

**Enter and View Visit to Ward 2, Springfield University
Hospital - Dec 2016 to Jan 2017**

Acknowledgement

The Healthwatch Wandsworth Enter and View Team would like to thank the management, staff , patients, relatives and friends who made us welcome and assisted us in carrying out our visits to Ward 2 and in preparing this report.

The Visiting Team

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Summary of Report

This visit was part of a series of Enter and View visits to inpatient wards of South West London and St George's Mental Health NHS Trust. We had a preliminary meeting with ward management on 29 November 2016 and visited the ward twice, on 8 December 2016 and 12 January 2017. We spoke to 11 patients and to the friends or relatives of 2 patients.

The full report gives a detailed account of what we were told at the preliminary meeting, what we observed and what we were told by staff, patients and relatives. We recognise that the information we obtained was mixed, patchy and in some respects hard to interpret reliably.

Subject to this caveat, our principal finding is that despite the ward's apparent clinical success in helping seriously unwell people return to the community in a relatively short time, for a significant proportion of the patients we spoke to their experience of the ward was a disagreeable, even frightening one, although there were some positive comments. Patients' view of nursing staff was a mixed one and we saw little informal interaction between staff and patients. We found indications that, despite the efforts made, information of various kinds was not getting through to some patients and in some cases patients' needs were not getting through to staff.

The ward management team has changed since our visits and the new team have plans for improvement. We make a number of recommendations of areas for attention including:

- ensuring effective distribution and display of information for patients;
- ensuring all patients are aware of the opportunities for and benefits of 1:1 time with nursing staff and of the arrangements for giving feedback on their care;
- the importance of gender preference and the need for vulnerable women to feel safe in a mixed-sex environment;
- other possible ways of making the ward environment and culture more welcoming.

More generally, we want to encourage the development of a friendly, informal atmosphere with more interaction between staff and patients and the spread of best practice between similar wards.

The Trust's response to the report will be published alongside it on the Healthwatch Wandsworth website.

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The Full Report

1.0 Introduction

1.1 About Healthwatch Wandsworth

Healthwatch Wandsworth (HWW) is the patient and public champion in the areas of health and social care services. At the national level, we send our reports to Healthwatch England. HWW is funded by the Department of Health through the local authority, Wandsworth Borough Council. Our staff and volunteers are managed by an independent local voluntary organisation, Wandsworth Care Alliance (WCA). HWW is governed by an Executive Committee consisting of four Trustees of WCA and four members directly elected by the community. Our activities are developed in consultation with the public at our Assembly meetings.

1.2 Enter & View

Healthwatch Wandsworth has the statutory authority to visit health or social care services provided in the borough, or which cater for the local population but are located outside the borough. We can observe how services are delivered. Our main aim is to talk to patients or clients, their close relatives or carers, and senior staff responsible for managing the services. Our main focus is on the service user's experience of care, but we also try to assess whether the service being provided is adequate for meeting the needs of the local community.

Our E&V volunteers receive full training, and are DBS (Disclosure & Barring Service) checked before they can become authorised visitors. After each visit, the team produces a report containing its findings and recommendations. The reports are then sent to the service provider for comment, and to relevant bodies such as Healthwatch England, the Care Quality Commission (CQC), and the people responsible for commissioning and providing the service we have visited.

1.3 Our E&V strategy

One of the main aims of our current E&V strategy is to collect feedback on the experience of in-patients on the wards of South West London and St. George's Mental Health NHS Trust.

The Trust has recently been inspected by the Care Quality Commission (March 2016) which gave Ward 2 along with other adult acute wards an overall rating of Good. We wanted to complement the findings of this inspection with more detailed information on the functioning of wards, their role within the overall mental healthcare system, and the experience of patients. When we approached the Trust about this we were invited to visit Ward 2 in the first instance.

2.0 Background

2.1 Purpose of the ward

Ward 2 is a mixed 18-bed acute admissions ward for adults between 18 and 75. It is on the first floor of Building 30 at Springfield University Hospital, part of South West London and St George's NHS Mental Health Trust.

People between 18 and 75 are admitted when acutely unwell if their care cannot be managed in the community by the Crisis and Home Treatment Team. The aim of the ward is to keep patients safe while they are acutely unwell and to help them return to a level of stability in which they can safely return to care in the community.

Most patients are already under the care of a CMHT, the Early Intervention Team or the Complex Needs Team (for personality disorder) although a few are admitted from A&E or from the new assessment suite (Lotus Suite) at Springfield. As many as 80 to 90% of patients have had a previous admission to a mental health inpatient ward before their current admission. The majority of patients are admitted on a compulsory basis under a section of the Mental Health Act or by order under the criminal justice system and often lack capacity when first admitted but some patients are admitted on a voluntary basis.

The most common diagnoses for patients on the ward are bipolar disorder, schizophrenia and personality disorder. There has been a noticeable increase in admissions of patients with personality disorder.

Ward 2 is currently operated by the Wandsworth Service Directorate and formerly served mainly the East Wandsworth area (Balham Tooting and Furzedown and Battersea). But patients from other boroughs and CMHTs are often now admitted depending on bed availability and equally, East Wandsworth patients may be admitted to other Wandsworth wards (Laurel and Rose at Queen Mary's Hospital, Roehampton) or to the Merton ward at Springfield. The Trust's Borough-based organisation is about to be changed to a Service Line Management structure (under which all adult wards will be managed together as part of the Acute and Urgent Care Pathway) in April 2017: this will involve a complete change in the chain of management above the ward manager.

We were told that the ethnic makeup of admissions to Ward 2 tended broadly to reflect the general population in Wandsworth but there was great variability over time. The majority have some degree of ongoing support from family or friends.

2.2 Staffing

Ward 2 has a Consultant Psychiatrist supported by two junior doctor posts, one of which is currently a job share. Both posts are currently filled by GP trainees. There is also regular input from a Senior Registrar. The doctors' timetables mean that they are not on the ward on Thursday afternoons (so we did not see them on either of our two main visits).

There is a ward manager (the postholder changed between our first and second visits) and two part-time administrative staff who jointly act as receptionist and ward clerk. The ward works with 2 Registered Mental Nurses and 2 Health Care Assistants each shift (early, late and night) there is a 9-5 shift Monday to Friday RMN shift which is usually filled by the Deputy Ward Manager. We were told that there had been recent staff changes and two of the RMNs we met had been working on the ward for only a few months. At the time of our first visit there were 2 vacancies for RMNs, currently filled by bank or agency staff, but permanent staff had been recruited and were due to start shortly. A notice board reported that the ward's vacancy rate for December was 23.9%, nearly double the Trust rate of 12.4%.

In addition to nursing staff, Ward 2 has a fulltime Occupational Therapist, who provides assessments and activities; another Occupational Therapist working in the role of Discharge Co-ordinator ; and a fulltime Activities Co-ordinator who organises a weekly schedule of activities and can provide other assistance to patients such as occasional shopping (which is also carried out by nursing staff as time permits).

2.3 Layout and facilities

The ward is designed around a large open-plan area for sitting and dining leading to two separate corridors for male and female use. There are 7 female bedrooms, 7 male and 4 "flexible" i.e. they can be linked to either the female or the male corridor as needed. The bedrooms are good-sized and have en suite shower and toilet facilities. There is a shared bathroom on each of the two corridors for those who wish to take a bath. There are separate lounges or "quiet rooms" on each of the two corridors with comfortable seating and TV/video facilities. There are two enclosed courtyards as outside space, where smoking is currently permitted - one is reserved for women while the other is used as a smoking area for both sexes. As from October 2017 the Trust will be operating a no smoking policy throughout the Springfield site.

Outside the ward is a Reception area with some seating. There is a small but well-designed sign reading "Welcome to Ward 2". Entry to the ward is controlled by a security door. The open plan lounge area is flanked and overlooked at one end by the ward manager's office and the nursing office, which is a narrow corridor and must be uncomfortable to work in: we understand there are proposals to upgrade it. Here basic information about each patient, including their current risk status and observation level and their Named Nurse (see below), is shown on a whiteboard and an array of lockers is used to keep patients' property considered unsafe for them to retain such as lighters and mobile phones. There is a telephone for making external calls in a corner of the lounge and a large screen TV which effectively separates the lounge from the dining area. Next to the nursing office there are a kitchen and a laundry room available for patients' use.

Beyond the dining area is an exercise room with a table tennis table and a exercise bike. This room has a hatch into the dining area so that meals, after heating up in the kitchen by domestic staff, can be wheeled in here and served out to the patients by nursing staff through the hatch.

Also accessible from the open-plan area are an activity room which is large with tables and chairs and a computer, decorated with inspirational quotes and patients' art work, and the OT's office.

The ward is light and airy and has good visibility throughout, thanks to the widespread use of glazing for wall areas - but this limits the space available for notice boards. There is a wide range of information displayed but some of it is in places which are not readily accessible.

In the Reception area there is a family room for patients and their visitors, comfortably furnished and also decorated with quotes and pictures and a meeting room where ward meetings and care plan reviews are held which is also used as the Consultant's office.

2.4 Care and treatment

A printed information pack (designed to cover the generality of Trust inpatient wards) is available to be given to patients on admission and there is a separate leaflet for carers. While on the ward

patients receive treatment according to a care plan which is discussed with the patient and, if they agree, with their carer. Care plans are reviewed weekly on the ward.

While on the ward each patient has a "Named Nurse", one of the RMNs, who is responsible for coordinating their care and if they already had a care coordinator in a CMHT, the latter is encouraged to participate in the main planning meetings. The named nurse is seen as the person to whom each patient could turn to discuss his/her care plan and sort out issues of importance. It is recognised that this person would not always be on duty and also that patients may build positive relationships with other members of staff. The objective is that each patient should have some 1:1 discussion with a member of staff each day and that this should be recorded as having occurred. When it is with the Named Nurse this is recorded as "1:1 with Named Nurse". We understand that the delivery of 1:1 time is audited regularly by ward management.

Like the rest of the Trust, Ward 2 endeavours to uphold the standards of the Triangle of Care for working with carers as promulgated by the Carers Trust. One of the ward team (currently the fulltime Occupational Therapist) has been identified as Carers' Lead to whom relatives can look for information and advice. Visiting is from 4 to 8pm on weekdays and 2 to 8pm at weekends. It can be flexible if necessary to meet carers' needs.

Patients and their carers have access to a dedicated computer terminal located on the edge of the dining area to give real-time feedback which is monitored and acted upon as appropriate by the ward manager, matron or operational manager. It is also brought to the ward's Community Meeting for discussion on an anonymised basis.

Treatment normally but not invariably includes medication, often one of a range of antidepressant, anxiolytic or antipsychotic medications. Psychological therapy, if appropriate, is provided by psychologists from the relevant CMHTs. Checking on physical health is seen as very important and all patients are assessed initially to ensure that their care can be managed adequately on the ward and that they do not have any urgent need for physical care. Blood pressure, blood sugar, weight and other factors are monitored regularly and advice on lifestyle and health is considered to be important.

2.5 Activities

There is a regular weekly programme of activities and groups which at the time of our visits included the Ward Community Meeting, exercise sessions, movement therapy, a walking group, art therapy and an art group, a current affairs group and a more general Time to Talk group with the chaplain and the activity coordinator. In addition there are computer, board games, puzzles, musical instruments, art materials, books, newspapers, Wii, table tennis and exercise equipment freely available throughout the day.

An advocate from Rethink comes weekly and someone from PALS come to the ward on a monthly basis. The ward is visited twice weekly by Canerows and Plaits, a user-led befriending group in Wandsworth. There are also individual volunteer visitors, often people intending to pursue careers in nursing or psychology.

2.6 Discharge

Ward 2, in line with all other wards in the Trust, has a Discharge Co-ordinator. Currently the post is filled by an experienced Occupational Therapist. The majority of patients discharged from Ward 2 will be followed up by one of the CMHTs or specialist teams and many will require a care package of some kind from Social Services. There is a weekly Wandsworth meeting to review obstacles to discharge and to notify the Council if the delays are caused by a package of care not being in place. Lack of an appropriate care package together with a lack of supported accommodation are the principal reasons for delayed discharge. Over 200 patients are discharged each year after an average length of stay of 6 to 8 weeks.

3.0 Preparations for our visit(s)

3.1 Setup meeting

On 29 November three members of the Enter and View team had a two-hour meeting with Ann Traynor, Operational Manager, Wandsworth Service Directorate for the Mental Health Trust, Jimmy Cangy, Matron for several Wandsworth wards including Ward 2 and Sing Siong Teoh (known as Teoh), then Ward Manager for Ward 2.

We were given background information about the ward, its purpose, staffing, and ways of working, much of which is set out in the Background section above. We agreed a date and time for our visit. The staff were asked to let patients know about our visit and to distribute letters explaining that we would like to talk to them about their experiences on the ward. We also agreed to provide a poster for the ward to display about Healthwatch Wandsworth, and the date and purpose of our visit. Unfortunately we did not succeed in getting the letters or poster to the ward before our first visit but the ward manager informed patients verbally about our visit. In the interest of causing minimal disruption to the ward, we agreed to limit the number of the E&V team to four people.

3.2 Planning and Methods

The team planned to:

- Identify examples of good working practice.
- Observe patients and staff and their surroundings.
- Capture the experience of patients, and relatives and visitors and any ideas they might have for change and/or improvement.

Before the visit, we decided on some key topics and prompts to use. We also agreed on a list of specific issues to observe on the ward. We aimed to conduct most of our conversations with patients in pairs, thus enabling one person to develop rapport with the interviewee, while their partner made notes. In order to avoid imposing our own concerns, at the end of each interview we would invite patients to tell us what they particularly liked about Ward 2, and what they thought could be improved.

As we wanted to capture an idea of what the experience of being a patient on Ward 2 was like, we drew up an observation schedule to complement our interviews. This covered items such as the overall 'feel' of the ward environment, how safe it seemed for patients, special provision for people with physical disabilities, how staff interacted with patients and so on.

4.0 Our visits

In the event we made two main visits to Ward 2. The first, with the full team of 4 visitors, was on Thursday 8 December 2016 from 2.30 to about 5.30 pm. On this occasion we were welcomed by a receptionist and given personal alarms and a tour of the ward by the ward manager, Teoh. This was briefly disrupted when we had to draw his attention to a patient making a 999 call from the ward phone. We then proceeded to interview those patients (6 in all) who were in or came into the main open-plan area of the ward and who were willing to speak to us. Some of these conversations were quite brief. For a variety of reasons we did not feel that the information we were able to obtain from the patients that we spoke to and from our observation amounted to a sufficiently clear or balanced picture of the ward and patients' experience of it. So we decided (in agreement with ward management) to come back for a further visit in the New Year with the aim of talking specifically to further patients who might be able to supplement our information and of continuing our observation. We also decided that to ensure a balanced view we would postpone the completion of our report on Ward 2 until we had been able to visit another of the Trust's adult acute wards. Subsequently to the visit we telephoned one relative who we only had the opportunity to speak to briefly as we were leaving.

Our second visit to Ward 2 was on Thursday 12 January from 6.30 to about 8 pm. As one of our original visiting team was unable to take part, there were only three of us on this occasion. We emailed to the ward a poster explaining our visit and showing our photos and this was displayed. We were received onto the ward by one of the two RMNs on duty: he and his colleagues assisted us in identifying patients we might usefully speak to. On this occasion we were not given personal alarms. Several of the patients we had spoken to on our first visit had already been discharged and in the event we did not re-interview anyone we had spoken to the previous time. We were introduced to two patients who were in their rooms and interviewed them in one of the communal rooms. Three other patients we spoke to, in some cases quite briefly, in the lounge or dining area, in one case along with friends who were visiting. We did not encounter any other visitors and were unable to identify any further relatives we might speak to. Finally, two of the visiting team revisited Ward 2 briefly on Tuesday 31 January to verify certain aspects of the ward environment. They also spoke to the ward consultant, Dr Peter Hughes.

In all during our two main visits we spoke, albeit briefly in some cases, to a total of 11 patients (the ward has capacity for 18 and was either full or nearly full when we visited). Of these 6 were men and 5 women; 6 appeared to be White British, 2 White European and 3 of Black or Minority Ethnicity. In addition we spoke to the family or friends of 2 patients.

5.0 Our Findings

Without spending a good deal more time on the ward we do not think we could have obtained a more representative sample of patients' and relatives' views but we must acknowledge that the information we obtained was limited and patchy. Moreover we have not found it easy to interpret some of what we were told and saw during our visits to Ward 2.

5.1 General experience of Ward 2

Evidence of Ward 2's effectiveness in fulfilling its allotted clinical and therapeutic role is arguably provided by the fact that over 200 seriously unwell people are admitted each year and helped to recover sufficiently to return to the community in a relatively short time. Moreover at least 2 of the 6 patients whom we spoke to in December, when they were clearly quite unwell, had been discharged by the time of our second visit 5 weeks later. Another patient who was admitted on the day of our first visit had already returned to their family by the time we spoke to a relative three and a half weeks later. These are indications of success.

But nearly half of the patients we spoke to described their subjective experience of the ward in negative terms such as "not good", "horrible", "unsafe" or "not the place for me". One or two experienced aspects of their time on the ward as persecutory or punitive. Some of this negativity clearly has to be attributed to the mental disorder from which they were suffering. And it must be borne in mind that nearly all of those on the ward were detained under a Section of the Mental Health Act, in other words they were there against their will, even though they might be benefitting from it.

On the positive side we spoke to one patient who was clearly feeling better and was able to give the ward credit for this as well as for having been given good advice on staying well. One or two other patients implicitly recognised positive aspects of their experience of the ward in what they told us. The relative of the discharged patient referred to above had "nothing but good to say" about the ward, which they had visited a number of times during the patient's short stay.

Turning to the more detailed aspects which we attempted to explore, it seemed to emerge from what we were told that the principal curative or restorative factors responsible for the ward's effectiveness are seen to be on the one hand medication (including the continued taking of medication previously prescribed but not always adhered to) and, on the other, removing the acutely unwell person from the pressures and stresses of their everyday life while meeting their basic needs for food, drink and sleep.

This second factor should be qualified: at least two patients found the ward "noisy", another described it as "not very relaxing" and we felt these were accurate descriptions of the communal areas for part of the time we were there. Several patients said they were able to find peace and quiet in their individual rooms or in the single-sex "quiet rooms". While a variety of measures are in place to assure patients' safety, the ward is inevitably subject to incidents of disordered, sometimes violent behaviour by individual patients. This can be distressing for other patients. Two female patients in particular told us of inappropriate sexual advances by male patients. While we witnessed staff intervening to defuse or contain antisocial behaviour, we felt it necessary to report allegations of sexual harassment on behalf of one female patient who had apparently not felt able to do so herself (and who was very unhappy about being placed in a mixed ward and felt unable to talk to male staff although she had been allocated a male Named Nurse).

On the positive side one patient who had just been transferred to Ward 2 from the Psychiatric Intensive Care Unit (Ward 1) thought it would be less violent and was expecting to feel safer. Another patient who had also been on Ward 1 felt more relaxed on Ward 2.

5.2 Ward staff, activities, and leave

We heard a wide spectrum of views about the ward staff. Two patients described staff as "helpful" or "friendly" and another, without using descriptive terms, made it clear that they felt able to talk to staff. Three patients were quite negative, characterising the nursing staff as impersonal, uncaring or uninterested in their patients as people. Phrases used included: "they are not nice people", "they stand doing nothing", and "patients are just numbers to them". One patient in particular complained that staff left the observation flap to his room open or the light on after routine night time observation (we were subsequently told that this problem had been brought to the ward manager's attention and resolved). Finally, two patients said some staff were good, others not.

We asked a number of patients specifically about their Named Nurse and the availability of 1:1 time: while 3 patients told us they knew who their Named Nurse was, 6 patients did not know or were uncertain or vague; no patients seemed to be aware of having had 1:1 time with nursing staff while a number specifically said they had not (in a few cases they said they did not want it).

The one relative we spoke to had found ward staff welcoming and helpful. A patient suggested that staff behaved differently to visitors than they did to patients.

We must also report our own observation that in the course of the four and a half hours we spent on the ward we saw little interaction between nursing staff and patients which was other than task-oriented. The one exception was when one of the HCAs played table tennis with a patient in the Exercise Room. Clearly we were not able to see what was happening throughout the ward but we did observe that the RMNs in particular spent a good deal of their time working in the nursing office. At one stage we observed two members of nursing staff standing talking to each other for several minutes on the edge of the lounge area but not engaging with patients.

We received some mainly favourable comments about the ward's Activity Co-ordinator and the OT. Several patients mentioned attending the activity groups, particularly the current affairs group and the Time to Talk group, and finding them helpful. One patient preferred not to join in and for another it depended on how they were feeling. One patient made good use of the gym equipment in the Exercise Room.

Two patients mentioned arrangements for leave outside the ward. One had been give leave for two hours a day after a week on the ward. Another said they enjoyed going round Tesco with a member of staff. But one patient said that escorted leave was often cancelled because of staff shortage. This patient also felt that withholding leave was used as a punishment for bad or violent behaviour (but there clearly may have been other considerations e.g. safety involved here).

5.3 Care Planning, information and feedback

We were able to ask a number of patients about their involvement in their care and discharge planning while on the ward. Only one patient reported being given a "leaflet" on admission, although we are not sure whether this was the full ward information pack that we were shown. Another patient denied having received more than a one-page schedule of activities and a third reported having received a ward information pack on another ward but not on Ward 2. The first-mentioned patient was clear that staff talked to them about their care and planning for the future, including after discharge but the second said that they had had no information about a care plan or regular reviews although they were clearly aware of the work of the discharge coordinator. Another patient, who may only have been on the ward for a few days, "had no idea " about their care other than being "doped up with tablets". Another patient who had only just arrived on the ward had seen a doctor who had explained about their treatment and medication. Yet another patient, although feeling better, seemed to be unaware of a care plan as such but was aware of having regular reviews and had been given good advice on avoiding relapse by eating, drinking and sleeping properly and

recommended courses at the Recovery College. Finally another patient, although not telling us anything about care planning or reviews, was clearly involved in the question of discharge.

We observed that there appeared to be very little information for patients inside the locked area of the ward and some of information was not readily visible to most patients and some was out of date. The "You said, we did" feedback board and the Stop Smoking posters were in the exercise room which was locked on each occasion that we visited. The poster about courses in the Recovery College was out of date. The information about the ward's achievements in relation to Trust targets, information on advocacy and all carer information was in the reception area or family room.

We understand that there are information sheets on the door or wall of each patient's room (we did not examine these) containing contact details for PALS, advocacy etc. plus names of ward management and the named nurse - but some of the patients we spoke to did not seem to be aware of this.

We received little comment on the system of Real Time Feedback (see under 2.4 above). One patient had used the kiosk to give feedback but was doubtful whether feedback given in this way was followed up (although we were told by ward management that feedback is discussed at the weekly ward community meeting). Another had used the kiosk while on another ward.

We observed that there was poor mobile phone and data reception on the ward.

5.4 Physical healthcare and food

We received some fragmentary, mainly positive, evidence of physical healthcare on the ward. A few patients mentioned an initial checkup on admission, others the daily monitoring of temperature, blood pressure etc and three mentioned receiving medical care on or outside the ward during their stay (patients are escorted to any medical appointments outside the ward by ward staff). One patient was without their glasses, which they needed to read, but this did not seem to have been noticed. Two patients mentioned difficulty with obtaining other items they needed like a toothbrush, or personal care products - but this seemed to result more from confusion on the patients' part than from failure of staff to assist when asked.

We asked a number of patients about the food served on the ward. Of those who commented (7) the majority (5) were happy with the food, although one of these said it lacked flavour. One patient thought the food "not good" and another lived entirely from food ordered in, almost as a matter of principle. One patient said that they could not get food if they got up late (we were told by ward management that breakfast is cleared away at 10 am but that snacks, including fruit, biscuits and crisps, are served at 10.30 am) . The relative of the patient who had been discharged said that the food was not to the patient's Asian taste and they had brought some food in when they visited. Staff told us that many of the patients ordered takeaway, especially pizzas despite the emphasis on eating healthily.

6.0 Our Conclusions

We did not find it easy to apply our usual Enter and View methodology to the situation of an acute adult psychiatric ward like Ward 2, with its role of a last or near-last resort for people both acutely unwell and at serious risk to themselves or others. The Mental Health Trust operates a whole panoply of surveillance, monitoring, risk assessment and incident reporting systems which, together with the commitment and daily hard work of ward staff in difficult conditions, make wards like Ward 2 a temporary place of safety and recovery for people who would otherwise be at serious risk. Its success must clearly be measured principally by its clinical performance in expediting recovery and avoiding harm. We are not qualified to assess this but we note that the Care Quality Commission has recently rated the Trust's adult inpatient wards as a whole, as well as the Trust's collective leadership, as Good.

We have always seen our main role in exercising Healthwatch Enter and View powers as being to discover and report the subjective experience of service users. In this case we have to report that, at least at the time of our two main visits, while there were a number of positive comments, for a significant proportion of patients whom we talked to on Ward 2 the experience was seen as a largely disagreeable, confusing, disempowering or even frightening one. Undoubtedly much of the upset, confusion and fear will have arisen from or been exacerbated by the very mental disorders which were the reason for the patients being there. The question comes down to whether the ward, its systems and its staff, could do more to mitigate those effects and to address some of the particular weaknesses which this report appears to identify.

We are aware that the new ward manager for Ward 2, Jayne Evans, and her team have a programme of work in hand to further improve the quality of care and of patients' experience. This will no doubt be further reinforced when the new Service Line Management structure takes effect. In the light of what we saw and were told during our visits we would like to recommend that attention should be paid in particular to the following areas:

- ensuring the effectiveness of procedures for distributing ward information packs and carer information packs, for giving patients a copy of their care plan (including updates following reviews), and for ensuring patients are aware of the identity of their Named Nurse and of other allocated nurses on a daily basis;
- considering ways of making all patients aware of the potential therapeutic benefits of 1:1 time with trained nursing staff and of ensuring that staff regularly offer and if necessary re-offer it;
- checking whether patients have a gender preference for their doctor, Named Nurse and 1:1 time and ensuring that this is respected to the extent possible;
- considering whether there are any further ways of helping vulnerable female patients feel and be safer in the mixed ward environment;
- considering possible ways to alert all patients to the value of giving feedback, in particular through the Real Time Feedback system;
- reviewing the placing of displays and notices on the ward to make useful information more readily accessible to patients;
- considering the possibility of displaying individual information such as the identity of the patient's Named Nurse in patients' rooms;
- inviting the ward staff to develop a statement of its "philosophy of care" in keeping with the published values of the Trust and displaying this on the ward;

- considering the possibility of giving the ward a name rather than just a number to promote a shared sense of identity;
- enlarging the Welcome notice in the reception area;
- considering the scope for practical noise reduction measures in the communal areas.

More generally, we would wish to encourage as much as possible the development of a consistently friendly and informal atmosphere on the ward, including more personal, potentially therapeutic interaction between nursing staff and patients so that all patients, even those harder to reach, may benefit from feeling listened to and able to raise any concerns.

Finally, we hope that the Trust will use the advent of Service Line Management to ensure that staff working in similar wards across the Trust will increasingly be able to learn from each other and thereby spread best practice.

The Trust's response to this report will be published alongside it on the Healthwatch Wandsworth website.

Disclaimer

Please note that our findings in this report relate to observations and interviews on three particular days. It should not be taken as a representative portrayal of the experiences of all service users and staff on Ward 2 over time.

Revised 8 March 2017