Who Cares

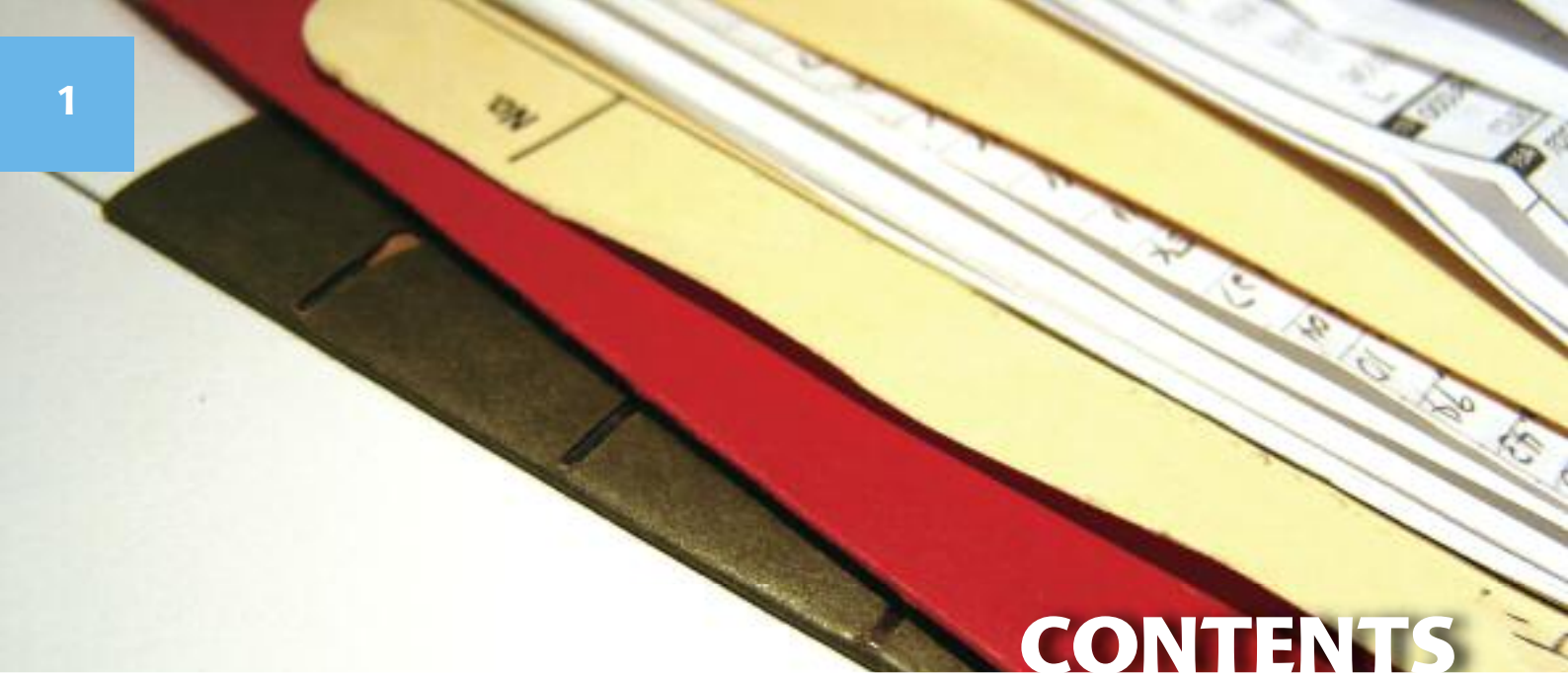
The voice of the people of North Lincolnshire in Health & Social Care

The health & social care Local Involvement Network for North Lincolnshire

Review of recommendations made in 2011 to Mental Health Services in North Lincolnshire.

Voluntary Action North Lincolnshire

Advancing Local Voluntary Action



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FOREWORD

Following on from the publication of *Experiences of Mental Health Services in North Lincolnshire* in April 2011, Rotherham Doncaster and South Humber NHS Trust (RDaSH) adopted a most welcome approach to liaison and communication with *Who Cares* Mental Health Sub-group. Senior staff have met with the group on a six monthly basis and provided updates on where they understand changes have taken place in terms of delivering improved services to service users and carers at a practical level.

Whilst this exchange is welcomed there does seem to be a variance when service users and carers report back on their own recent experiences. There is a sense that the changes have not been fully communicated and when service users are in urgent need of help or support the new system is not clearly understood which causes confusion and added stress at a difficult time to service users and carers.

Anecdotal reports need to be tested otherwise there is the risk that the service providers may seek to be dismissive of contributions as being out of date or from the past rather than either recent or ongoing.

Care also needs to be taken, in terms of ensuring that reporting is accurate and not subjective beyond the relaying of the experience by the service user or carer. It is a facet of human nature to report negative experiences. However, positive feedback has also been encouraged and it is pleasing to hear of good and improving practice. What continues to cause distress is the ever present "communication" issue. People suffering from mental health issues really do need to be carefully communicated with as it is unfair to raise expectations because poor communication will add to distress. We all of us lead busy lives but we do need to factor in quality communication, particularly when dealing with vulnerable people. Who knows when any of us will need that kind of care and if professionals adopted the maxim of "So in everything, do to others what you would have them do to you" (derived from Matt. 7:12), then there is a real chance that there is hope on the horizon.

It is very important that communication is a priority with transparency high on the agenda so that patients, staff, management and supporting agencies get the right information on time, first time. Whilst it is good to hear of the positive achievements being made it is also important that those things that are not being achieved also be shared with the addition of what steps are being taken to rectify these situations.

It is unfortunate that there appears to have been little progress made in terms of provision of Crisis Accommodation. This requirement is not currently available in North Lincolnshire and it is understood that there is work being undertaken by commissioners looking at provision.

This will be the final piece of research work *Who Cares* will be involved in as *Who Cares* will cease to exist as the project comes to an end in March 2013, so I would just like to take the opportunity to thank all who have helped us over the past five years. We hope that HealthWatch North Lincolnshire will take forward recommendations and to continue to be a voice for service users and carers.

Thank you to all the volunteers who have supported the staff of *Who Cares*, thank you too to the service providers and voluntary organisations who continue to do their best in difficult times.

Richard Leach
Mental Health Sub-group Lead.

1. INTRODUCTION

In 2010 the Mental Health Sub-group of *Who Cares* identified a number of areas of concern in respect of service provision at the adult mental health unit at Great Oaks. Subsequent to this the Executive Group approved a research project. Experiences of Mental Health Services in North Lincolnshire was published in April 2011 and the supplement to this was produced in September 2011 to provide RDaSH and NHS North Lincolnshire with the opportunity to respond. Both the aforementioned documents make interesting reading.

The Recommendations contained within the April 2011 *Report Experiences of Mental Health Services in North Lincolnshire* can be summarised as follows:

Areas of concern	Recommendations
Great Oaks	Ensure that regular training updates and opportunities made available to staff. Encourage all staff to interact with patients to break down the 'them and us' culture.
Treatment & Therapies	Activities are offered as diversion from negative thoughts to aid recovery. Statutory service providers to work with VCS to offer meaningful options.
Dual Diagnosis	Ensure that there is accommodation available and separate for mental health and drug/alcohol patients. Re-evaluate and re-instate the provision of crisis accommodation. Consider establishing a 'half-way house' type of hostel through joint working.
Medication	Ensure that changes, alterations to levels &c. are communicated to patients to provide understanding. Many patients are aware of the impacts of alteration to dose on their systems. File notes regularly updated and communicated to other health professionals to ensure consistency of approach.
Psychiatrists	Thorough communication is essential to gain trusts and confidence. Ensure that notes are communicated. Ensure consistency and continuity of assignment.
Crisis	Ensure that crisis help is available 24/7. This provision can be delivered by Crisis Team or LincsLine &c.
Poesis	Ensure that GPs are trained in mental Health and able to recognise the need for early intervention.
Access	Work towards a single point of access for patients, whether the first instance or existing service users or carers. Ensure that the telephone number is widely available through media campaign, GP surgeries, libraries, community centres &c. Ensure that access to services are promoted through rural community newsletters, centres, GP Surgeries &c.
Rural access	Rural isolation can exacerbate impact so care needs to be taken to ensure that if service users return home to isolated properties then they are not just signed off but progress followed up.
Staff	Ensure that health and social care professionals receive regular training opportunities in mental health and wellbeing treatments.
Crisis	Access to crisis services must be available out of office hours, in the first instance through a helpline and in an emergency as accommodation.
GPs	Ensure that they are offered and encouraged to take up training opportunities to update knowledge and skills.
Services	Counselling services need to ensure that service user's expectations are not built up only to be dashed by cancelled sessions and failure to follow up with alternatives.

North Lincolnshire Mental Health Services
Mental Health Services in North Lincolnshire are commissioned by NHS North Lincolnshire and are provided by Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust (RDaSH). RDASH have been managing all mental health services in North Lincolnshire since 2008.
www.northlincs.gov.uk/socialcare/carersupport/

2. AIMS

Following the 'Modernisation' (changes made to operational delivery, designed to deliver more services in community settings) of Mental Health Services introduced by RDaSH in 2010 and implementation of the changes, alongside those recommended in the *Who Cares* Research report, it was felt that the time was right twelve months on to review those changes. This latest piece of work is the result of that decision; it is also timely as issues are beginning to be fed through by service users and carers.

The aim of this research is to measure the distance travelled since the 2011 work. The 2011 report listed thirteen recommendations and this review uses these as a baseline against which to determine any changes. Service users and carers were asked to share experiences of the last twelve months.

3. WHO CARES

Local Involvement Networks (LINks) have been established under the provisions of the Local Government and Public Involvement in Health Act 2007 and have a mandate to provide a body through which local people can influence improvements in the health and adult social care services that are available to them. Each local authority area has its own LINk, they are run by their members and are supported by independent host organisations. In North Lincolnshire the LINk is known as *Who Cares* and has around 275 members, and a proactive Executive Group of 18. *Who Cares* is hosted by Voluntary Action North Lincolnshire.

In order to function effectively LINks have several legal rights including the right to information, a right to receive responses from service providers to the reports they make and a right for authorised members to enter premises where care is being delivered to observe the standard and suitability of that care.

This Mental Health Report is the latest research to be undertaken by the team and is the result of service users and carers concerns raised through the *Who Cares* project.

4. ENTER & VIEW

Enter and view is an essential tool that enables LINks to review the quality of care services and the suitability of the premises used for the delivery of Public funded care.

To conduct enter and view visits LINks members must be authorised and trained. There is no national framework for the authorisation process or the training, the only legal requirement is for enter and view representatives to have satisfactorily undergone a Criminal Records Bureau (CRB) check. From December 2012, this is now known as the Disclosure and Barring Service (DBS).

Who Cares have implemented a rigorous selection process which requires all members who wish to carry out Enter and View duties to complete the relevant training which covers the legislation and the code of conduct behind enter and view, personal conduct and communication skills, evidence gathering and reporting, diversity awareness and safeguarding responsibilities. At the conclusion of this training, the candidate will then attend an interview, with an appropriate interview panel deciding if the candidate has sufficient understanding of the role of the LINk and of the functions of Enter and View to be appointed. If successful, and the candidate obtains a satisfactory CRB certificate, the candidate becomes an authorised Enter and View representative.

Enter and view representatives can enter any premises in connection with health and adult social care service delivery where that care is wholly or partially funded through public money. There are exceptions which exclude a right of entry to people's homes and to make visits where the visit may compromise privacy, dignity and the standard of care. The code of conduct governing enter and view powers can be accessed by the following hyperlink: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_087285

5. METHODOLOGY

As a consequence of limited time available to undertake research it was decided to adopt the following focused approach:

- Visits to Great Oaks to interact with staff and patients
- Undertake an unannounced Enter and View visit to Great Oaks
- Attend support group meetings for service users and carers
- Arrange focus group meetings for service users and carers and with individuals if appropriate

6. LIMITATIONS

The changes implemented by RDaSH through the 'Modernisation' programme as well as the changes subsequent to the Serious Incident Report (investigation into reported allegations, incidents etc.) instigated by RDaSH required time to settle in before being evaluated. In reality even a year on, the changes are still taking time to 'bed in' so it is still not easy to be able to draw comparisons and report on progress. Add in the fact that the *Who Cares* project is drawing to a close and any research or enter and view had to be within a tight framework, it was inevitable that there would not be great numbers reached. Having said that the initial piece of work engaged with 47 individuals, and this follow up has been with 37 service users or carers. This does not include interaction with service provider staff or volunteers.

Because there was a view that it may not be easy to reach many current service users with experience of mental health services over the last twelve months it was decided to utilise the voluntary sector support network. This sector is generally able to monitor changes because of its capability to operate at grass roots and it was felt useful to approach a number of these groups and organisations to see if they had

experienced any increase in demand for their assistance within the last 12 months.

Whilst RDaSH were very accommodating by permitting attendance to observe a number of monthly Patient Experience Meetings and Morning Meetings, it was apparent that there was reluctance on the patient's part to either raise or discuss any issues. This may have been because of privacy issues or discomfort in public discussion, it may have been that they had no issues to raise, or that they were reluctant for fear of staff remembering what they raised. Any of these scenarios is completely understandable and no interpretation is drawn from them.

7. RESULTS

The current research focused on service user experience during the last twelve months. There were some service users who were able to draw comparisons to other periods but they understood that feedback was to be from the period under review. Some service users and carers also drew upon experiences in other areas of the country and sadly it appeared that they found North Lincolnshire service provision lacking.

Sample profile:
In this research, 37 service users and carers have provided feedback and valuable insight to service provision. In terms of gender, a good balance has been achieved from both service users and carers. In respect of RDaSH staff, only one of those interacted with was male. There has been interaction with some 12 operational staff who directly work with patients or service users. Unfortunately, an attempt to engage with and enter into dialogue with a Service Manager from North Lincolnshire Adult Community Mental Health Services failed.

Enter & View visit to Great Oaks
30th November 2012
It was agreed that an Enter & View visit would be conducted at Great Oaks as many of the more serious concerns identified in the 2011 research were around the care being provided at Great Oaks.
2011 Recommendations :

- Ensure that regular training updates and opportunities made available to staff.
- Encourage all staff to interact with patients to break down the 'them and us' culture.

Given that Mullberry House is an acute care facility for vulnerable people it was deemed appropriate and wholly reasonable that RDaSH be alerted to this planned 'unannounced visit'. Senior RDaSH staff and Great Oaks staff were provided with a time period in which this visit would take place.

The visit took place on Thursday 30 November and was undertaken by three Authorised Representatives, Susan Marrison (Lead), Harold Edwards and Roni Wilson.

Overleaf is a summary of the findings observed and noted during the visit. The visit was undertaken over the morning and lunch time period.

Topic	Observations
Ambience of building	External appearance described as pleasant by Authorised Representative. Quiet location with ample parking. Secure entrance. Internally described as 'welcoming', clean with good decor and comfortable furnishings. "More a hotel reception than a mental health care unit". Nurses Station is now a separate room. En suite facilities to each room. Privacy maintained (through-fare glazing now misted).
Facilities	Safety conscious. Snack kitchen where patients are able to prepare their own beverages, equipped areas with kettles, microwave etc. A female only room. Selection of books and games available in the communal area. Activities on offer advertised on a white board in the same area. Facilities were available such as a n ironing/laundry room for patients to undertake basic house keeping duties in attempt to allow a measure of self pride in their appearance and normal daily chores. The Enter & View team were given unlimited access to patient accommodation which had clearly been designed to address various needs in terms of gender segregation, security and safety of patients. The accommodation itself offers en suite facilities and pleasant furnishings and comfort equal to that a budget main stream motel would offer. At the time of the visit patients/staff were actively engaged in joint activities and the TV area was not being used. The main "patient" area of Mulberry House is most welcoming, clean, good décor and comfortable furnishings. The nurses' station is in a separate side room with a good view of the main area as well as the female's only room and also the beverage/snack unit. Staff were also physically present in the patient area.
Staff	Clear ID was visible on staff and they were happy to acknowledge our presence and introduce themselves. The welcoming positive and approachable attitude is not only shown to the Enter and View visitors but also clearly evident in their interaction with patients. 6 nurses and 19 patients were on the Unit and a clinician was also observed having a briefing with some members of the nursing team in the nurse's station. Enter and View representatives were given the opportunity to discuss with the Senior Staff member at length and in depth at two separate opportunities.
Patient Care	The assessment regime for patients care needs seems most comprehensive and efforts are made to ensure they are as least restrictive as possible. A traffic light system is used to assess the level of clinical involvement to determine if a patient needs to be involved with the doctor directly or nurse led clinics are more appropriate. Individual care planning with the patient's engagement and approval was evidenced and access given to the documents showing the complexities of care requirements for patients having multi faceted needs. Patients are given daily 1 - 1 informal sessions with their nominated carers and these were evidenced. Multi-Disciplinary Team meetings are held and the outcomes recorded in the patients records. The assessment regime for patients care needs seems most comprehensive and efforts are made to ensure they are as least restrictive as possible. A traffic light system is used to assess the level of clinical involvement to determine if a patient needs to be involved with the doctor directly or nurse led clinics are more appropriate.
Diet	The varied menu programme was displayed on the unit walls and rotation is on a 7 day basis which would not be a issue for the majority of patients based on their average stay. The choice of meal and quality and availability of both hot and cold beverages were sampled and no fault could be found with this provision. From observations of the patients taking the meals there appeared to be no issues.

Topic	Observations
Activities	The white board showed a large variety of activities available for patients to be involved with. Further a library of books was available of varied topics. Patients have direct access to an enclosed secluded garden, simply but attractively laid out with seating areas and plant/grass areas. Patients were free to engage in all activities and positively encouraged by the staff, who led by example.
Medication	On the subject of multi-medication, on patient admission to the unit action is taken where possible s to reduce drug dependence and all effort is made to strip this down with therapeutic treatment being the care option. This is done in consultation with patients and as necessary a new medication regime is implemented.
Care Plans	Patients records evidenced 6 care plans to address their issues. Individual care planning with the patient's engagement and approval was evidenced and access given to the documents showing the complexities of care requirements for patients having multi faceted needs. The unit was caring for patients with a wide variety of issues, Substance abuse, paranoia, depression, self harm, personality disorders, bi-polar disorder, split personality, adjustment disorders, schizophrenia , brief psychotic episode, learning difficulties.
Patient feedback	A patient that we were able to speak to individually confirmed that the care received and interaction with staff was very good and that he would be receiving medication to maintain his state of recovery. Volunteer participation and a range of varied activities were confirmed by a patient who felt that did help pass the time positively rather than just have the option of watching television which could be easily accessed.
Carer involvement/ interaction	No carers were present so involvement or interactions could not be observed.

Fig. 2: Summary of findings by Authorised Representatives

Following the visit, a debriefing took place between a *Who Cares* staff member and Authorised Representatives and whilst the visit was considered very positive and the staff extremely helpful, one representative felt that the visit was somewhat 'stage managed'. This person felt that there was insufficient opportunity for un-chaperoned interaction with patients. That is not to say that there was neither appreciation nor understanding of underlying constraints that patients were the priority. Only one of the Authorised Representatives actually managed to achieve any interaction with patients.

Attendance at Great Oaks meetings

Who Cares staff visits to Great Oaks were always very positive and staff were helpful and appeared happy that there were visitors. A member of *Who Cares* staff attended three Patient Experience Meetings and two Morning Meetings. Both these meetings are facilitated by RDaSH staff and involved patients being asked if they had any concerns or issues to raise, similarly staff might offer reminders about house-keeping matters or forthcoming events.

It was great to see the artwork on display on the previously bare walls. These excellent photographic images had been taken by patients who had taken part in therapies which had been part of their stay at Great Oaks. To see the project deliver these 'refreshing' images which lifted the otherwise bland decor created a far more positive ambience to the building.

Another aspect which was appreciated and recognised particularly by patients was the fact that the 'Ward Room' where reviews were undertaken in Great Oaks was moved to a quieter area.

Attendance at VOICE service user meeting

Attendance at a "VOICE of service users" meeting (a self help group facilitated by Scunthorpe & District MIND) provided access to five current service users and insight from two support staff who have been employed within the period in question. This group provided useful and helpful information which has been incorporated within this research report.

In addition to the face to face feedback from VOICE members, the following issues were reported through staff at a later date, confirming the face to face reports about Great Oaks:

- There are still reports that Discharge Packs are not being issued to service users when leaving.
- The programme of activities does not happen. However it must be noted that this was not the experience or impression of two of the Enter and View team during their visit
- That there was bed shortages reported and these were considered consequential of patients returning from leave.
- From a positive perspective there was praise for the newly recruited Occupational Therapist and she was described as bringing new and fresh ideas to inpatient experience and this was clearly seen as valuable.

Follow up provided by one of the service users was particularly revealing, illustrating incidence of continued failure in some situations, to fully communicate decisions and offer explanations as to decisions made or actions undertaken by professionals. It re-iterates previous concerns expressed about consistency in terms of professionals assigned to a service user and a conviction that they (service users) are not listened to. It highlights the complexity of challenging decisions made about patients without patient (or their carer) involvement. However, it is recognised that this is the experience of one individual but the observations made also reflected other experiences of interactions with other service users.

RDaSH reported a number of outcomes achieved in partnership with other stakeholders including MIND, such as the establishment of a moving on group, however MIND staff reported that the lack of communication resulted in little success and MIND staff had to reconsider involvement because of poor use of their time for little service user benefit.
The failure in communication with RDaSH, resulted in constant cancellations or reschedules to such an extent that the collaborative project was effectively abandoned.

Rethink Carer's Focus Group
A focus group was facilitated by Rethink Carers Support and seven of twenty two invitees attended the session. This was a good turn out as many have great difficulty accessing support for their family member so are not able easily to attend such events. Support to accommodate carer absence or 'down time from caring' is not easily obtained, this inevitably increases strain and can bring additional stress to difficult circumstances. It is therefore testament to carers commitment that they act in such selfless ways in their endeavours to secure improvements to service provision for family members.

The North Lincolnshire Council website estimates that 10% of the population of North Lincolnshire (c.161,000) are carers (figure derived from the 2001 Census). For a more in depth profile of mental health across North Lincolnshire see www.nepho.org.uk/cmhp/index.php?pdf=E06000013

	Service Users	Carers	Staff	Volunteers
RDaSH	25		12	1
Rethink Carers Group	1	6	1	
Scunthorpe & District MIND	5		3	

Fig. 1: Summary of number of research interactions and their sources.

Themes from 2011 report:
The results reported in this section follow, in the main, the themes established in findings from the 2011 work. Themes are dealt with on pages 7 to 19 of the 2011 work. The recommendations from which are detailed in section 2 above. Where new issues are included in this report this is because they have been raised by a number of service users or carers and deemed to be of sufficient magnitude to be included here.

Within each of the sections there is inclusion of verbatim experience from service users and carers, and other contributions have been reported as faithfully as is practical to ensure anonymity is assured.

Great Oaks - 2011 Recommendations

- Ensure that regular training updates and opportunities made available to staff.
- Encourage all staff to interact with patients to break down the 'them and us' culture.

One carer reported that it had been over three years since they had last seen their daughter following a staff revelation to the patient that their Mother had passed information to them (this was regarded as necessary and helpful to treatment). Professionals refused to allow the carer to make contact because her daughter had refused in early stages of her stay in Great Oaks as a result of learning of her Mother's disclosure. No review had been undertaken by service staff to see if reconciliation might be possible. Professionals were aware that there were issues of concern with the partner. The family had concerns that the daughter would be discharged back into an environment not conducive to recovery.

Other carer's confirmed that there was frequent refusal to share progress or updates to family members of patients in Great Oaks. Whilst there may have been an initial refusal by the patient to share information, there appeared to be no review about any permitted disclosures.

Some service users reported that they had not been given Discharge Packs. However, on a number of visits to Great Oaks these were seen in plain envelopes as if ready for issue.

Treatments & Therapies - 2011 Recommendations:

- Activities are offered as diversion from negative thoughts to aid recovery.
- Statutory service providers to work with VCS to offer meaningful options.

A service user received a letter requiring them to attend a Nurse Led Clinic. The letter indicated that this option was usually one which was for someone who was considered to be making steady progress. In reality, their carer, a family member who knew and understood them well considered the service user to be at crisis point. No one would take responsibility for the decision to send such a letter, but the carer eventually established who had authorised the letter but has, to date, received no explanation or apology.

A number of individuals reported that recovery and psychosis treatment team have seen staff leaving and moving across to therapies team. This has resulted in no consistency of care. However, it is recognised that staff leaving and retention of good professionals is not an easy issue to address by the service providers

Since I am not privy to much of what is said and written about me I would like to know who made the final decision for me to be placed within this team?"

"A Community Treatment Order would have been restrictive to me, not helped my recovery and most probably set me back in numerous areas of my life. The fact that it was even mentioned to me poses some concern for me, since it seems that to some extent that the Mental Health Services in Scunthorpe take a very hard line on patient care. Often selecting the option [which] poses least risk, but may not in the long run be in the best interests of the patient."

On a positive note however, the Enter & View team visit to great Oaks did see evidence of a wide range of activities being on offer with staff actively encouraging and participating with the patients. Patients appeared to be appreciative of the variety of activities on offer. Service users have also praised the newly recruited occupational therapist who is bringing fresh ideas which are much appreciated by those in her care.

A service user reported .... "Another area which needs addressing is psychological therapies." Adding that they had been ...." requesting this type of treatment since my discharge in November 2011. "No psychologist ever materialised and now that I have been transferred to the recovery team I will probably have to join the waiting list. It is my argument that I could have joined the waiting list last November and then I would have most probably (hopefully) had some therapy by now

Medication - 2011 Recommendations:

- Ensure that changes, alterations to levels &c. are communicated to patients to provide understanding. Many patients are aware of the impacts of alteration to dose on their systems. File notes regularly updated and communicated to other health professionals to ensure consistency of approach.

A number of carers reported that consultants fail to discuss medication issues with service users and carers. Some examples of this are detailed below.

Difficult to get to see consultant about the level of medication.

Potential medication clash and conflict (which caused undesirable and unpleasant side effects) and the possibility of this happening was not always communicated.

Promised changes to the medication of a service user did not materialise.

No proper explanation over use of Haliperidol, no choice just stripped to boxer shorts and then left on own in a cold room

There have been medication issues (Clopixol), reported by service users and carers where prescriptions have been unfilled and only been available at the last minute, and there have been occasions when Service Users have been left without medication.

The Anti-Psychotic Injection Clopixol was first administered whilst I was a patient at Great Oaks. It was authorised by [a Doctor] and I did not have a choice about it. At no time was there any negotiation regarding this drug and I did not select it. At the time I challenged this decision as did my advocates but they were not listened to. The drug was continued when I came out of hospital for a further 5 months." The service user believes that they lost at least six months of their life through this drug. "It clearly disagrees with me and doesn't give me any quality of life. In brief it totally de-motivates you, makes you sleep for 18 hours a day, when waking you do not feel re-freshed from your sleep, you feel soul less, lack of any emotion, do not enjoy anything, feel weighed down, heavy and useless, like a zombie, and totally depressed etc."

As well as the main affects of this drug it had numerous side affects, I simply could not live like this and around March / April 2012 I reached breaking point. Despite discussing this matter with the locum doctor this medication regime was continued. I am sure that he had no idea what it was like to live with this drug in your system and he did [not] really want to know. It was during [this] time that I realised that it was always safer to "drug up" your patients and then they would not cause any problems. However their quality of life was not issue or a concern for the professionals. Luckily I managed to state that I would refuse the depot [a body area in which a substance, e.g., a drug, can be

cont...

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accumulated, deposited, or stored and from which it can be released slowly] and he reluctantly agreed to write me a prescription for Abilifiy. So I had to fight for my quality of life and battle with the professionals for my desired outcome. I do not believe that others would go through this battle and they simply take whatever drug or treatment is prescribed to them from the psychiatrist. I believe that this attitude is relatively common amongst psychiatrists and they place far too faith in medications, without listening to their patients.

Crisis Team - 2011 Recommendation:

- Ensure that crisis help is available 24/7. This provision can be delivered by Crisis Team or LincsLine &c.

A carer reported that after failing to get response from the Crisis Team, they approached their GP who similarly was unable to contact or get responses from the Crisis Team whilst another carer had to get the Police to phone the Crisis team.

Other observations, issues and comments received from service users and carers

One family have come to the reluctant conclusion that because of the level of care received they may be better to return the service user to another NHS area in order that they can receive better care. This is a distressing decision because it will mean that there is no nearby family support.

"Staff attitude at St Catherine's [Doncaster] very different from Great Oaks". This comment was made with regard to receiving positive and engaging communication from staff.

Carers and service users report that the voluntary sector support they have accessed or been offered is good and similarly the advocacy *"support has been great".*

Carers and service users reported that post modernisation the Psychosis Team had reduced staff with more staff in therapies team. A reduction in the number of staff available to support acute services was not considered beneficial to services users.

Carer's focus group reported that there was a failure to understand or recognise family knowledge of a patient.

In respect of an issue following discharge and returning to 'life in the community' the following is an example of patient experience

I have been through an experience that has been a total waste of my energy and not good for my recovery and it is still not resolved. In the first instance the [Doctor] completed information about me, when they didn't even know me. Secondary evidence which was out of date and somewhat dubious was used. All the time which has been wasted on this issue could have been used in a pro-active forward looking activity and I could have built a better rapport with [the Doctor] instead of argument and challenge. I do not have any faith or trust with either [the Doctor] or [AOT Project Manager].

One service user who had experience of mental health practice in different parts of the country expressed a view that the people who I have contact with (mainly nurses and social workers), have very little input into the decisions which are made much higher up in the organisation. *"The re-structuring (new service model) as far as I can see poses no benefit to the patient."*

Adult Community Mental Health Team (ACMHT)

A Service Manager told a service user with their carer present that they were "not to become reliant upon the service" no additional explanation as to what other support was available or could be accessed was offered. A Community Psychiatric Nurse told a carer to take a service user to Accident and Emergency (A&E) as a result of being unable to get a response from the ACMHT.

Service users and carers reported poor communication with and between Care Co-ordinators when there had been staff on holiday.

A common view expressed by a number of carers was that Scunthorpe General Hospital (SGH) staff are better with incidents that the ACMHT.
A patient was threatened (with their carer present) with sectioning by a member of staff from ACMHT for anxiety and depression. The carer involved in this incident (who commended the MIND Legal Team as

being brilliant) had it explained to them that service providers are not legally allowed to mention sectioning to a patient. MIND also advised that if they have to attend A&E that the duty Psychiatrist should be requested.

Another carer reported they had received no feedback from a Senior Manager in the Community Mental Health Team about a planned meeting (from September 2012).

A carer reported of the failure to explain the existence of ACMHT by service providers. They believed that it would have been helpful to have been provided with literature about what services and support they offered and the ACMHT contact details.

Youth Intervention Team
A carer reported that it was a long time to get an assessment from this team for their family member. That same carer also explained that were issues around where service users have to be clean of drugs for 28 days otherwise Mental Health (MH) Services refuse to see them. The difficulties experienced trying to get help had left them with a view that as a carer they were *"Lost before you start"*

Assertive Outreach Team (AOT)
One service user reported that he had been placed with the Assertive Outreach Team but had not been offered an explanation as to why. That same service user also promoted the need to tell professionals their story once. An example was cited where

"During our last meeting the psychiatrist could not even remember the name of my [child], even though she had written a report for me regarding him." **The same patient and this was also echoed by other service users and carer comments that** ***" The problem of recruitment and retention of doctors is a worrying problem."*** **The service user explained that** ***"The AOT operate a system where by different members of staff come and visit me. The treatment has never really been dynamic or progressive. In my last appointment with the psychiatrist, [the Doctor] wanted me to praise the AOT for my current good health. The service user considered this unreasonable "since did not feel it would have been deserved. Recovery has been predominately through my family and friends, without help from the professional health services."***
"I had weekly contact with the team, and this provided me a friendly chat, but very little was actually achieved. During the first 5 months the team administered the dose of anti-psychotic (Clopixol), which I didn't like and it didn't suit me. I was simply told to accept it. I did get a referral to the options team, which resulted in a worker coming out to see me. At the time I was severely sedated through the clopixol and could not interact with the worker."

Care Plans
A service user explained that as a patient they were …. *"aware that it is statutory requirement that patients have an up to date care plan".* They were told by staff that in their case that the statutory obligations had been met. However [in their opinion] the *"documents [were] meaningless".* One was prepared in November 2011 (for a hospital discharge) and another in November 2012 (for a hand over to the Recovery Team). *"I did not have any input into either of these documents. Surely it would have been beneficial to me to at least discuss the care plan with Care Co-ordinator and perhaps write some of it?".*
"The fundamental point of the care plan has been lost and (the patient) … has not been involved in its production."
[RDaSH Care Co-ordinator] …. *" knew that I was interested and capable of having significant input into my care plan, however he still produced one without consulting me (November 2012). " When asked …. "why I was not consulted on my care plan I did not receive an answer."* The service user was told that *" all his clients were not like me, and did not have any interest in their care plan."* The service user considers that this is an example of stigmatisation where a mental health worker is stating that all his clients have the same view.

We are all individuals, whether we have a mental illness or not. I appreciate that different people will have different opinions or priorities, however we are not all the same. It did not help matters that MH Worker stated that I was the "exception rather the rule". His comments have annoyed me and not been helpful. However they have reaffirmed some of the attitudes that I have come across during my dealings with RDaSH (over the past 5 years)."

8. RECOMMENDATIONS

Recognising that there are limitations on the time available to undertake a review of service provision since the 2011 reports and the limited number of people engaged in this review.

However it is our view that further work on the identified trends would be useful and recommend that HealthWatch North Lincolnshire (which will be implemented on 1st April 2013) should continue work with service providers, commissioners and a wider group of service users.

There are some recurring themes which merit highlighting, and it is disappointing that communication remains high on the list. Many of the points relayed by service users, carers, professionals and individuals can broadly be incorporated within some of the generic headings below:

Area of concern	Recommendations
Communication	All professionals to ensure that the service user and/or carer fully understands what is happening or going to happen to them in terms of treatment or care.
Communication	Ensure that family members and carers are included in decisions where service users are comfortable and consent to this. Professionals to provide reassurance and comfort to carers and family members about service user progress whilst in Great Oaks. Review of family involvement in care to be undertaken at regular intervals. Professionals to explain the issues they face if patients decide not to see or allow contact by family members. Professionals to explain the issues relating to refusing information about family members because of the Data Protection Act.
Communication	Ensure that promised contact with service users or carers is made in a timely manner, and that commitments to set up meetings, to return calls or provide information is honoured to an agreed timescale.

Area of concern	Recommendations
Information	Ensure that up to date service contact details (including named posts or staff where appropriate) are available for service users, carers and support organisations, including what can be expected from Mental Health service providers, and groups who and where that support is available Develop a leaflet or card giving contact details of who to contact or which managers (including senior staff) are responsible for the different Community Mental Health Service Teams.
Enter & View Visit	Any future unannounced Enter and View visits need to ensure that there is opportunity for Authorised Representatives to mix freely in the 'open areas' of Mullberry House and engage with a more representative number of patients. Adult Community Mental Health Team Service users and their carers need to feel confident that they are being supported and that professionals do not leave people feeling abandoned having raised expectations that responses will be made, calls returned and appointments kept
Adult Community Mental Health Team	Ensure that service users understand why they are on a particular treatment or programme
Care Plans	A Care Plan is effectively an agreement to an approach of a programme of treatment towards recovery. That Care Plan is weakened if it is not a collaborative endeavour by all parties involved. To increase the value and take up rate service users, their families, carers, care workers or nurses all need to contribute to it and deliver it. Patients and carers.... *care plans are produced every six months and [at regular intervals] that the patient should be at the heart of this process.*
Medication	To ensure a clear understanding of medication decisions, Professionals need to explain to patients the benefits and necessity for medication and take patients experiences and views in to account where possible about which medication suits them best.
Medical Records	Patients and their families have been reported as being unable to access medical records. For patients wishing to understand their problems and behaviour patterns and to take control themselves this is unhelpful. Where possible, information requests by patients or their families should be complied with. Where this is not possible, for example through legislation, a clear explanation should be given to the party making the request why services are refusing information under the Data Protection Act 1998, or other relevant legislation.
Further work	The *Who Cares* project will finish at the end of March. A new organisation, HealthWatch North Lincolnshire, will take forward the patient voice. It is the recommendation of *Who Cares* that HealthWatch North Lincolnshire undertake a review of the recommendations made in this research report to establish progress made in terms of service user and carer experience but also that the service providers are able to demonstrate improvements in service provision to service commissioners.

ACKNOWLEDGEMENTS

Gratitude is expressed to RDaSH staff, particularly to their Chief Executive Christine Baine and Senior Managers notably Ian Jerams and Wendy Joseph for encouragement to *Who Cares* to review the changes implemented across the service provision and, similarly their agreement to the suggestion that a 'unannounced' Enter and View visit be conducted. It has to be said that despite the findings of the 2010-11 *Research which resulted in the Experiences of Mental Health Services in North Lincolnshire Report*, published in April 2011 they have taken on board many of the recommendations and there does appear to be a genuine willingness to seek to improve service provision. *Who Cares* staff also place on record appreciation to Julia Goddard, who afforded access to Mullberry House at Great Oaks, to its staff and to some of its inpatients. It is acknowledged that the patient must always come first and people are in Great Oaks as a consequence of need of specialist care. Wendy Fisher is also thanked for her help with the review.

Both Rethink and Scunthorpe and District MIND are particularly thanked for allowing access to their various support groups and for facilitating focus groups. To Claire Chapman, Director at Scunthorpe and District MIND and previously the VOICE project officer, particular thanks for her willingness to assist the research. Thanks too to Barbara Wright of North Lincolnshire Rethink Carers Support for generous access to her network and for facilitation of a focus group which really did reveal the widening gaps. Thank you to those carers especially who told their stories in order that others may benefit from their experiences and that they might not suffer the same problems.

One abiding recollection is from a gentleman who had been long term carer for his wife and who wondered what use it would be for him to accept the invitation to attend a focus group meeting, he "was pleased that I came" and it had given him a break and talking had helped vent some of the frustration and anger at service failure and that had been good. No promises were made beyond assuring those who had shared their stories with *Who Cares* staff that the issues they had raised would be reported back to the service providers in order to try to get accountability for poor communication.

To all the service users and carers who have selflessly shared their experiences in the hope that it will help deliver better services for the service users, carers and community of North Lincolnshire, thank you.

& finally...
I have been privileged to be allowed into people's lives, I have been humbled by their willingness and openness to share their stories. I can without hesitation, say that there has not been anyone who has helped in this research who has not done so in the hope that by sharing their story it will help improve the patient experience for others.

For allowing me this insight I hope that I have helped in a small way to repay that by seeking to secure better service provision.

I am reminded of a service user's explanation on reflection. To that individual (and no doubt others) it was important to continually assess treatments in order to look at future options and learn from the past. To me this is a neat summary but it might also be a recommendation that could be undertaken by service providers and their staff on a frequent basis and this review should then check attitudes and approach to the care they deliver. Factor in a 360 degree appraisal of staff, then there may be a light in the distance.

Thank you to all, you know who you are.
Take care and long may community campaigning continue to be MADE (Make a Difference Effectively).

Helen R Kirk
December 2012.

Statutory Responses
The report was sent to North Lincolnshire Council, NHS NL, the Clinical Commissioning Group and RDaSH.

The responses received from statutory service commissioners and providers are include here verbatim:
Christine Baine, Chief Executive RDaSH
Response to Review of recommendations made in 2011 to Mental Health Services in North Lincolnshire (Research Report)

Thank you for providing the draft report for us to formally comment on and for acknowledging the positive approach to regular liaison and communication by senior Trust staff with the *Who Cares* Mental Health Sub-group.

We value and appreciate the time taken by all involved to provide feedback about our services, and will continue to use it to make improvements on an on-going basis, working with the North Lincolnshire Collaborative Group and the successor organisation to *Who Cares*.

We appreciate the positive feedback and recognition of the good and improving practice contained within the report, which provides evidence of the improvements made since the publication of *Experiences of Mental Health Services in North Lincolnshire in April 2011,* whilst acknowledging that there are still some areas where we can do things better. We are committed to a transparent and collaborative approach to making further improvements.

We appreciate the acknowledgement of some of the tensions and conflicting evidence in the report, and whilst we are not able to provide a response to the individual concerns contained in the report, would wish to reiterate that the Trust intention is to act on feedback about people's experience of our services in a supportive, open and timely way.

I have set out our response below under the main headings of the draft report.

Enter and View Visit to Great Oaks 30 November 2013
We were very pleased to welcome the three Authorised Representatives who undertook the visit on 30 November 2012. Enter and View is an excellent way of gaining real time feedback and we were pleased to note the team's positive findings and observations in relation to the areas reviewed and their experience of the visit.

We note that one member of the team felt there was insufficient opportunity for un-chaperoned interaction with patients. As Mulberry House is an acute mental health in-patient facility and the patients admitted there are by definition vulnerable, un-chaperoned access may not be appropriate for a variety of reasons and indeed patients may decide they do not wish to speak to visitors.

Staff are required to make a judgement about these factors in relation to all visits, in order to safeguard patients and to maintain a safe environment. We welcome future visits and will help facilitate appropriate access to people in our care and the environment.

Attendance at Great Oaks meetings
We are pleased to note that the visits by *Who Cares* staff were all found to be positive and the ward staff helpful and welcoming of visitors. In addition, that the environmental improvements we have made are recognised, particularly through the display of artwork created by patients within therapies, which has created a more positive ambience to the building.

The ward meetings continue to be held daily and are used to discuss and promote the daily activity programme and to encourage patients to raise any concerns relating to the ward in order that these can be resolved as swiftly and easily as possible.

Attendance at Voice service user meeting
We are sorry that some patients report not being issued with the Discharge Pack. The packs are made available both in the patient's own bedroom and should be provided at the pre-discharge review meeting. We have taken immediate action based on this feedback to monitor the issuing of the packs more closely.

We note a comment about the programme of activities not happening, but agree that this is not consistent with the findings of the Enter and View team or our own monitoring. As well as through individual discussions with patients, the daily activity programme is discussed and promoted through the daily ward meetings. In our last patient satisfaction survey carried out in December 2012, 90% of patients on the ward at the time of the survey reported being aware of the activity programme.

Demand for adult acute mental health in-patient beds does fluctuate and at the time of the review, we were experiencing increased demand. A bed management protocol to ensure effective demand

management is used at these times in order to safely manage the demand for beds whilst minimising the impact on patients.

We are sorry there is an impression of poor communication about the establishment of a group with MIND. The group was promoted to patients via ward meetings and by posters displayed on ward information boards. Unfortunately, at the time in question, none of the patients wished to attend such a group. We would be very pleased to work with MIND to identify joint initiatives based on identified need and to help facilitate attendance.

Rethink Carers Focus group
It would not be appropriate to provide a response to the individual concerns in this section of the report, but we would actively encourage contact with the service to discuss any matters which carers feel have not been satisfactorily resolved. This can be via the Modern Matron at Great Oaks, or the Trust's Patient Advice and Liaison Service (PALS) or complaints process.

We are very pleased to have jointly established a Carers Support Group with Rethink, which will be facilitated by Rethink staff and the Occupational Therapist at Great Oaks. The first meeting has been arranged for March 2013 and will be held on the first Wednesday of each month. The group will provide a valuable means of engaging with carers and gaining feedback about our services so that we can identify areas for improvement and work jointly to achieve them.

Following feedback, we have recently improved our Carers Information Pack by adding the following information:

A leaflet introducing the Modern Matron and how to make contact
One leaflet containing information on local support groups with contact numbers (these were previously separate leaflets)

Information on medicines management
The Carers Support Group will provide an opportunity for discussion and feedback on the pack, including identification of any additional information which carers would find helpful.

Outcome of the action plan from the 2011 report and on-going priorities
We would like to thank *Who Cares* and the North Lincolnshire Collaborative Group for working closely with us to support the implementation of the action plan to address the recommendations in the 2011 report.

A meeting was held with *Who Cares* on 6 November 2012 to discuss and provide a final update on the action plan. It was noted that a number of improvements have been made which is borne out by this report. We have taken the opportunity to implement these improvements in the other acute mental health in-patient facilities across the Trust, to support more consistent and positive patient experience of our services.

We are aware there are still areas where we can do things better, and that some of the changes need to be further embedded in the service and sustained. The feedback and recommendations contained within the report will enable us to focus on the key areas of concern identified by patients and carers.

I have provided some information below to clarify the narrative within the report as follows:

With regard to the feedback provided by a carer about the time taken to get an assessment from the Youth Intervention Team, we presume this refers to the service provided by North Lincolnshire Council, but can confirm that the Trust does not operate a policy where people need to be clear of substances for 28 days before adult mental health services will engage with them. Indeed, a significant number of our patients have dual needs and a joint approach is in place locally between adult mental health services and substance misuse services for meeting these needs.

The Trust has some medical training posts it is unable to fill, as a full complement of trainee doctors cannot always be guaranteed by the training scheme organisers. As most of the trainee doctors are based in and around Sheffield, they often prefer placements that do not involve excessive travel. This is a recurrent problem which the Trust is addressing, for example through the development of Advanced Nurse Practitioner posts. We have successfully recruited to vacant senior medical posts, with the new Consultant for the Recovery Team due to start in March 2013.
In conclusion, we appreciate the positive feedback and recognition of the good and improving practice contained within the report, which provides evidence of improvement. The report has provided a focus for us to look at particular areas where patients and carers have identified the need for improvement.

We are committed to testing out anecdotal reports and actively encouraging and acting on patient and carer feedback on their experience of our services. We would suggest that the recommendations contained within the report are used to jointly develop an action plan with measurable objectives which can be monitored by the North Lincolnshire Collaborative Group, in order that progress can be tracked year on year.

Allison Cooke, Chief Officer
on behalf of NHS North Lincolnshire and NHS North Lincolnshire CCG.

Re: Response to review of recommendations made in 2011 to Mental Health Services in North Lincolnshire
Thank you for providing the draft report for us to formally comment on.

We welcome the report as providing us with insight into the experience of patients using the Mental Health Services provided by Rotherham, Doncaster and South Humber Mental Health Trust. NHS North Lincolnshire hands over its commissioning responsibilities for mental health services to NHS North Lincolnshire CCG from 1 April 2013, this report will be used by the CCG to support future commissioning.

I note the report includes positive feedback and recognition of the good and improving practice since the publication of Experiences of Mental Health Services in North Lincolnshire in April 2011, however as identified there are still areas where improvements can be made.

The CCG supports the recommendations set out in the report and will work with RDASH to continue to address them through our contract and partnership working with them.
I would like to place on record NHS North Lincolnshire's thanks to *Who Cares* for supporting us in ensuring the patient voice in our commissioning of health services.

Frances Cunning
Director Public Health, North Lincolnshire

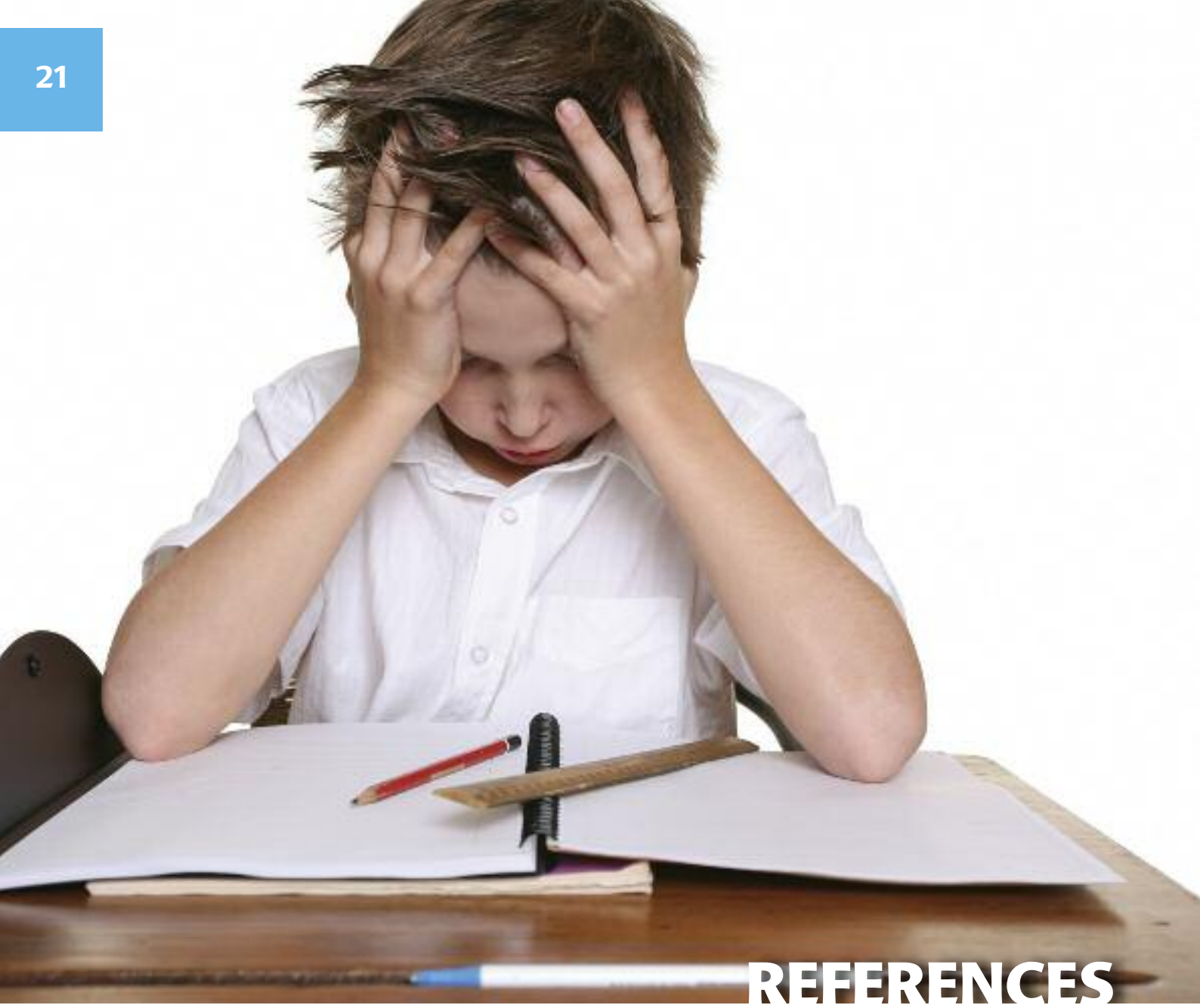
As a Public Health partner, I am aware that local RDASH provision is in accordance with all latest national strategy, providing a recovery focussed service wherever possible e.g. striving for a wide range of access to psychological therapies, providing the award winning Poeisis service, opening the Talking Shop, delivering Mental Health First Aid etc.

I would also add that this report appears to be written from the negative e.g. "no fault could be found" whilst stating the need to be objective. In my experience, great care needs to be given within the consultation of patients experiencing mental illness

as negative opinion/experience is intrinsic to the condition. In addition, small sample numbers are also not representative.

That said, it is always good to encourage 360 degree appraisal and I would always support evaluation of all services across the board.

No other responses were received by the twenty day period allowed under the legislation.



REFERENCES

- Experiences of Mental Health Services in North Lincolnshire. 2011 (LINk VANL) available as a downloadable pdf via http://www.who-cares-online.org.uk/files/view/projects-and-reports/mental-health-service-user-report/110414_FINAL_Mental_Health_booklet3_Layout_1.pdf
- Experiences of Mental Health Services in North Lincolnshire : A Supplement. 2011 (LINk VANL) also available as a downloadable pdf via http://www.who-cares-online.org.uk/files/view/projects-and-reports/mental-health-service-user-report/MH_Report_supplement_Layout_1_(2).pdf

Access to medical information:

- http://www.nhs.uk/chq/pages/1309.aspx?categoryid=68&subcategoryid=160
- http://www.nhs.uk/carersdirect/guide/mental-health/pages/confidentiality.aspx
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_087285
- http://www.northlincs.gov.uk/socialcare/carersupport/
- http://www.nepho.org.uk/cmhp/index.php?pdf=E06000013

APPENDICES

1. Enter & View Pre-visit Questions

APPENDIX 1
Pre-visit Questions (to be completed by Great Oaks Manager ahead of visit).

1	Can you provide details of training undertaken by staff over the last 12 months?	The Trust provides a wide variety of training details of which are contained in the training programme. There is a training file available in the Modern Matron's office which provides the detail as to the training attended by staff and this is available anytime for viewing.
2	Can you provide us with a rota showing the activities that are available and how often they are offered? And do staff participate in these?	As the ward cares for patients during the acute phase of their illness a flexible programme of activities is provided. Ward staff both participate in and facilitate these activities. The rotas for November and December are attached to this document.
3	Do all patients receive a one-on-one daily session with a member of staff? And if so, how are these recorded?	One-to-one sheets are available in the Ward Office and were reviewed by the unannounced visit on Friday 30th November 2012. All Care Plan reviews are done within the Multi-Disciplinary Team meetings which are at the minimum once per week.
4	Do you have a volunteer manager who is tasked with developing recovering service users to become volunteers? If yes, how many volunteers do you currently have assisting at Great Oaks?	The local volunteer manager is Carol Fish and we have a bank of volunteer's according to the needs of the service users at that time. There are 16 volunteers within the Mental Health Service at North Lincolnshire at this present time. With six being currently active within Great Oaks.
5	Can you provide us with information on the current and future position in relation to the provision of crisis accommodation?	The provision of crisis accommodation is not a responsibility of RDaSH, this would be for the local commissioners to commission and appoint a provider. As a provider, we may be interested in tendering for any crisis accommodation that may be commissioned in the future as would other providers such as private organisations and the third sector. We have been working with our commissioners to identify what need there may be for crisis accommodation. In terms of crisis housing, we have been working in partnership with North Lincs Council around the housing needs of people with mental health problems.
6	When undertaking Care Planning, is consideration given to the impact on family members/carers?	Yes, we have developed a good practice guide for staff following a number of complaints in order to ensure that families and carers are involved in care planning discussions where possible and family and carers are offered assessments in their own right. We have also built this into care pathways work in community services.
7	Have the crisis team been accessible 24/7 to users of this service?	The Access Team, which incorporates the functions of crisis and home treatment (the name changed when the service model was introduced last year) is available 24 hours a day 7 days per week. In addition to this there is also an Approved Mental Health Practitioner and medical staff available 24 hours per day 7 days per week.

8	Has the single point of access for adult mental health services been developed and made available to potential users? How and where is this advertised?	The Access Team is our single point of access and the number for this is available on our Trust website. The Access Team is available 24 hours per day 7 days per week. All GP's and primary care facilities have the numbers of the access team and service leaflets are presently in development for all service users who are referred.
9	What services are now available in rural areas, e.g. nurse led clinics and therapeutic groups, and when and where are these offered?	There are a number of services offered out with the Scunthorpe area both in primary care and specialist services. Our POIESIS teams run a variety of groups such as Stress Busters in different localities and these are available when needed. We have recently finished refurbishment of Barnard Court in Brigg and from January will be providing a range of services there. These will include, nurse led clinics, therapeutic groups, individual therapy. We also run nurse led clinics in care homes outside of Scunthorpe such as Barrow Hall. In addition to this service users still have visits in their own homes.
10	Has the provision of counselling services been reviewed and if so, what is the new policy that is currently implemented?	We haven't just reviewed the provision of counselling, but access to psychological therapies as a whole. Each team, including the ward, now has dedicated therapy staff working within the team. Our assistant director of psychological therapies has also developed an action plan that we are working with to improve access to psychological therapies. This will include training staff who are not therapists to work in more psychological ways. Three senior clinical staff are undertaking training in Dialectical Behaviour Therapy and will then train staff working in the Intensive Community Therapy teams to adopt this approach. DBT is an evidence based approach for working with people with personality disorder. There is also a range of therapies available in primary care services – POIESIS. We are also opening a Talking Shop in the town centre early in the New Year which will allow people to self refer and receive some psychological interventions.

APPENDICES

Ward/Unit Profile (To be completed by Ward Manager/Matron before the Enter and View visit

Unit Manager	Linda Schofield, Modern Matron
Unit	Mulberry House, Great Oaks
Location	Scunthorpe, North Lincolnshire
Specialism	Adult Mental Health Inpatient Unit
Number of beds: Bed arrangement Segregation male/female.	19 beds which provides flexible use. All single sex accommodation with facilities to segregate males and females.
Ward/Unit area includes: Day Room Visitors Room	Yes
Patient pathways Including receiving patient information on admission and discharge arrangements	Admission information is available in all bedrooms with current care plans once admitted. Discharge information is contained within the current care plans but further discharge packs are available in MDT room as the need for information varies on each individual person.
Catering facilities 'Open access' on site Times of meals Protected mealtimes	There is a snack kitchen available on the ward which is open 24hrs a day for hot and cold drinks and light snacks. Breakfast, lunch and evening meal are served in the dining room which have protective meal times.
Do you have an accident book?	IR1 reporting system.
Level of infection/Infection rate	Nil
Layout of the Ward/Unit including accessibility	Ground floor accommodation with flexible use of single sex bedrooms which are accessible to disabled service users.

Staffing

Level of staff	Number of staff	Full-time/ part-time	Total Hours	Qualification/ Training
Consultants/ Doctors linked to the ward or unit	3	Full time	120 + meal breaks	Consultant Psychiatrist. Specialist Doctor Foundation Yr 2 trainee.
Ward Manager/Matron	1 Modern Matron 1 Ward Manager	Full Time Full Time	75 hrs	As per job description. Diploma in Higher Education and MSc in Bio- Research.

Level of staff	Number of staff	Full-time/ part-time	Total Hours	Qualification/ Training
Qualified Nurses	14	12 full time 2 part time	504hrs	4 Staff Nurses have degrees related to Acute Care and as per job description. Clinical Support
Workers/Auxiliary staff	25 Clinical Support staff	10 full time 7 at 30 hrs per week and 7 at 22.5 hrs per week	667.5hrs	As per job description
Domestic /Housekeeping	1 Supervisor 7 Domestics 3 Kitchen staff 2 As and when	1 full time 7 part time 2 full time 1 part time	Total hours pro rata	As per job description
Administrative	1 Admin Manager 1 Band 4 Secretary 1 Band 3 Team Secretary 1 Receptionist 1 Ward Clerk 1 Bank- reception 1 wd clerk vacancy	3 full time 1 25hrs per week 2 20 hr	177.5 hrs plus vacancy	As per job description
Other	1 full time OT. 1 Technical instructor 1 Dietician (as and when) 1 Access to a Dentist as and when	1 x 37.5 1x22.5		
Ratio of Staff to patients (if this is a specified regulation)				

Training

Please indicate if the following training is mandatory or optional and applicable to which levels of staff on the unit:

Training subject	Mandatory/ Optional	Level of staff	Comment
Communication difficulties/disabilities	Mandatory	All Staff	
Values and attitudes/ dignity and privacy	Mandatory	All staff	
Dementia awareness			
Mental health	Mandatory	All staff according to grade	
Rehabilitation	Mandatory	All staff according to grade	

Training subject	Mandatory/ Optional	Level of staff	Comment
Food and nutrition/ feeding techniques		According to grade and dietetic advice	
Person centre care/Care Planning	Mandatory	For all trained staff	
Managing inappropriate behaviour	Mandatory	All staff (MVA)	
Safeguarding	Mandatory	According to their grade	
Mental Capacity Act/Deprivation of Liberty	Mandatory	All staff according to their grade	

Who Cares

The voice of the people of North Lincolnshire in Health & Social Care

Voluntary Action North Lincolnshire

Advancing Local Voluntary Action

NAVCA Quality Award

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