Enter and View Visit to Laurel Ward, Queen Mary's Hospital - 1 February 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 Laurel Ward and in preparing this report.

The Visiting Team

Aline Colville, Martin Haddon, Cherill Scott, Sara Turner.

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Summary of Report

This was the third of a series of Enter and View visits to in-patient wards operated by South West London and St George's Mental Health NHS Trust, our second visit to a working-age adult acute ward but our first to a single sex ward. It was also our first visit to Queen Mary's Hospital, Roehampton. We had a preliminary meeting with ward management on 26 January 2017 and visited the ward on 1-February 2017. We spoke to 8 patients and received comments from 2 relatives whom we contacted by email or by telephone.

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. While one patient was very confused, we felt that most of those we spoke to, even though in some cases clearly quite unwell, were able to give us a coherent account of their experience of Laurel Ward. We recognise that some of the information we obtained was unclear or unreliable but we are satisfied that we have captured an adequate snapshot of the ward.

With the exception of one patient who was still shocked by the process of compulsory detention, all those we spoke to seemed generally happy with the ward. Detail of the views and comments we received on various aspects of the ward are given in Section 5.0 of the report along with our observation of peaceful, orderly activity and informal, friendly interactions between staff and patients. We feel that as a whole our findings reflect great credit on the staff and management of Laurel Ward as well as on the more senior leadership of the Trust. We are confident that the ward manager and her team will be able to maintain their high standards of care through the immediate period of change in the senior management chain.

At the same time we hope that the Trust will reflect carefully on the individual comments we received of a more critical character. We wish to highlight the need for patients' concerns to be listened to with empathy, particularly in the first few hours of admission. In addition we suggest some specific ideas for improvement, concerning 1:1 time. real-time feedback, meals and the carers support group.

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 bodes 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 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 Laurel Ward 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. After visiting Ward 2 (see separate report) we asked to see another acute adult ward as a point of comparison and the Trust suggested that we should visit Laurel Ward.

2.0 Background

2.1 Purpose of the ward

Although originally designed as a mixed ward, Laurel Ward at Queen Mary's Hospital, Roehampton, is now an up to 23-bedded male acute admissions ward for adults between 18 and 75 from Wandsworth. When demand for beds allows, the ward can be reduced to 18 beds (in line with Royal College of Psychiatrists best practice recommendations) as was the case at the time of our visit.

There is a female acute admission ward, Rose Ward, of similar design close by. Laurel and Rose are the only single sex wards in the 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 or CMHT. The aim of the ward as for Ward 2 and the Trust's other adult acute admission wards 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 admitted are already under the care of a Community Mental Health Team (CMHT), the Early Intervention Team or the Complex Needs Team (for personality disorder) although a few are admitted from A&E or St George's. Such admissions are avoided where possible using a separate assessment suite (Lotus Suite) to try to get people home, under the Crisis and Home Treatment Team as an alternative. About 75% of patients have had a previous admission to a mental health in-patient ward before their current admission to Laurel.

The most common diagnoses for patients on the ward are bipolar disorder, schizophrenia, schizoaffective disorder with a few patients with personality disorder. Although Laurel principally serves the Putney/Roehampton, Central Wandsworth and West Battersea areas, patients from other areas (including Merton) are often admitted depending on bed availability and equally, patients from the aforementioned areas may be admitted to Ward 2 at Springfield or to the Merton ward at Springfield (Jupiter). The Trust is moving in April 2017 from a Borough-based directorate structure to one based on service lines but it remains to be seen whether this will affect the pattern of admissions. Currently patients are admitted as close to where they live as possible bearing in mind other considerations. For example, some patients are admitted to a single sex ward because of their disinhibited behaviour. This could apply to men or women. Most patients are admitted compulsorily, under a section of the Mental Health Act, and often lack capacity when first admitted. Although most admissions are unplanned there are some which are planned, for example for clozapine titration or because of non-compliance with medication in the community. The ward is almost always full and there are normally 2 or 3 admissions weekly.

We were told that the ethnic makeup of admissions to Laurel Ward 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 and the ward seeks to establish this as soon after admission as possible to plan effectively for discharge. We were told that implementation of the Triangle of Care (a set of standards for working with carers developed by the Carers Trust) has increased the number of carers identified.

2.2 Staffing

Trust policy is to have a Consultant Psychiatrist for each in patient ward. Laurel Ward thus has a Consultant Psychiatrist supported by two junior doctors, one of whom is generally a psychiatrist in training (SHO or Registrar) and the other a GP trainee. There is also a Staff Grade doctor (a psychiatrist) shared between Laurel and Rose wards.

There is a ward manager (who has been in post for 7 years)) and a ward administrator. The management chain above the ward manager will change from April with the Trustwide move from

Borough-based to Service line management. Laurel Ward will come under the Acute and Urgent Care Directorate. The nursing staff consist of 2 (qualified) Registered Mental Nurses and 3 (unqualified) Health Care Assistants, all of whom have opted to work long days (7am to 8.30pm), apart from one person who has some flexible working. At night, there are 4 members of staff on duty when the ward is up to capacity and 3 when the ward is reduced to 18 patients (2 qualified staff and 1 or 2 HCAs). At the time of our visit there were vacancies for 1 Deputy Ward Manager and 5 Associate nurses. These vacancies are currently filled by bank staff. Although the majority of nursing staff tend to be female there is an effort to recruit male staff and there are always male staff on duty because behaviour of some patients can be challenging. There is a lot of joint working with Rose Ward with cross-cover provided including between the two Consultants.

There is a full time Occupational Therapist on the ward who sees each patient soon after admission for an assessment, including of their interests, and an activity coordinator.

Laurel Ward, in line with all other wards in the Trust, has a Discharge Co-ordinator. Currently the post is filled by someone with both nursing and social work qualifications who works very closely with the OT.

2.3 Layout and facilities

Laurel Ward is on the first floor of Queen Mary's Hospital, Roehampton, a general hospital which was opened in 2000 having been built under the Private Finance Initiative. Support services, including meals, are provided by a facilities management company, Sodexo.

On arrival at the ward there is admission by intercom into an "airlock". This space is without direct access to the ward except by card-swipe and similarly to exit the ward a card-swipe is needed. This area has a meeting room, a staff room and the Consultant's office. There are also a number of comfortable chairs and a lot of information on the walls including information for carers and information about which cleaning staff, provided by Sodexo are on duty each day.

Inside the ward is light and spacious. The nursing office has a clear view of both the corridor and everyone coming in but also the dining area and quiet room. The facilities include a TV room, a room for computing which doubles as a patient library, an activity room, a beverage bar (open 24 hours), a laundry room for patients (also open at night), a quiet room, a room with exercise equipment and a clinic room. The computer has limited internet access because of previous misuse. There is an outside courtyard which in winter is mainly used by smokers. Patients can also access the hospital gym, but only if escorted. The walls of the corridors have a great deal of information on them arranged in an inviting and easy-to-read way and it appeared to be fairly up to date:

- A photo board with all of the nursing staff and members of the wider multi-disciplinary team shown;
- Information about the Mental Health Act and patients' rights with each section clearly explained;
- The full activity programme;

- A board with information about physical wellbeing, including smoking cessation, detailing the lead nurse for physical health;
- A board showing how the ward is doing on various Trust targets with percentages and bar charts and a comparison with other wards.

In the dining area there is a large whiteboard with the day's allocation of patients to nursing staff. The day's activities are also listed. Leading off this area are the courtyard and other communally available rooms and a corridor leading to the bedrooms. These are arranged in two corridors reflecting the fact that the ward used to be mixed. Each bedroom has a bed, chair and ensuite shower and WC behind a curtain. There is also one "assisted" bathroom.

Under the Trust's longer term estate modernisation programme which will involve the rebuilding of Springfield and Tolworth Hospitals, it is intended to surrender the use of wards at Queen Mary's Hospital.

2.4 Care and treatment

An information pack, tailored to the needs of the ward, is given to patients and their carers on admission. 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. There is a full MDT meeting on a Monday (called a Zoning Meeting but described as a lengthy handover with all of the team present). At this meeting review meetings are planned for the week. Relevant staff from the CMHT and carers (if the patient agrees) are invited to review meetings.

While on the ward each patient has a named nurse who coordinates their care. The role of the named nurse, as the person to whom each patient could turn to discuss his plan and sort out issues of importance from admission through to discharge, was strongly emphasised to us. The named nurse is responsible for care plans. Each patient receives a copy of his care plan, on yellow paper, and updates following reviews. It is recognised that this person will not always be on duty and also that patients may build positive relationships with other members of staff, including nursing assistants. 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 in RiO (electronic patient records) as "1:1 with named nurse" and this is audited monthly and discussed in supervision. Patients can ask for a different named or allocated nurse if they have better rapport with one person rather than another. One to one times may be refused by patients who are acutely unwell and the ward is flexible in how this time is spent to respond to individual needs and engage patients, for example, one to one time may occur over a mealtime (staff eat the two main meals with patients) or over a game of table tennis.

If patients already had a care coordinator in a CMHT, the latter is encouraged to participate in the main planning and review meetings. If they do not have a care coordinator and they will need follow up, the policy is to link with the CMT (or specialist team) and allocate a care coordinator as soon as possible after admission.

Like the rest of the Trust, Laurel Ward endeavours to uphold the standards of the Triangle of Care for working with carers as promulgated by the Carers Trust. The role of Carers' Lead, to whom

relatives can look for information and advice, is currently shared between the ward manager and a staff nurse and this is advertised on the carers' noticeboard at the ward entrance . Visiting is from 4 to 8pm on weekdays and 2 to 8pm at weekends. It can be flexible if necessary to meet carers' needs. A carers support worker run a carers support group for Laurel and Rose on monthly basis to signpost available support for carers

Treatment normally but not invariably includes medication, often one of a range of antidepressant, anxiolytic or antipsychotic medications. The Consultant Psychiatrist also runs a weekly Family Clinic on Friday mornings for carers, family and friends of patients with the psychologist, OT and sometimes a CPN. Two Clinical Psychologists from the Community Mental Health Teams each have a designated session for this ward and visit: one for the family clinic and the other to offer 1:1 time.

Checking on physical health is seen as very important and all patients are assessed on admission by a junior doctor and a nurse. Blood pressure, blood sugar, weight and other factors are monitored regularly and advice on lifestyle and health is considered to be important. A dietician visits the ward regularly. There is a Physical Health Lead who is named on the notice board giving advice on where to find information about physical health issues including smoking cessation. As the ward is sited is in a general hospital blood tests can be done very easily and patients can readily have outpatient appointments in many specialities.

Patients and their carers have access to a computer terminal 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 weekly Community Meeting for discussion on an anonymised basis. The Patient Experience Team for the Trust also receives this feedback and the Lead for that team visits the ward monthly and patients are informed in advance about her visit and can speak to her directly. An advocate (provided by Rethink) visits the ward weekly and someone from PALS comes each month.

The progress of Laurel and Rose wards is discussed at an Acute Care Forum which is held monthly and is attended by service users' and carers' representatives as well as clinical and other staff.

2.5 Activities

The Activity Co-ordinator runs a programme of groups and activities which include a walking group, art group, current affairs group , games session, reflection group, individual psychology group, art group, welfare and benefits advice, open discussion group, creative writing, together with provision of art material, library, guitar, table tennis, board games , dvds, cards, which are available on request for weekend and evenings . Many patients do not like groups and so the Activity Co-ordinator does a lot of 1:1 activity with patients on this ward such as playing games. Activities are discussed in the Community Meeting and also in the Acute Care Forum . The ward has 3 volunteers who come to the ward on a regular basis and are supervised by the OT. Befrienders from Canerows and Plaits, a user-led service in Wandsworth, also visit regularly.

There is also a "shop round" daily where patients can request that things are bought for them and the trolley service, provided by Friends of Queen Mary's, comes 3 times a week with toiletries and snacks.

2.6 Leave and discharge planning

Patients gradually take periods of leave from the ward as part of their treatment and preparation for discharge. As the ward is in a general hospital, all visits outside the ward for patients on section have to be approved as Section 17 leave. This is decided in review meetings. Nevertheless, there are walking outings by the activity coordinator and/or nursing staff each day and some leave may be in the care of family members. Gradually patients build up to having unescorted leave.

The Discharge Co-ordinator is responsible for planning for patients' discharge which should begin as early as possible after admission. The majority of patients discharged from Laurel Ward 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, which the Laurel discharge coordinator attends, to review obstacles to discharge and to notify the Council if the delays are caused by a package of care not being in place. The Council can be required to pay the Trust if a delay in a care package results in a delayed discharge. Lack of an appropriate care package together with a lack of supported accommodation are the principal reasons for delayed discharges although sometimes patients themselves do not feel ready to leave when the team thinks that they are ready. The average length of stay is 4 to 6 weeks. Most patients are followed up by CMHT or specialist teams and they are encouraged to attend the Recovery College.

3.0 Preparations for our visit

3.1 Setup meeting

On 26 January three members of the Enter and View team had a meeting with Ann Traynor, Operational Manager, Wandsworth Service Directorate for the Mental Health Trust, Gina Mogan, Acting Matron for Laurel and Rose Wards and Gaitree Mottram, Ward Manager for Laurel Ward. Ann had to leave early but we spent two hours with Gina and Gaitree and then had a tour of Laurel Ward. Two of the team also briefly visited Rose Ward.

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. In order to minimise disruption to the ward while extending the period of our visit, we agreed to take turns to visit in pairs with a half-hour overlap.

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 of relatives and visitors and any ideas they might have for change and/or improvement.

We revised our interview prompts slightly in the light of our experience visiting Ward 2 at Springfield but we used the same 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.

4.0 Our visits

We visited Laurel Ward as agreed on Wednesday 1 February 2017. One pair arrived at 2 pm and stayed until about 4 pm, while the second pair arrived at 3.30 pm and stayed until about 6.45 pm. We spoke to the Ward Manager and the nurse in charge but we spent most of the time interviewing patients in the quiet room, where we could be in view from the nursing office. Between interviews we were able to observe activities in the communal area and adjoining rooms, including the serving of the evening meal around 5.30 pm. Some of the patients we approached directly in the communal area while others who had expressed an interest in speaking to us came to us in the quiet room or were brought to us by staff. In total we interviewed 8 patients, of whom 5 appeared to be White British, 1 White European and 2 of Black or Minority ethnicity, in the course of the afternoon and evening. Before the second pair left we had a short debriefing with the ward manager. Subsequently to our visit we received comments from two relatives whom we contacted by telephone or email.

5.0 Our Findings

On arrival at Laurel Ward we were told that 5 beds had been kept empty to allow some pipework to be done and that as a result the ward was being run with 18 beds. We got an impression of peaceful, orderly activity with plenty of people about on the ward but no excessive noise or disturbance - although we were told by a few patients and a relative of occasional violent incidents in the recent past. We saw several patients in the dining area throughout our visit. There was a game of Scrabble between patients and the activity coordinator and a student nurse. Some patients were watching TV in the adjacent room. Staff were passing through the ward and speaking to patients from time to time.

The patients who we spoke to had been on the ward for periods ranging from a day and a half to three months. For only two of them did this appear to be their first admission to a psychiatric ward. Four were apparently voluntary admissions, and four compulsory under the Mental Health Act. One patient was very confused but we felt that most of those we spoke to, even though in some cases clearly quite unwell, were able to give us a coherent account of their experience of the ward.

With the exception of one patient who was still shocked and upset by the process of his compulsory detention and admission the previous morning, all those we spoke to seemed generally happy with the ward. Some contrasted it favourably with other wards they had been in at Queen Mary's, Springfield or Tolworth Hospitals, describing Laurel as "luxury " or "the Ritz". Other comments ranged from "fantastic" to "safe", "well run" or "pretty good". At least half of those we spoke to were clear that the ward was helping them to get better. This generally positive assessment of the ward was shared by the relatives we contacted.

We asked about patients' experience of the admission process. Not all we spoke to were able to tell us much about this. But most of those who did (4 out of 5) commented positively: they had been given enough information and had a written copy of their care plan. One patient was critical of his initial reception on the ward: he felt the admitting staff were too focussed on getting him through the process and reacted unhelpfully to his anxieties - it was not until some hours later that the nurse in charge gave him the sympathetic attention which he needed.

Another patient. who was positive about the admission process, reported that when he arrived his room had not been fully prepared and initially smelt of drains (this was we understand reported immediately to Sodexo as it has been an ongoing problem which Sodexo have regularly attended to when reported . He also mentioned a "minor" issue shortly after admission on which he had felt that he was not initially being listened to but the problem was later satisfactorily resolved.

The majority of patients we spoke to seemed to feel well involved in the planning of their care and treatment on the ward as well as in planning for eventual discharge. Two patients mentioned attending the weekly Ward Community meeting and another showed awareness of the Real Time Feedback system, but we did not pursue these topics with most patients.

We asked patients whether they were aware of having a Named Nurse and whether they had the opportunity to talk to staff on a 1:1 basis about any concerns. Almost all recognised that they had a Named Nurse although a few were unclear who this was or gave us names that proved incorrect. Almost all were satisfied that they could talk to staff 1:1 when they needed to. One patient told us that earlier in the day he had been able to get a 1:1 which had helped him resist a suicidal act prompted by his "voices".

More generally, we received positive comments about the staff from virtually all the patients and relatives we spoke to. The most commonly used description was "approachable" but others were "brilliant", "extremely nice", "good people". A relative mentioned the "endless patience" and optimism of staff. A number of nurses were singled out for special mention by several patients. One relative expressed concern that sometimes, particularly in the early afternoon, there seemed to be little interaction between nursing staff and patients. But we observed a number of informal, friendly interactions while we were visiting, particularly around the time of the evening meal (see below).

We asked patients about medication and other therapy, physical healthcare and advice. A few patients mentioned problems they had had with particular psychiatric medications which had led to changing or discontinuing medication. A clear majority confirmed that they received a physical health check on admission and daily checks thereafter. Two patients mentioned physical health issues which had been attended to but not without some delay: one had had to wait for several days before staff found time to take him downstairs to have a problem attended to in the Minor Injuries Clinic but had been able to see the doctor promptly for his chesty cough; another patient had to make a fuss before his back pain was taken seriously and he was prescribed ibuprofen. Two patients said they had seen a psychologist and two others that they had seen a dietitian or been give advice on eating.

The majority of the patients we spoke to (5 out of 8) told us of activities that they took part in on the ward. These included: art, music, dance, exercise, table tennis, board games and watching TV. Some of these were group activities and some 1:1 with the Activities Organiser. Three patients mentioned that talking to other patients was helpful or enjoyable. Only one patient admitted to being bored although the relative of another thought he was bored some of the time and that his needs were not attended to as he did not push himself forward.

Four of the patients we spoke to had been given periods of leave from the ward although in two cases leave had subsequently been disallowed because of deterioration in their state of mind or behaviour. This seemed to have been accepted by the patients concerned.

We heard a mixture of views on the food served on the ward. Four patients were very positive: the food was "brilliant", "always enough" and "enough choice". On the other hand, two patients were negative: one thought the food was "not always very appetising" while another described it as "slush and mush" with little taste. A relative suggested that supplies of basics like potatoes and beans tended to run out so that if you were at the back of the queue you could not put together a meal without mixing together foods which you would not normally eat like that. Finally, one patient who had been on the ward for two months said there was enough to eat but he was starting to find it a bit boring.

On the day of our visit two of the visiting team stayed to observe the evening meal being served at about 5.15pm. This seemed to be an orderly and sociable occasion. Patients lined up to be served from a trolley by a member of Sodexo domestic staff and sat down in twos and threes at tables, apparently where they chose. Once the patients had been served staff were served and sat down with the patients.

After serving was complete we spoke to the serving lady who showed us a clear daily menu pinned up with information about dishes which were vegetarian, gluten free and suitable for those needing a soft diet (although tuna was incorrectly included under vegetarian). There was a choice of jacket potatoes, mashed potatoes and hash browns, cottage cheese, baked beans and chicken nuggets, cauliflower cheese and various vegetables. Most of the food had gone by the time we came to look. We did not notice the dessert choices but there was fruit. The menus apparently follow a regular cycle.

We were told that a lot of take away food was ordered by patients. A relative we spoke to subsequently was concerned about healthy eating, particularly for people on certain types of medication, and suggested that there should, at least in some cases, be a limit on the number of takeaways that an individual could order each week. This could be negotiated as part of a care plan.

Following the evening meal we were told that there was toast available later in the evening, made by ward staff, as the time between supper and bedtime was long.

Finally, we were interested to find out how visitors are received and how the ward works with carers, friends and families. At least half of the patients we spoke to were having regular visits from relatives or friends and there were several relatives visiting during our visit. A few seemed to have few friends or relatives within reach while one said he did not want to be visited by former friends as he was making a new start.

The two relatives we contacted said that ward staff were helpful and did involve carers. One relative, while not aware of the role of Carers' Lead, said the ward manager (who in fact shares this role with one of the nursing staff) often came to say hello and asked for any feedback. This relative was particularly pleased with the arrangements for the Family Clinic on Friday mornings, which they had not encountered elsewhere. This had allowed them 20 to 30 minutes with the consultant who had been very open. They did not however seem to be aware of the support group for carers.

6.0 Our Conclusions

On this occasion our Enter and View methodology, adapted a little in the light of our experience of visiting other wards in the Mental Health Trust, seems to have served us reasonably well and we are satisfied that we have captured an adequate snapshot of Laurel Ward.

We are pleased to be able to report generally very positive feedback about the ward and its staff from patients and relatives, supported by our own observations and impressions. We feel that as a whole the findings set out in the preceding section reflect great credit on the staff and management of Laurel Ward as well as on the more senior leadership of the Trust. We are confident that the ward manager and her team will be able to maintain their high standards of care through the immediate period of change in the senior management chain.

This is not however to ignore or belittle those individual comments we received of a more critical character on which ward and Trust management will we hope reflect carefully.

One theme which seems to emerge from some of the comments is the importance which mental health patients rightly attach to being listened to with empathy at key points in their journey. Admission to a hospital ward is definitely one of the most stressful of these. Staff, whether medical, nursing or otherwise, who are admitting patients or carrying out initial health checks and assessments clearly need to perform their tasks with care and attention in the interests of patients' safety, wellbeing and eventual recovery. But they must be encouraged to save part of their attention for the patient as an individual person with an identity and history of their own and to recognise all the upset and worry that this often forced transition can involve. The first few hours can make an important difference to a patient's perception of what is happening to them and affect their willingness and ability to engage in the recovery process. This is no doubt an issue which goes wider than Laurel Ward but we would like to highlight it for the ward's attention.

We would also like to suggest the following specific ideas for improvement:

- for the ward (and if appropriate, the Trust more widely) to review ways patients and their carers can be made better aware both of the Named Nurse for their stay and of the daily allocation of nursing staff for 1:1 contact, as well as of the benefits to be had from making use of 1:1 time;

- for the ward (and if appropriate, the Trust more widely) to review ways of giving greater prominence to patient feedback systems, including Real Time Feedback, and the benefits of making use of them;

-for the ward to consider with Sodexo facilities management possible ways of identifying and meeting some patients' specific concerns about the choice and availability of food;

- for the ward (and if appropriate, the Trust more widely) to consider the possibility in certain cases of trying, preferably by agreement, to limit the number of takeaway meals ordered where this would be in the best interest of the individual's health and wellbeing;

- for the ward to consider the possible need to advertise the carers support group more prominently.

Disclaimer

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

Revised 6 April 2017