healthwatch Enfield

healthwatch Barnet

Healthwatch Enfield and Healthwatch Barnet

Enter & View Report

Suffolk Ward, Chase Farm Hospital, 17 March 2015

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Enter and View Report

Premises name	Suffolk Ward, Chase Farm Hospital
Premises address	The Ridgeway, Enfield, Middlesex EN2 8JL
Date of visit	Tuesday 17 March 2015

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Enter & View visit to Suffolk Ward, Chase Farm Hospital

Purpose of the visit

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

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

CQC inspection reports of mental health wards at Chase Farm Hospital dating from 2011 and 2012 recorded numerous concerns, including staff shortage, lack of appropriate activities, lack of access to outdoor space and poor food service. Many concerns were noted with regard to the practice of seclusion – confining a disturbed patient in a special locked room for a period of time – in terms of the physical environment, observation of the patient, record-keeping etc. In January 2013 the CQC carried out a themed inspection with regard to the practice of seclusion on four mental health wards at Chase Farm, including Suffolk ward, and found there had been many improvements. The CQC found that there was generally good care, treatment and support for patients who spent some time in seclusion, and patients' rights were respected, but not all records had been completed.

We had received reports that some female patients have experienced harassment while staying in wards on other sites within the BEH Trust. We therefore decided to visit an acute adult female mental health ward at Chase Farm Hospital to see for ourselves whether female residents of Enfield and Barnet are receiving good care from this service.

Executive Summary

Suffolk Ward appears to be well-managed, and training and supervision for staff seems to be of a high standard. We met the deputy manager who impressed us as being confident, competent and empathetic.

We found that accommodation and facilities in Suffolk Ward are generally good. There is a good choice of activities on offer (although not at weekends or in the evening), and patients told us that they enjoy the food provided. Patients' physical health appears to be well-looked after, and patients spoke highly of the group therapy sessions, but there was no access to one-to-one talking therapies.

Patients told us that they were not always able to exercise choice, for example in terms of going outside, or having snacks outside mealtimes, as there were not always enough staff available to escort or assist them. The ward became noisy at times during our visit, creating an uncomfortable and unsettled atmosphere. We

witnessed some patients behaving in a disturbed manner and saw that staff did not always intervene effectively to restore a calm environment where all patients could feel safe and well-cared for. We heard that some patients and relatives did not feel their concerns were listened to.

From the observations we made during our visit and the comments we heard from patients, relatives and staff, we gained the strong impression that staff of Suffolk Ward are overstretched, which reduces their capacity to maintain a peaceful and healing environment and to provide person-centred care to all patients.

We have made some recommendations for the management of Suffolk Ward, which we believe, if implemented, would assist the staff in their efforts to provide excellent care for the patients.

We have also made three recommendations for the consideration of Barnet Enfield and Haringey Mental Health Trust, and Enfield Clinical Commissioning Group (the lead commissioners).

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

Since preparing our draft report, which we sent to the management of Suffolk Ward for their response, we have received an Action Plan setting out how they plan to act on the recommendations we made. We are pleased to see that they have made a commitment to implement a number of changes in response to our recommendations. Their Action Plan is included in full on pp.5-11. In one or two cases we felt that their response was not completely satisfactory, and in those instances we have added a further comment. The Trust also made some additional statements which we have included on p.16 (footnote 2) and p.28.

We are also pleased to learn that the service has made a commitment to take account of a recent service user and carer event in Enfield facilitated by Enfield Mental Health Service Users Group (EMU) (which) generated feedback on the crisis pathway including the role of the CRHT. Comments from this event echo some of the points raised in our recommendations and we note the commitment to developing an action plan with specific action for the Trust and look forward to seeing progress in light of this commitment to addressing user concerns.

Recommendations

Recommendations for management of Suffolk Ward

1. *All patients who need it should have access to regular one-to-one talking therapy in addition to protected engagement time with their named nurse. (p.16)*
2. *Consideration should be given to changing the system for alerting staff to an emergency in an adjacent ward, so as to maintain a calm atmosphere on the ward. (p.18)*

3. *Healthy snacks and hot drinks should be more readily available to patients. (p.20)*
4. *More activities should be available at weekends and in the evenings. (p.21)*
5. *Patients should be able to lock and unlock their bedroom door without having to wait for a member of staff to help. Secure lockers should be provided for all patients and kept in good working order, so patients can keep their property safe. (p.22)*
6. *Patients should have access to a functioning emergency call bell at all times. (p.22)*
7. *Staff should follow the agreed policy on smoking breaks. (p.23)*
8. *Staff should ensure that they listen to patients and speak to them regularly to find out if they feel safe, secure and comfortable on the ward. Appropriate action should be taken to ensure that harassment and aggressive behaviour are prevented and tackled. (p.24)*
9. *Where clinically appropriate, patients should have access to reliable wifi, and should be able to make personal telephone calls in private. (p.25)*
10. *Patients and relatives should be confident that any concerns or complaints which they raise will be listened to and dealt with fairly and objectively. (p.26)*
11. *Arrangements should be made to enable patients to have more frequent access to a pleasant outdoor space. (p.27)*
12. *We recommend that staff shifts are reviewed to assess whether the current shift patterns are capable of providing adequate support for patients. (p.28)*

Recommendations for Barnet Enfield and Haringey Mental Health Trust (BEH MHT) and Enfield Clinical Commissioning Group (ECCG) (lead commissioners)

1. *We recommend that the capacity of the Crisis and Resolution Home Treatment Team (CRHTT) to respond in a timely fashion to the needs of patients experiencing a mental health crisis, or needing admission to or discharge from an acute mental health ward, should be reviewed. (p.19)*
2. *We recommend that a review be undertaken of the adequacy of the number of acute adult mental health beds available, in conjunction with a review of the availability of alternative intensive support in the community. (p.20)*
3. *We recommend that a review be undertaken as to whether current staff allocations for acute mental health wards can adequately ensure that the prevailing mix of patients consistently receive high quality person-centred care. (p.28)*

SUFFOLK WARD ACTION PLAN

Recommendation	Comment	Action taken in response to recommendation	Lead	Review Date	Comments / Evidence of implementation
1. All patients who need it should have access to regular one-to-one talking therapy in addition to protected engagement time with their named nurse.	We welcome the recommendation. Within our current resource we aim to provide individual sessions to all who, in our clinical view, can utilise this. At times, however, and depending on the clinical mix, it is not possible to provide the service to everyone on the ward who could potentially benefit.	We do provide group interventions both to maximise the clinical advantages the approach offers and to increase access. Additionally our psychologists input to clinical meeting and support staff e.g. in providing structured behavioural interventions, in order to maximise the spread and benefit for all of the small resource.	Kajori Mukherjee, lead Psychologist	On-going	Additional resource is not expected from our commissioners and we continue to work to maximise the benefit for all patients of the small ward psychological therapy resource. ***Further comment from Healthwatch:*** *In subsequent correspondence after our visit, the Trust informed us that 'the post formerly named as CBT coordinator for the ward is now part of the psychology resource' and went on to say that 'when the numbers of clients requiring talking therapy are particularly high one to one may not be immediately available, however, we do provide alternative evidenced approaches….' (See page 16 for full reply to our query). This response appears to confirm that there are occasions where patients who need to have access to one-to-one talking therapy aren't provided with this. This lack of access to one-to-one time was confirmed by patients and we hope that the Trust will review the level of resource required to offer person-centred care to patients in the ward.*

Recommendation	Comment	Action taken in response to recommendation	Lead	Review Date	Comments / Evidence of implementation
2. Consideration should be given to changing the system for alerting staff to an emergency in an adjacent ward, so as to maintain a calm atmosphere on the ward.	We are exploring our alert system with the company who provide our alarm system, Edison Telecom looking at pager systems along with our current 'warden call' wall mounted panels.	Exploration of current alarm system in place with potential changes to be considered and suitable alternatives to be implemented.	Michael Salfrais, Team Leader	30/10/2015	We are exploring our alert system with the company who provide our alarm system, Edison Telecom looking at pager systems along with our current 'warden call' wall mounted panels.
3. Healthy snacks and hot drinks should be more readily available to patients.	For health and safety reasons, the ward kitchen cannot be left open to service users. However we recognise the need for more readily available healthy snacks and drinks.	Exploration of healthy snacks availability is being explored with the trust dietician, and will be made available on the ward.	Paula McKevitt, Ward Manager	30/10/2015	Paula has contacted the trust dietician on 16/9/15. Awaiting feedback.
4. More activities should be available at weekends and in the evenings.	We welcome the recommendation and are liaising with our Occupational therapy in order to increase activities evenings and weekends, also to be facilitated with ward staff.	For discussion in next Acute Care Forum in order to explore further and make a plan of formal timetable.	Paula McKevitt, Ward Manager	30/10/2015	Next Acute Care Forum is on 6/10/15.

Recommendation	Comment	Action taken in response to recommendation	Lead	Review Date	Comments / Evidence of implementation
5. Patients should be able to lock and unlock their bedroom door without having to wait for a member of staff to help. Secure lockers should be provided for all patients and kept in good working order, so patients can keep their property safe.	We welcome the recommendations and are proactively working towards resolving the issues.	A review of availability of keys for all bedrooms to carry out and missing keys to be ordered. Capital bid to be raised to purchase individual secure lockers for all bedrooms.	Paula McKevitt, Ward Manager	30/10/2015	We welcome the recommendations and are proactively working towards resolving the issues.
6. Patients should have access to a functioning emergency call bell at all times.	All bedrooms and communal areas have access to emergency call bells.	On admission, part of the admission process will be that patients are shown the emergency call bells.	Paula McKevitt, Ward Manager	On-going	Being discussed in the daily activities planning meeting at 9am. ***Further comment from Healthwatch:*** *We were told that staff can switch off the emergency call bell if they feel a patient is "over-using" it, which means that patients do not have access to the bell in their room at all times.*
7. Staff should follow the agreed policy on smoking breaks.	This is usual practice.	This will continue to be offered hourly. At times, however when emergencies arise there may be a short delay which can be unavoidable.	Paula McKevitt, Ward Manager	On-going	***Further comment from Healthwatch:*** *We made this recommendation because patients told us that the agreed policy is not being followed.*

Recommendation	Comment	Action taken in response to recommendation	Lead	Review Date	Comments / Evidence of implementation
8. Staff should ensure that they listen to patients and speak to them regularly to find out if they feel safe, secure and comfortable on the ward. Appropriate action should be taken to ensure that harassment and aggressive behaviour are prevented and tackled.	This is part of ward policy and is our expectation.	As part of supervision, this recommendation to be reinforced with instruction that all incidents and actions taken should be documented in clinical records and Datix incident reporting for review.	Paula McKevitt, Ward Manager	On-going	
9. Where clinically appropriate, patients should have access to reliable wifi, and should be able to make personal telephone calls in private.	We agree with this recommendation, however need to explore the possibility of installing WiFi within the ward.	This issue is being reviewed at corporate level for all BEH sites and discussions are taking place with current IT provider. Whilst this is ongoing, the majority of inpatients have their personal mobile phones on the ward and a hands free phone has been ordered.	Leigh Saunders	30/10/2015	

Recommendation	Comment	Action taken in response to recommendation	Lead	Review Date	Comments / Evidence of implementation
10. Patients and relatives should be confident that any concerns or complaints which they raise will be listened to and dealt with fairly and objectively.	We agree with this recommendation and have systems in place to address concerns/complaints.	We have a patient experience advisor who regularly attends the ward and can deal with any informal complaints. He will escalate any formal complaints through his team. The ward manager and Consultant are also available to meet with patients and family members.	Paula McKevitt, Ward Manager	On-going	
11. Arrangements should be made to enable patients to have more frequent access to a pleasant outdoor space.	There is access to a dedicated outdoor garden space for the ward.	Staff are encouraged to facilitate escorted trips to the garden as often as possible.	Paula McKevitt, Ward Manager	On-going	
12. We recommend that staff shifts are reviewed to assess whether the current shift patterns are capable of providing adequate support for patients.	Staffing is commensurate with national safe staffing levels. A staff survey has recently been completed with feedback given to ward management.	Staff survey is due for presentation to the Operational Management Group for review.	Leigh Saunders	30/10/2015	Staffing is commensurate with national safe staffing levels. A staff survey has recently been completed with feedback given to ward management. ***Further comment from Healthwatch:*** *Our recommendation referred to the length of the shifts, not the number of staff deployed, as the deputy manager had told us that "staff get very tired on these long shifts".*

Recommendation	Comment	Action taken in response to recommendation	Lead	Review Date	Comments / Evidence of implementation
BEH1. We recommend that the capacity of the Crisis and Resolution Home Treatment Team (CRHTT) to respond in a timely fashion to the needs of patients experiencing a mental health crisis, or needing admission to or discharge from an acute mental health ward, should be reviewed.	Response times are within four hours for emergency referrals and if these are not met there is a process for escalation of concerns.	A recent service user and carer event in Enfield facilitated by EMU (4/9/2015) generated feedback on the crisis pathway including the role of the CRHT. This will be used to generate an action plan, which will include specific action for the Trust to take forward including with CRHTs. This is currently at write up and development stage between commissioners, EMU and the Trust.	Kathryn O'Donnell	Completion date to be set.	
BEH 2. We recommend that a review be undertaken of the adequacy of the number of acute adult mental health beds available, in conjunction with a review of the availability of alternative intensive support in the community.	Recent external reviews, including Carnall Farrar and the work of the Early Intervention NHSE Project Group, have determined that the current bed base is appropriate for the local population, however, this continues to be subject to scrutiny by, and discussion with, our commissioners.	Bed base and use of additional beds is subject to daily reporting to commissioners and regular review at contract review.	Kathryn O'Donnell	On-going	

Recommendation	Comment	Action taken in response to recommendation	Lead	Review Date	Comments / Evidence of implementation
BEH3. We recommend that a review be undertaken as to whether current staff allocations for acute mental health wards can adequately ensure that the prevailing mix of patients consistently receive high quality person-centred care.	Staff numbers, training and deployment are under regular review at local and Trust wide level.	Recruitment for all vacancies has taken place with a small number of new recruits waiting start date. This is being proactively followed up. There is also an on-going review of staffing amongst the inpatient wards with internal staff moves being made when indicated.	Michael Salfrais, Team Leader	On-going	

The Enter & View Team

The Authorised Representatives who took part in the visit were Parin Bahl (team leader) and Rajinder Sunner from Healthwatch Enfield, and Lisa Robbins and Linda Jackson from Healthwatch Barnet.

General information

Suffolk Ward is one of three acute adult mental health wards at Chase Farm Hospital, and is the treatment ward for female patients. The treatment ward for male patients is Sussex Ward; Dorset Ward is a mixed assessment ward.

The manager of Suffolk Ward on the day of our visit was Sean Edwards, and the Deputy Manager was Eugenia Tackie.

There are acute mental health wards in each of the three boroughs served by Barnet Enfield and Haringey Mental Health Trust (BEHMHT), at Chase Farm Hospital (Enfield), St Ann's Hospital (Haringey) and Edgware Community Hospital (Barnet). We have been informed that although they try to treat patients in their home borough, patients from any of the three boroughs may be admitted to any of the acute wards within the Trust, depending on availability of beds. Patients and their families usually prefer it if the patient can be accommodated close to home.

Suffolk Ward has 18 beds; there are 14 single rooms and two double rooms. All beds were occupied at the time of our visit.

There is a seclusion room available for the patients of Suffolk Ward which is shared with the other acute wards on the site. There are also two "place of safety" rooms where people from the community who are very disturbed may be brought in to stay for short periods to calm down. Some of these people are sectioned under Section 136 of the Mental Health Act, others are informal (voluntary).

At the time of our visit, the age range of patients on Suffolk Ward was between 23 and 76. We understand that although in theory adult wards are for those aged 18 - 65, in practice some older patients with a long-term history of mental illness are placed in adult wards rather than elderly mental health wards. Patients come from a mixture of ethnic and social backgrounds.

Most patients in Suffolk Ward are "formal" patients, detained under Section 2 or Section 3 of the Mental Health Act (can be detained for up to 28 days or up to 6 months respectively); they have conditions such as depression, schizophrenia, bi-polar disorder and personality disorder. Patients of any age with dementia are accommodated in specialist provision so are not admitted to this ward. The deputy manager told us that the average stay in the ward was around 3 months. It could be six months or more if the patient's condition warranted a longer stay, or if suitable accommodation could not be found for the patient to be discharged to. Patients are discharged into the care of the Crisis Resolution and Home Treatment Team (CRHTT); they may go back home, or may move to independent or supported housing or to a local recovery house.

Methodology

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

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

We informed the ward manager of our planned visit two weeks in advance, and sent letters to be distributed to the patients explaining about the visit. The ward manager replied, letting us know that he was going to be on leave during the week of our visit, and that he would brief his deputy; when we arrived she was fully prepared for the visit and able to answer our questions and provide copies of documents requested.

During the visit, five patients and one relative engaged with us and shared their views, while we had fleeting conversations with a further two patients. Another relative who had not been able to attend while the visit took place phoned the Healthwatch Enfield office the following day and gave feedback about the service. Members of the team spoke to the deputy manager, two nurses and one healthcare assistant, and also observed staff interaction with the patients.

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

In making our recommendations, the team bore in mind the *Standards for Acute Inpatient Services for Working Age Adults* (5th edition) published by the Royal College of Psychiatrists as part of their Accreditation for Inpatient Mental Health Services (AIMS) Programme.[1] These standards are not mandatory but are regarded as good practice and are aligned with Department of Health policy implementation guides and NICE guidance.

A draft of this report was sent to the manager of Suffolk Ward to be checked for factual accuracy and for an opportunity to respond to the recommendations prior to publishing. The Action Plan sent to us by Kathryn O'Donnell, Clinical Director for Enfield at Barnet Enfield and Haringey Mental Health Trust appears on pp. 5-11 of this report.

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

[1] http://www.rcpsych.ac.uk/pdf/AIMS-WA%20Standards%205th%20Ed.pdf

Acknowledgements

Healthwatch Enfield and Healthwatch Barnet would like to thank the manager of Suffolk ward and the people who we met there, including the deputy manager, staff, patients and relatives, who welcomed us and whose contributions have been valuable.

Disclaimer

This report relates to the service viewed on the date of the visit only, and is intended to be representative of the views of the patients and staff who met members of the Enter & View team on those dates, and the views of relatives who spoke to us.

Key area 1: physical and mental health care

Admission

The deputy manager gave us the information in this section. She told us that the Crisis Resolution and Home Treatment Team (CRHTT) are the gatekeepers of the acute inpatient service. Care coordinators contact the CRHTT if one of their patients needs to be admitted. The team also deal with referrals from GPs and A&E etc, and self-referrals, and liaise with the Bed Manager if admission is required. Most patients are admitted first to Dorset ward for assessment and then move on to Suffolk ward (women) or Sussex ward (men). Most of the patients in Dorset ward are informal patients, or have been detained under Section 2 of the Mental Health Act (this means they can be detained for up to 28 days).

Many of the patients who are admitted to Suffolk ward have a history of mental illness, and have come off medication and need to restart treatment. Medication is reviewed and psychological assessments are carried out.

The deputy manager told us that almost every day, police bring in patients who are very disturbed, who are then put in the "Section 136" or "place of safety" rooms. These patients may have a mental illness or dementia, and have to be kept under constant observation. The senior nurse on duty checks their physical health, assesses whether they are likely to self-harm and whether they need to be admitted to an acute or elderly mental health ward. Assessment can take up to an hour. Additional staff are sometimes booked in to support these patients, but the senior nurse has to oversee them in addition to managing the ward.

A formulation meeting must take place within 72 hours of admission for all patients, to decide what is needed and draw up a Care Programme Approach (CPA) care plan.

We were told by the relative of one of the patients that they had had to wait a long time for a response from the CRHTT when the patient experienced a mental health crisis at home. It took five hours before the team arrived to assess the patient; they agreed that she needed to be admitted, but the family then waited over 24 hours for someone to take her into hospital, and eventually took her there themselves. During the long wait for help, the patient was extremely disturbed and had refused to eat, and the relative said the family had been very worried for her safety.

This relative's account of what had happened gave us cause for concern. The alleged failure of the CRHTT to ensure that this patient was swiftly taken to an acute ward after she had been assessed as needing admission seems to indicate that the CRHTT was not able to provide effective support in this instance during a mental health emergency. (See Recommendation 1 for BEH MHT on p.18.)

Care planning and review

Individual records are kept on the secure RIO computer system. A patient's progress is reviewed every week by the named nurse and the records are updated, with input from the patient. Relatives are included in the care planning and review process if the patient agrees.

Staff carry out routine observations for all patients on an hourly basis. One-to-one observation can be done at arm's length, keeping the patient within eyesight. Staff are required to do a lot of recording of observations etc, and this means they have to spend time in the office, which has internal windows giving sight of the communal area.

Patients will be seen by the consultant once a week (minimum) for a medical review, and there is also a weekly meeting involving the patient, carers, community team etc to discuss issues and agree on support required. Social workers sometimes visit patients whilst they are in the ward and attend meetings if appropriate.

There is a monthly quality assurance checklist for all requirements which helps keep things on track.

Types of treatment

We were told that treatment may include medication, psychological therapies, one-to-one or group therapy sessions, and groups facilitated by the Occupational Therapists (OTs). The OTs also provide one-to-one support for activities for daily living (ADL) to help prepare patients to cope outside the ward.

Patients are also entitled to have one-to-one protected engagement time with their named nurse each day, lasting approximately half an hour. The deputy manager told us that staff are allocated time for this and are expected to engage with 4 or 5 patients in each shift.

One patient we spoke to told us she saw her doctor every Thursday for 30 minutes or an hour. "He deals with any concerns, medication, if you don't know why you are here, explains about your section" etc.

Patients we spoke to said the group therapy session run by the consultant was very good. However, it appears that patients do not receive any one-to-one therapy. We were told that the CBT coordinator had retired in 2013 and had not yet been replaced, and CBT had not been available since then. We asked two patients if they had received one-to-one counselling or therapy sessions; one said no, and the other said "You can talk to the staff for a few minutes if you need to." [2]

Recommendation 1 for management of Suffolk Ward
All patients who need it should have access to regular one-to-one talking therapy in addition to protected engagement time with their named nurse.

[2] In correspondence after our visit, we received the following comments from the Trust: "The post formerly named as CBT coordinator for the wards is now part of the psychology establishment for the wards. We do have a small psychology resource, which we describe in our response [Action Plan]. When the numbers of clients requiring talking therapy are particularly high one to one may not be immediately available, however, we do provide alternative evidenced approaches to provision of appropriate therapy including group approaches and supervision to nursing staff, to ensure that a broad range of psychological approaches are appropriately used as part of each client's intervention plan."

Physical health needs

We were told that each patient receives a physical health check as part of the admission process, with regular check-ups throughout their stay. While they are in the ward their physical health is the responsibility of the consultant, who liaises with the patient's GP if necessary. If a patient becomes ill on the ward, observations are made and the ward doctor is informed. If the ward doctor assesses the situation as serious they use 999 or the Urgent Care Centre at Chase Farm Hospital.

One patient told us that the regular physical check-ups do not always take place.

We were told that escorted visits to an optician can be arranged if needed, and the ward can arrange dental treatment on the hospital site. One patient told us she had to book and pay for her own dentist and chiropodist.

The ward now has a link pharmacist so can get access to medication urgently if required. We were told that this works well and has led to fewer delays.

Nutrition and encouragement to eat if necessary

Breakfast consists of cereals, bread etc.

Patients go to the Willow Restaurant elsewhere on the hospital site for lunch; those who are unable to go to the restaurant have their food brought to the ward.

The evening meal is served at 5pm and is provided by Steamplicity who supply many of the local hospitals. We were shown a menu. Patients have a choice in what they eat, and the food looked healthy and nutritious, and culturally appropriate for the mix of patients. Patients order their food the day before, and the meals are delivered pre-cooked, and are heated to the correct temperature by the healthcare assistant.

We observed part of the evening meal. Most residents seem to eat together in the dining room, although they can take it to their rooms if they want to. All plates were cleared and most seemed to be enjoying the food.

One patient who said she was unsteady on her feet was assisted to get her food, and we saw a member of staff sitting beside a patient and encouraging her to eat. Apart from that there did not appear to be any social interaction between staff and patients during the meal.

Some patients mentioned that certain drugs can make them hungry and they may over-eat given the chance.

One patient said, 'The food is good. I wish there was more. I can get more if I need it, but I have to ask.' She added: 'Some people can't have more because they might have diabetes.'

During the meal, one patient who was very upset caused a disturbance (see p.24); an alarm also went off during this period and we were advised that this was a call for help from an adjacent ward and a staff nurse left to go and help. The alarm

was extremely loud and persistent, and this noise added to the uncomfortable atmosphere. This meant that patients were not able to eat their dinner in a peaceful and relaxed environment.

We have found that in other acute wards within BEH MHT, a bleep system is used to alert a senior nurse rather than a loud alarm which everyone can hear.

Recommendation 2 for management of Suffolk Ward

Consideration should be given to changing the system for alerting staff to an emergency in an adjacent ward, so as to maintain a calm atmosphere on the ward.

Opportunities to drink plenty of fluids

We saw two jugs, one with orange squash and the other with another diluted fruit drink and a water dispenser in the canteen. Patients told us that if they want tea or coffee they have to ask the staff, and if the patients are allowed and the staff have time, the staff will make it for them.

Access and encouragement to exercise

There are several exercise, dance and gardening sessions on the activities programme but none of the patients we spoke to mentioned them. One patient told us there are basketball courts they can use, but a patient sitting next to her did not seem to be aware of this.

Use of the seclusion unit

The deputy manager told us that the seclusion room is only used as a very last resort. She said that it had been used 3 times in the past 8 weeks.

Precautions against self-harm and suicide

We observed that rooms are furnished with care to reduce any opportunities for self-harm, and all ligature risks had been removed.

Record keeping of accidents and incidents

We were told that staff are expected to record all accidents and incidents.

We asked to see the incident book, which is managed electronically. We were shown the records straight away and noted that recent reports were on verbal and racial abuse, and a medicine error.

We asked to see the last entry made, as one of the patients we had spoken to said she had been ‘hit by one of the other patients using her bag in front of staff and they did nothing’. She said it hurt. Her relative who was present checked her shoulder and there was no mark. The patient said this had happened the previous day. We cannot know for sure if this incident took place, and we found that it had not been recorded in the incident book. When we mentioned it to the deputy manager she told us this was the first she had heard of it, and said she would look into it straight away. There are cameras in the communal area where the patient said this had happened, with a 30-day recording ability, so it should be possible to

check through the recordings. When we sent our draft report to the ward, we asked the manager to let us know the result of this investigation. The management were unable to answer this query. This is of concern to us because it is an issue raised by a patient and a lack of response could mean that potentially an allegation that a serious incident took place has not been investigated. We would expect such queries to be dealt with promptly.

(See recommendation 8 on p.24.)

Planning for safe discharge

Planning for discharge starts as soon as the patient is admitted, as part of the CPA. Housing issues can be very difficult to resolve so they need to be looked at from the start. About 50% of patients go back to their own home, but some patients cannot return to the place where they have been living. Sometimes families say they cannot cope any more, sometimes the home environment from which the patient has come is unsafe eg there is domestic violence.

The JONAH discharge system is used to record actions and who is responsible, and to keep things moving. MIND provides an advocacy and advice service and there are two London Borough of Enfield (LBE) social workers who also help with benefits and other issues which may be delaying discharge.

The Deputy Manager told us that ward staff sometimes had to wait a long time (for example from 1pm to 6pm) for a response from the CRHTT when they were trying to organise a discharge. She mentioned that members of the CRHTT might be anywhere – at a patient's house, at a GP surgery etc.

We understand that the CRHTT continue to support patients after they have been discharged, for example checking that medicines are being taken if they are part of the recovery process.

Recommendation 1 for BEH MHT and Enfield CCG

We recommend that the capacity of the CRHTT to respond in a timely fashion to the needs of patients experiencing a mental health crisis, or needing admission to or discharge from an acute mental health ward, should be reviewed.

When we visited, all 18 beds were occupied and we were told that there were four other patients who were on home leave from the ward but had not been discharged. If these patients need to return to inpatient care they will try to accommodate them in Suffolk Ward but this may not always be possible so they would have to go to whichever ward within the Trust had a bed available.

We were concerned to learn that Suffolk Ward is operating at well over 100% capacity. The system of allowing patients home on leave without discharging them, but not saving their place in the ward, appears to us to be an uncomfortable compromise which is likely to disrupt continuity of care and does not demonstrate a person-centred approach.

Recommendation 2 for BEH MHT and Enfield CCG

We recommend that a review be undertaken of the adequacy of the number of acute adult mental health beds available, in conjunction with a review of the availability of alternative intensive support in the community

Key area 2: personal choice and control

Patient involvement in care planning

Patients told us they are consulted about their care plans and their choices are respected. These are reviewed regularly. They said they were aware of their rights.

Control of personal schedule

Patients told us that usually they can get up when they like but on the day of our visit they had been 'made" to get up because we were coming (although our visit was not until the afternoon).

One patient said if she wants to go back to bed after breakfast no one stops her, but 'if you want to have breakfast you have to be out of bed by a certain time'.

The deputy manager told us that patients can follow their own schedule and eat when they like, and that biscuits and tea are available at night if a patient needs these. We saw that water and fruit juices were available and were told that hot drinks are provided several times a day.

However, we got the impression from patients that meal times are set and there isn't an option to eat at different times. Some patients told us they would prefer the evening meal to be served later, as they get hungry between dinner at 5pm and snack time at 9pm. Patients told us they would appreciate hot drinks more often.

There does not appear to be an emergency store for snacks on the ward, and a patient who had missed lunch because she had been on a visit to the dentist said she had been upset by a member of staff who had 'shouted at her' when she asked for a sandwich.

When we asked a patient if they were allowed to make tea and toast late at night, she said, 'Only if the staff think you need it and then they will make it for you, but you can't do it yourself.' One staff member said that if they have the food then they will give it to them, which seemed to suggest that the bread, milk etc was not always available.

Recommendation 3 for management of Suffolk Ward

Healthy snacks and hot drinks should be more readily available to patients.

Availability of planned activities and meaningful occupation

An occupational therapist (OT) and a technician are linked to each ward to run activities. All patients attend a meeting with the OT each morning and discuss what they plan to do.

We were given a copy of the current 'therapeutic group timetable' which appears to offer a good range of activities on weekdays, some of which take place on the ward and others in different parts of the hospital buildings or grounds. Some patients can go out on their own, others are escorted out. Some of the activities are delivered by OTs, and others are provided by EMU (Enfield Mental Health Service Users group). Scheduled activities include music and dance, gardening, music therapy, cooking, self-care and pampering, exercise, relaxation, art and design, storytelling and games, film group, creative group, and various therapy groups. The therapeutic activities programme is reviewed each month.

When we asked one of the patients what activities are available, she named self-care and pampering, music, film night, cooking, creative writing, book club, dance and relaxation. This confirmed for us that these activities do take place. This patient told us she enjoys the book club.

Patients told us they would appreciate regular visits from a hairdresser.

Some activities, such as dance and horticulture provide exercise. In addition some patients may have escorted walks in the garden, or escorted trips to the hospital shop to buy snacks or newspapers. Patients told us that trips further afield, such as the seaside, would be appreciated. There did not appear to be any free access to a secure outside area. The team saw an exercise machine, but it wasn't working at the time.

According to the schedule, group activities for each day usually finish at 3pm, followed by protected engagement time on an individual basis. Only one activity is scheduled to take place during the evening – the film group on Thursdays. Nothing is planned for Saturdays, and on Sundays all that is offered is bingo once a month and gardening once a month.

Free newspapers are provided, and one patient told us, 'The OT brings good books to read.' Another patient said that around 7pm they are 'struggling for things to do.' When we asked how it is decided what TV programmes to watch, two patients smiled at each other and said that they watched whatever was on, as the remote control tends to go missing.

There is a garden shared with another ward, but patients have to be accompanied there by staff.

Recommendation 4 for management of Suffolk Ward

More activities should be available at weekends and in the evenings.

Meeting cultural needs

The ethnic and cultural mix amongst patients and amongst staff appears to be balanced. Patients told us that their cultural and religious diversity is respected,

especially with the menu. Kosher, Halal and vegetarian meals are offered as well as authentic Afro-Caribbean, Indian and European food.

We were told that there is an awareness of the need to offer spiritual support and that the manager is keen to meet patients' individual needs. The deputy manager told us that prayer rooms are available for patients, and access to the hospital chaplain and visits to church can easily be arranged. However, one patient said 'The chapel on the hospital site is multi-faith so anyone can go, but staff are stretched to accompany you,' and another said, 'A church visit is not really possible.' We were told that a Church of England vicar has attended, but not recently. We were unable to ascertain if a Rabbi, Imam or Catholic priest had visited. A bible group is part of the weekly activities.

The ward staff are able to communicate in a range of languages, and interpreters are easily available in many languages at short notice when needed. The deputy manager said she couldn't recall dealing with a Deaf patient (British Sign Language user) but would expect to provide an interpreter if needed.

Safety and security

We were told that keys for bedrooms often go missing, so patients have to ask staff to lock and unlock their bedroom doors. This is unsatisfactory as it makes patients dependent on staff assistance. There are no communal toilets, so patients who need the toilet urgently sometimes have to wait, if staff are busy attending to an incident. One patient said 'This is a problem if you have a weak bladder like me and need to go.'

We were told that the manager is arranging for additional keys so that patients can retain a key if they want to.

Patients have a lockable cupboard to keep their valuables in, but it appears they are not secure so patients are encouraged to give valuables to staff to lock up in the office safe. However one patient said 'but you don't get them back', so she carries her things in her bag and keeps them with her all the time.

Recommendation 5 for management of Suffolk Ward

Patients should be able to lock and unlock their bedroom door without having to wait for a member of staff to help. Secure lockers should be provided for all patients and kept in good working order, so patients can keep their property safe.

There are call buttons in all the bedrooms but staff can switch them off with a key if they feel a patient is 'overusing' them.

Recommendation 6 for management of Suffolk Ward

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

Arrangements for patients who wish to smoke

The deputy manager told us that there are escorted smoking breaks once an hour. However patients told us that in fact they are only allowed out for a smoking break

once in the morning and once in the evening, and that the staff accompanying them always hurry them up.

Recommendation 7 for management of Suffolk Ward

Staff should follow the agreed policy on smoking breaks.

Key area 3: communication and relationships

Relationships between patients

Patients we spoke to said they tended to be caring and supportive of each other, and we witnessed instances of this when a rather timid patient was disturbed by the noise made by an angry patient, and was comforted by another patient. However, while we were there, the ward became very noisy at times and a number of patients caused a disturbance, which led to an unsettled atmosphere. We also witnessed and heard allegations of some aggressive behaviour between patients.

Relationships between patients and staff

The deputy manager appeared to be very open, and was happy to deal with all of our questions as fully as possible. She seemed to know all the patients we came across on our walk around the ward.

Patients told us they thought the senior staff were 'committed, approachable and down to earth'. However, they felt that the attitude of some staff was less respectful and brusque.

Patients' comments on staff included:

> 'Some staff are really responsive and respectful and are compassionate and consistent.'
>
> 'The staff here are good. Trained, experienced.'
>
> 'Some of them are here for the money and are not afraid of showing us.'
>
> 'You don't need training to be polite.'
>
> 'The staff don't do anything. They sit in the office. They are on their mobile phones.'

The patients were aware that there were staff shortages and that agency staff had to be relied upon at times. They also felt that the handovers seemed to take a long time.

We did not see many staff around during our visit. Several patients told us that more patient supervision was needed, and that there should be more counselling after upsets. This was repeated several times.

When we spoke to a group of patients together, some of them seemed uneasy about giving any negative feedback.

Some staff wore name badges, but not all of them, which made it difficult to be clear who was who. Most of the staff did not wear a uniform.

Response to 'challenging behaviour'

One patient said 'Staff deal with challenging behaviour well.'

However while we were there we witnessed more than one incident where a patient behaved in such a way as to create an unpleasant or intimidating atmosphere for other patients, without staff intervening effectively.

We witnessed a disturbance during the evening meal. One patient was using the payphone in the dining room, and was getting very upset. She was shouting and banging the receiver on the wall. This happened several times, but staff did not appear to intervene effectively. Afterwards, we saw staff nurses attempting to speak to the patient and were told that she was refusing to take her medication.

We asked another patient how she felt about the incident in the dining room. She said, 'It is difficult to hear other people upset. I want to help her but I can't. I'll have to speak to them later.'

While we were sitting in the quiet room talking to one of the patients and her relative, another patient barged into the room and shouted at them both. The relative got up and closed the door. None of the staff appeared to have noticed what went on. The patient told us that on the previous day a patient had hit her with her handbag and staff had not intervened. (See p.18)

When we asked the patient who said she had been attacked whether she felt safe in the ward, her answer was 'No.' The relative who was with her said that the patient now had her own room, which was an improvement. The patient appeared to be reassured by the fact that her relative spent many hours visiting her each day.

Another relative gave us an account of a patient being bullied, and said that staff had not done anything about it. (See p.25)

Recommendation 8 for management of Suffolk Ward

Staff should ensure that they listen to patients and speak to them regularly to find out if they feel safe, secure and comfortable on the ward. Appropriate action should be taken to ensure that harassment and aggressive behaviour are prevented and tackled.

Staying in touch with friends and relatives

Patients told us 'The quiet room is where we see relatives.' One said, 'You get privacy if you want it.'

Patients are allowed to use their mobile phones, but they said reception was patchy. There is a public payphone they can use if they run out of credit on their mobiles, but this telephone takes coins only, and is not private: 'Everyone can hear you.' Sometimes staff allow patients to use the phone in the office, and relatives can call and leave messages.

Patients may use a computer which is on the ward. Wifi is available in the restaurant but we were told that the wifi does not always work. One patient told us 'You can use the internet 30 minutes at a time'. Another patient said access was for 15 minutes only, and it hadn't been working for a while. One patient said she had not been able to check her work emails since she had been there.

Recommendation 9 for management of Suffolk Ward

Where clinically appropriate, patients should have access to reliable wifi, and should be able to make personal telephone calls in private.

Information provided to patients and relatives

When patients are admitted to the ward, staff give relatives an information pack with ward information including details about meal times, complaints procedure, support for families and reassuring them that the doctor will call them if they want to follow anything up.

While we were there we saw notices about the Healthwatch visit on display in several places, and several of the patients we spoke to knew of our visit and why we were there. Information about the activities rota and about Independent Mental Health Advocates (IMHAs) was also displayed on the notice boards.

Involvement of relatives

A close relative of one patient had been asked to come in especially at meal times as the patient concerned was not eating and was very underweight. The relative was bringing in the patient's favourite foods and staying for long periods to encourage her to eat. This relative said the patient was now eating well, and the family was pleased with the progress towards recovery that the patient was making since she had been in hospital.

Listening to patients' and relatives' views and concerns

There is a weekly patients' meeting where patients can raise any concerns eg their room hasn't been cleaned, comments on the food, smoking breaks etc.

The deputy manager said she feels that relatives are involved in the patients' care, and they can attend review meetings if they want to. If relatives have concerns they can come and talk to staff. If it is a clinical issue they can talk to the consultant. The ward staff try to resolve issues informally but patients or relatives can make a formal complaint if they wish to. Very few formal complaints are received.

However, the relative of one of the patients told us that the family was not at all happy with the treatment and care the patient had been receiving in Suffolk ward. The relative said the patient had been bullied by other patients but the staff hadn't done anything about it, even after the relative had raised concerns on the patient's behalf. This relative said that the patient in question 'is too scared to talk to the staff or make a complaint' and that staff in Suffolk ward 'don't want to talk to relatives' if they have concerns about patient care.

Recommendation 10 for management of Suffolk Ward

Patients and relatives should be confident that any concerns or complaints which they raise will be listened to and dealt with fairly and objectively.

Key area 4: the environment

The ward is relatively new and purpose built. It is spacious, functional and uncluttered.

Furniture is generally in good repair, with plenty of seating in alcoves for socialisation. There are few personal touches, such as pictures or plants, and the team felt there was no feeling of cosiness.

A staff office with internal windows is located next to the communal areas so that staff can observe patients even when in the office.

There is a quiet room for patients and another room which has a piano and a computer. However internet access is patchy and unreliable.

Lighting seemed good throughout although there was not any soft light anywhere to create a more relaxed atmosphere. The only rooms with natural daylight are the bedrooms.

The ward seemed clean, but there was an unpleasant smell in the seating area near the office.

There are two televisions, but only one was working. Patients said it would be nice to have TVs in their rooms.

Bedrooms

Bedrooms are a good size but sparsely furnished. All the bedrooms have en suite bathrooms containing shower, toilet and washbasin, which appeared clean and well-maintained.

In one bedroom we noticed a broken bedside table. A couple of the bedrooms had mirrors or windows marked with lipstick and an attempt had been made to clean this off.

The seclusion room

The seclusion room contains a bed and chair, which are both soft without sharp edges. The room can be observed through an observation panel; a nurse has to keep watch all the time. There is also a video camera which covers the whole room. The bedroom is linked to a bathroom.

Access to outdoor space and fresh air

We were shown the new garden, shared with another ward, which has just been opened. We were told that this is working very well and makes a difference. However, it appears that patients cannot go outside unless they are escorted.

Recommendation 11 for management of Suffolk Ward

Arrangements should be made to enable patients to have more frequent access to a pleasant outdoor space.

Key area 5: staffing and management

Management and leadership

The ward appears to be managed in an orderly fashion. We were unable to meet the manager but correspondence with him was dealt with efficiently. The deputy manager impressed us as being confident and empathetic. She clearly understood her responsibilities and related well to staff and patients.

Staff numbers

There are 3 qualified nurses and 2 healthcare assistants (HCAs) on duty each day, and 2 nurses and 2 HCAs at night. The manager is supernumerary and works Monday to Friday office hours, so is not there at weekends or nights. One nurse is designated the nurse in charge when the manager is not on duty. If a patient needs full-time one-to-one observation and support, the ward can sometimes get agreement to book an extra person; otherwise the staff on duty take it in turns to do this and change over every 2 hours. One-to-one support is used if a patient is very unwell or thought to be suicidal.

If there is an incident in one of the acute wards, when a patient becomes aggressive or violent, a loud alarm sounds, and one of the trained staff from another ward has to go and help. This means that there are fewer staff left behind to look after the other patients.

A relative of one of the patients said she thought the staff were good but they were too stretched: 'They are trying, but they do not have enough staff.'

From the observations we made during our visit and the comments we heard from patients and staff, we got the impression that staff are overstretched. This reduces their capacity to provide person-centred care. For example, staff are often too busy, apparently, to escort patients to the multi-faith chapel, to accompany them to the garden, to give them the smoking breaks they are entitled to or to make snacks and hot drinks when requested. Hardly any activities are provided in the evenings and at weekends. The incidences of aggression between patients which we witnessed and heard about *(see pp.18, 24, 25),* where staff apparently did not intervene effectively, suggested to us that not enough staff are available to give concerted one-to-one support to patients who are very disturbed or distressed.

Writing reports of observations and care plan reviews is an important part of staff duties, but this is time-consuming and means less time is available for interacting with the patients. The requirement to help out with emergencies in the other acute wards or with an emergency section 136 admission also adds to the pressure.

Recommendation 3 for BEH MHT and Enfield CCG

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

In correspondence after our visit, we received the following statement from the Clinical Director for Enfield at BEH Mental Health Trust:

> "High quality compassionate care is about people not institutions and in order to achieve this as an organisation we need to ensure we take action that means we are providing appropriate staffing levels for all our inpatient and community teams, that this is subject to regular review and that we inform the public of what our staffing levels are and when we are unable to meet the required numbers/levels what action we are taking to address any shortfall. Nationally it has been agreed to 'define staffing ratios' would potentially miss the point and that we must ensure we have the right staff, with the right skills in place at the right time. In order to address this within our organisation we have undertaken extensive skill mix reviews within our inpatient wards. We have also benchmarked establishments against defined methodology namely: Professional Judgement; Nurse Per Occupied Bed (NPOB). The number of staff required per ward is reviewed regularly. Staffing ratios are uplifted in accordance with presenting clinical needs. We are also taking forward some work led by psychology to support staff in managing challenging behaviour."

Shift patterns

Staff work 12-hour shifts ,with a half-hour paid handover: 7am to 7.30pm or 7pm to 7.30am. They have a four-weekly rota doing 3 or 4 long days a week. Arrangements are fairly flexible if any variation is required to cover leave etc. The deputy manager told us that staff get very tired on these long shifts and she would like to see the shift system changed.

Recommendation 12 for management of Suffolk Ward

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

Staff recruitment, retention and turnover

We learned that at the time of our visit there were 4 vacancies for HCAs and recruitment was taking place, but were told that it is hard to find new staff.

We were told that whilst generally staff turnover is low, staff retention has been affected by recent pension changes, with older staff leaving. When people leave in normal circumstances it is usually to get more experience of working in the community.

Staff training

The deputy manager told us that staff are encouraged to develop their knowledge and skills through training.

We were given a list of the training available to staff which appeared to be very comprehensive. Mandatory training for all staff includes Equality and Diversity, Fire Safety, Infection Control, Health & Safety and Safeguarding Adults and Children, the Care Programme Approach, Clinical Risk Assessment and Information Governance. Staff nurses are also required to have training in resuscitation and life support, control and restraint techniques, and moving and handling. Staff must refresh the mandatory courses every 3 years. We were told that currently nearly all staff have completed all mandatory courses. A wide range of optional courses is also available.

Staff supervision and support

We were told that staff meet as a team every Friday, with the doctors, to discuss what has happened on the ward that week and see how things could be improved. There are also monthly staff meetings. Staff not on duty when the meetings are held (including night staff) are encouraged to come in if possible (payment offered), and receive the minutes if they can't attend. Staff receive a monthly clinical supervision.

We were told that all staff understand about whistle-blowing and would go to the manager if they had any concerns.

Conclusion

Suffolk Ward appears to be well-managed, and training and supervision for staff seems to be of a high standard. We met the deputy manager who impressed us as being confident, competent and empathetic.

We found that accommodation and facilities in Suffolk Ward are generally good. There is a good choice of activities on offer (although not at weekends or in the evening), and patients told us that they enjoy the food provided. Patients' physical health appears to be well-looked after, and patients spoke highly of the group therapy sessions, but there was no access to one-to-one talking therapies.

Patients told us that they were not always able to exercise choice, for example in terms of going outside, or having snacks outside mealtimes, as there were not always enough staff available to escort or assist them. The ward became noisy at times during our visit, creating an uncomfortable and unsettled atmosphere. We witnessed some patients behaving in a disturbed manner and saw that staff did not always intervene effectively to restore a calm environment where all patients could feel safe and well-cared for. We heard that some patients and relatives did not feel their concerns were listened to.

From the observations we made during our visit and the comments we heard from patients, relatives and staff, we gained the strong impression that staff of Suffolk Ward are overstretched, which reduces their capacity to maintain a peaceful and healing environment and to provide person-centred care to all patients.

We were pleased to learn from the Action Plan which the management of Suffolk Ward have sent us in response to our draft report, that there is a clear commitment to implementing a number of changes in response to our recommendations. Furthermore we are pleased that the service has made a commitment to take account of a 'recent service user and carer event in Enfield facilitated by Enfield Mental Health Service Users Group (EMU) (which) generated feedback on the crisis pathway including the role of the CRHT. Comments from this event echo some of the points raised in our recommendations and we note the commitment to developing an action plan with specific action for the Trust and look forward to seeing progress in light of this commitment to addressing user concerns.

What is Healthwatch?

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

What does local Healthwatch do?

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

Further information can be found on our websites:

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What is Enter and View?

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

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

Further information about Enter and View is available at:
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