is registered as a Community Interest Company no 08484607 under the name of Enfield Consumers of Care & Health Organisation CIC.
Healthwatch Haringey is delivered by Public Voice, a Community Interest Company no 9019501.

What is Enter and View?

Each local Healthwatch has the authority to carry out **Enter & View** visits in health and social care premises to observe the nature and quality of services. This is set out in Section 225 of the Local Government and Public Involvement in Health Act 2007.

Enter & View is part of the wider duty of local Healthwatch to find out about people's experiences of local health and social care services, and use our influence to bring about improvements in those services. Local Healthwatch can hold local providers to account by reporting on services and making recommendations.

Further information about Enter and View is available at:
http://www.healthwatchenfield.co.uk/enter-and-view