To Whom It May Concern:

I would like to bring forward a number of concerns about Bushey Fields Hospital, located in Dudley, West Midlands. This is a part of the Black Country Foundation NHS Trust, and is located next to Russell's Hall Hospital, which is a part of the Dudley Group NHS Foundation Trust. Although the two hospitals work together in terms of triage, sharing of some staff and patient handover, they are separate in terms of their actual function.

This is a combination of my experiences from three times spent as an inpatient at Bushey Fields Hospital between 2023 and 2024, as well as further input from a number of patients whom have formed a peer support group to try and positively further each other's personal recovery. This concerns two wards in particular, and whilst experiences may be different on the other wards within the hospital, I am of the opinion that these concerns are so serious that they require further detailed investigation and discussion, as there is profound impact on patient care and recovery.

As an NUJ / IFJ registered journalist, I am fully aware of the need for confidentiality, and therefore I have mentioned no names here. Being in an acute mental health hospital is a difficult experience alone without being identified as being a patient in such a situation. For the most part these concerns are a collation of concerns raised by a group of approximately 10 patients whom have been inpatients in the hospital over the above period, some whom are still inpatients within the hospital, further prompting the need for confidentiality. Where the experiences are my own alone, I have highlighted as such, though the majority of the points listed below have been experienced or observed by all patients within the group.

Whilst a lot of negative concerns are listed below, it must be stressed that there are a number of fantastic staff who work at the hospital, from Domestics, Healthcare Assistants, Nurses, to all levels of Doctors. I highlight how some of these staff however are forever hitting their metaphorical heads against a brick wall due to chronic understaffing, a lack of resources, and in some cases staff who seem to be there to 'make up the numbers', whom show little regard towards patient care. As I have always said, whilst a mental health hospital is not a hotel, it is after all a space for treatment,

and the first steps towards mental health recovery, with other aspects of recovery working alongside this.

No patient on a mental health ward is perfect, else we wouldn't be in such a situation, but the concerns raised here focus on some common aspects of patient dignity and basic principles of care and support. It considers the fact that patients shouldn't have to settle for a life of mind-numbing TV, a very limited range of activities, and a bed for the night. In fact, the reason why we formed a peer support group is ***because*** of the lack of support and engagement to help within our recovery, both as an inpatient, and at times once discharged.

Being a university lecturer by trade I have not only taught but championed peer support groups, and they are a fantastic way of allowing those in similar situations to provide support in a way that others may not understand; after all, there is a reason why groups such as Alcoholics / Narcotics / Cocaine Anonymous work. Yet, it shouldn't be the case that patients feel that their main support mechanism is another / a group of other patients, as at a time of crisis specialist support may not be available, and there could be a situation where potentially wrong advise could be shared, even if in good faith.

Whilst the below is a long list, it is not exhaustive. I have tried to limit it to issues that impact patients as a whole as agreed within our peer support network, rather than providing a list of personal gripes, but each of these are deemed serious and impactful enough that they simply cannot be ignored. Especially with chronic funding issues within the NHS there are some things which are simply accepted as being a part of this. There is also the under-reported but important impact on mental health hospital services as a result of both the early release of prisoners, combined with the fact that one of the last passed laws of the previous Conservative Government meaning that those on probation stop seeing their probation officer once two thirds of probation has been completed meaning that some on probation lose what otherwise may be a support network for them.

Yours truly,

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Staffing Issues & Staff Mobility

- Most wards are severely understaffed in terms of Healthcare Assistants (HCAs), often having to rely on either bank or agency staff. There is a strong degree of credit to those who are employed full time to work on the wards, as they often do generate positive relationships with patients, even those who present more verbal or physical abuse to staff, however the use of bank / agency staff can cause more harm than good to patients.

  I was involved in one such incident where bank staff failed to recognise that a patient suffers from intermittent psychotic episodes, and failed to appropriately de-escalate the situation. This led to me being inadvertently attacked by the patient, causing a serious wound to my head. Had a full time member of staff been in the area at the time, this would almost certainly not have escalated.

  The hospital uses an observation system of 1 – 6.

  - Level 1 observations require a patient to be accounted for every hour
  - Level 2 observations require a patient to be accounted for every 15 minutes. Patients who have recently been admitted are on Level 2 observations as standard until they have had a full doctor's review.
  - Level 3 patients require an HCA to be within sight of a patient at all times.
  - Level 4 patients require 2 HCAs to be with a patient at all times
  - Levels 5 and above are extensions of Level 4, just with more staff, and closer contact, such as within arms reach.

  On one ward, there are often a number of patients who are on Level 3 observations and above. In addition, it is not always possible for staff to be allocated to certain patients, for example if they have demonstrated violent or sexual behaviour towards them. On multiple occasions, staff have confided that if there were to be two fights going on at the same time on a ward, it would be impossible to respond to both at the same time.

  On another occasion, an HCA staff member attempting to make a staffing rota for the day conceded that it was impossible with the number of staff they had, number of patients on Level 3 and above observations, and the restrictions in

place in terms of staff / patient parings. On this occasion, the HCA requested for support from either another ward or agency, and whilst being promised that there would be more staff by noon, the advert for agency staff did not go out until past 1PM. This meant that staff were unable to have breaks, and the chronic understaffing meant that there was no way they could respond to any incidents in real time.

Some, but not all bank and agency staff fail to engage with patients. There have been numerous times when agency staff in particular sit around completing colouring activities / crosswords etc and essentially feel as if they are there to make up the numbers. When challenged, they have said 'Well, you are always welcome to join us'. Meanwhile, full time staff are unable to fully engage with patients due to the need to attend reviews, or have one to one sessions with patients.

- Further to this point, there have been a number of situations I and others have observed where staff are too scared to raise concerns, especially if they were bank staff who worked primarily on a specific ward. This has included racist, homophobic and sexual language and behaviour towards staff, including at points actions verging on sexual assault. Not only do staff feel as though they are not able to raise concerns with senior staff, they feel as though they are unable to fully confront patients on such behaviour for fear of reprisal or escalation.

<u>Ward Hygiene, Safety, Maintenance.</u>

- There is often a severe lack of hygiene on wards. This ranges from the lack of basic sanitary products such as hand soap, hand wash towels, toilet paper, and in some cases towels to have a shower. When supplies run out or are damaged by patients, staff often say that there is nothing that they can do until the cleaners next arrive, which could be up to 12 hours away.

  There is little consideration over cross contamination in a number of areas. As an example, some patients (*who often have little / no money*) would pick up cigarette ends off of the floor in the communal courtyard (*A process colloquially*

known as nubbing) and then ask staff to light it for them, a practise which is rarely challenged. These same patients would then utilise the communal kitchen which contains tea, coffee, bread and cereal, and would handle such products without washing hands or showing any sense of personal hygiene. Again, this is rarely challenged, and along the way patients often touch multiple surfaces such as door handles, mugs etc.

- Between the hours of 7PM and 7AM when the domestics are on duty, little regard is given to hygiene in terms of lavatory and shower provisions. Staff (*Especially agency staff*) have repeatedly told patients that there is nothing they can do, and this often impacts negatively on patient moral and wellbeing in their recovery, especially for those who may conditions which are triggered by such environments.

- There have been a number of instances when I have been an inpatient where damage to patient's windows / doors has not been fixed. In the instance where I was attacked, there was damage to my bedroom window. The only fix that was conducted at the time was to put some tape over the area which was impacted, and there were still shards of glass in the outside window roller area one week later, which could have caused harm to a patient via self-harm or other means.

  In another instance, two ward outside facing windows were broken on the same day. The only repairs that were done were to install wooden boards over the windows, meaning both that the patients were unable to get fresh air into their rooms, they also lost a considerable degree of sunlight. At time of writing, these repairs were not completed under the guise of patients being moved to another ward in the immediate future (*soon™*).

- In a situation where patients are potentially in a mental health setting in part due to previous violence / poor home living conditions, this poses both a risk to a patient in the fact that they stop feeling safe, and also could cause PTSD like symptoms. In fact one patient was so scared after this incident that despite being able to move rooms, they no longer felt safe in their room at all, and spent

the majority of their time in the ward communal area, too scared to go to their room even to go to sleep.

- Some of this damage has the potential to cause serious issues in the event of a fire. Patient doors are supposed to be FD30 rated, meaning that in the event of a fire, a patient's door should be able to withstand a fire for 30 minutes, allowing them to shelter in place. Whilst some damage had been caused by patients putting items over their doors in order to avoid them locking (*the ward in question at the time had almost no key cards for doors, meaning that patients had to ask staff for access to their rooms*), others were simply due to historic wear and tear, not rectified by maintenance staff. In addition, staff actively prop open the fire door which leads to the outside communal area, which had damaged the door on one ward to the point it had to be completely re-hinged. In the event of a fire, there is the risk of catastrophic injury, especially for those patients who have mobility needs, or whom are illy advised to shelter in place.

- Damage on the rest of the ward itself is also not rectified in an expedient manner. On one occasion most of the hand sanitiser / soap dispensers and hand towel dispensers were damaged by a patient, however there was no remedy for a number of days. One staff member commented to a patient that 'If we put them back up, they will only be torn down again. This is often an attitude of staff, where many patients have to suffer for the actions of a few.

<u>Drug Use On Wards</u>

- Despite there being a locked door policy, and patients being searched upon entering the ward, there is still a drug problem within the wards which I have been a patient on. A number of patients have been able to smuggle drugs in on their person, and because of the fact that the communal outdoor area is not always monitored, there have been a number of instances I and other patients have witnessed where drugs are passed through the outside fence. This can be from very blatant examples, to more covert attempts, especially late at night and in the early hours of the morning. Although there is drug testing, and there have been occasions when specialist drugs dogs have been brought onto the

wards, the issue remains, especially for those on section who cannot just be discharged for failing to comply with hospital policies.

- There have been a number of occasions where patients have either been offered, or have asked for drugs, including controlled medication, and there have been times when patients have witnessed other patients *cheeking* medication to give to others. Even when this is raised to HCAs / Nurses, in the majority of cases little / no action is taken. On more than one occasion, staff have either just shrugged their shoulders, or simply said 'What do you want me to do about it?'.

Patient Mobility & In Ward Environment

- Although informal patients are in theory allowed to leave the ward at any time, this is often not the case. Signage on the ward states that patients may choose to leave the ward for an hour, a few hours or more, but there are both unwritten restrictions, and also an abuse of 'patient duty of care' to restrict patients from leaving wards. There is a process known as 'The 5 C's', which should be used to assess if a patient is 'safe' to leave the ward, but this can be manipulated / abused depending on specific patients / nurse's mood. This has led to a number of occasions where patients are unduly delayed from leaving the ward, or arbitrarily kept on the ward for the sake of either not being bothered to complete the necessary paperwork for a patient to leave the ward, or what seems to be some form of 'patient punishment'.

  In some cases, care plans and discussions with doctors may suggest that as part of patient rehabilitation patients should be allowed to leave the ward unaccompanied to assess how they would fare in a 'community' setting, however patients have both been harassed, intimidated, and lectured beyond what would normally deemed appropriate. In addition, nurses have chosen not to allow patients off of the ward without providing a detailed explanation why, and do not allow patients to speak to a duty doctor to further assess a situation. Furthermore, night staff do not let patients off of the ward, even if it is written in a patients care plan that they not only have the right to, but a need to do so.

- Overall, ward ‘rules’, seem to vary without reason or rationale. Patients are supposed to receive a welcome booklet, outlining ward procedures, but on my three times at Bushey Fields Hospital, I have yet to receive one, and I am not aware of any patients receiving one. This often leads to confusion amongst patients, and staff members being free to make up / interpret things on the spot, and there is often a complete lack of consistency when it comes to sometimes even the most basic of things such as being allowed to have shower gel within a patient’s room. Myself and a number of other patients have also been in situations where invented rules seem to be used as a form of punishment if one were to complain about any aspect of patient care.

- Often, it seems as though nurses in particular are more like school headteachers rather than nurses to support patient care. Especially in a mental health setting where patients may not be able to communicate in the easiest way, or are more akin to get easily agitated or frustrated (*even if there is no verbal / physical abuse towards staff*), it is as if staff treat patients as below them in a number of cases (*NOTE: This is NOT all nurses, but in particular agency nurses, or those working at weekends*). It is as if patients are almost treated as children, and I personally have been berated for not looking a nurse in the eyes when I am talking to them, even though this is a long-standing personal trait of mine, especially considering my pre-diagnosis for Autism and other conditions. At points, it is almost as if nurses are almost bullying and berating patients for being who they are, and are expecting patients to conform to a pre-defined mould. In a mental health setting in particular, such actions can have a negative impact which either ruins a patient’s day, or means that patients simply give up trying to engage with nurses.

- Outside of MDT reviews, there is often little opportunity for patients to discuss any mental health concerns they have, due to the nature of there being so few staff on the wards. Patients are supposed to have a one-one with a named nurse and a HCA every week, but a number of patients don’t know who their named nurse is, let alone have the opportunity to have a conversation with them. Due to the nature of nurse working schedules, there is often little opportunity to have a full conversation with some nurses, even though they are

desperate to find the time to do so. On the flip side, there are some nurses (*most particularly agency nurses*) who go out of their way to ignore patients. As both the nurse's office and clinic room are locked, some patients have adopted a 'knock, wait and hope' approach to asking even the most basic of questions to some nurses, let alone a full conversation.

- Having spoken to nurses and student nurses who have worked at other trusts, they have said that there is normally a phycologist on the ward every day, which would provide patients with an opportunity to discuss any immediate concerns that they may be having that would affect their mental health on a day-to-day basis, rather than having to potentially wait up to a week to speak to a doctor. Unless a patient has the luck to find a member of staff who has the opportunity to find time to spend with them, they are often left to fester within themselves, meaning that they become withdrawn, and in some cases simply retire to their rooms. On a number of occasions, this has led to patients considering / acting on self-harm / suicidal thoughts.

- There is often very little for patients to do on the ward. Whilst there is a TV and provision of board games / colouring activities, anything else often relies on occupational therapists, who themselves are often stretched to breaking point. For those patients who are not under a section, there are two activities that take place in 'The Hub' Monday – Friday, though there are no such activities at the weekend. Those on section are generally not allowed to leave the ward to attend such activities, and therefore are essentially forced to make do with what is on the ward. Whilst most wards do have an activity room, it requires an HCA to be present, which as noted above often is not possible.

- This situation is exacerbated at weekends, when often there is little for patients to do at all. As staffing levels are both often lower at weekends, and with less full time staff, those patients under section whom have leave to go accompanied to the local shop are unable to do so due to the lack of staffing resources.

Staff Accountability

- There is often a lack of staff accountability on the ward, especially when it comes to staff handovers. Although there is supposed to be a robust noting system called Rio, there have been numerous occasions when myself and other patients have been assured that something has been handed over when indeed it has not. This has included the requirement for patients to see a duty doctor for physical medical needs, with patients either waiting for a doctor which had not been handed over properly, or having to request this again. In an establishment where a number of patients suffer already with anxiety, autism and associated mental health conditions, this places additional burden and stress on them.

- When points such as this are raised to staff, the common response is often “It’s not my problem”, or “It wasn’t handed over, so there’s nothing I can do”. When asked whom should be held accountable for such failures, it is often the case that no one is willing to take responsibility, even when there is a band 6 on duty. This impacts massively on patient’s perception of care and how they feel as a patient, in some cases feeling as though they are being a burden on the system. I personally have felt on numerous occasions that I did not feel welcome or wanted on the ward as a consequence of this, to the point that I have felt it would be better for me to discharge myself due to how low such experiences have made me feel, and other patients on the ward in the time that I have been on have felt the same.

- Where staff are more apologetic and recognising of the impact of patients, they themselves often come up against a brick wall in terms of trying to unpick a situation, causing further unnecessary work for staff meaning that they are unable to spend quality time with patients. This often leads to a situation where patients simply give up perusing such issues, knowing that there is unlikely to be any outcome or recourse.

- On at least one occasion, a patient’s clothing was given to another patient, due to the fact that the original patient in question didn’t pick it up from the drier in time, in part due to reasons listed above. Clothes washing facilities are behind a locked door, and therefore a patient must request access to it from staff. When there are multiple patients requiring washing facilities of this regard often

clothes are just dumped on top of the drier, as patients do not have individual wash baskets, and in this case it was assumed that the clothes of a patient were ‘donated’ clothes, when this was not the case. The patient was forced to take it into their own hands to retrieve their clothes.

- I personally had a situation where I was forced to go to the Outpatient Diabetic department at Russell’s Hall Hospital to get them to confirm that I utilise ‘Carb Counting’ to determine my short acting insulin, rather than taking a specific dose. This is despite it being clearly written in my discharge summary from Russell’s Hall Hospital (*Where I was an inpatient before being transferred over to Bushey Fields*), stating that I titrate my own insulin, which also had a dosage range. I was told ‘Because you are a patient with suicidal intention you could easily ask for too much’, yet by giving me an unacceptably low ‘fixed’ dose, it actually posed ***more*** of a risk to my physical diabetic health, impacting on my gout and neuropathy.

  Also, requiring me to leave the security of the ward at an early stage of my mental health recovery to fix this issue that should have been sorted out my nurses also had a negative impact on both my physical and mental health, counteracting any point that could have been made. Staff were simply unwilling to work to fix this issue themselves, and whilst it is appreciated that mental health nurses receive less diabetic training than general Staff Nurses, the situation overall provided the potential for a serious and dangerous incident.
- In another personal incident, I was told that I couldn’t have my wheelchair / walking stick on the ward, despite having diabetic neuropathy, gout and other issues in my legs. I was told that it was because of ‘infection control’, and because *their* OTs had not done an assessment on me, despite having been assessed various times. Upon further investigation, I discovered the real reason was because my named nurse had not bothered to complete a Personal Emergency Evacuation Plan (PEEP) for me, which is a requirement when someone has mobility aids. A nurse confided in me that there was no PEEPs done for anyone on the ward at the time of me discovering this, which as well as being a lack of staff accountability, is a massive health and safety risk.

- Patients are neither allowed to request a change of doctor, nor ask for a second doctor opinion. The response to the later is that in most cases a patient sees more than one doctor in an MDT, however as they are a junior doctor and part of the same team, it's unlikely that a difference of opinion would be vocalised, and patients are normally asking to speak to a different consultant, rather than a doctor at large. This means that there can be a lucky dip in terms of patient allocation, with no way for a patient to verbalise their concerns if they truly believe that a doctor is not treating them with dignity / respect, or fully understanding the reasons why they ended up on an acute mental health ward in the first place. In general hospitals patients have the right to a second opinion (*Martha's Rule*), but this seems not to apply in a mental health capacity.

<u>Discharge Planning and Discharge</u>

- As mentioned previously, every patient has a weekly review with a named Doctor, often with Junior Doctors assigned to them, a nurse from the ward, and other partners involved in patient care. Often, a line patients (*including myself*) hear is that preparations towards discharge starts almost immediately, as the best care is provided in the community.

- Every patient should have a care plan. This should be a living document, updated as a result of conversations with staff whilst on the ward, in particular during nurse and HCA one to one sessions. Often patients don't even realise that they have a care plan, let alone having seen one. In cases that they have, a number of patients have noted that they are either vague, or simply copy and pasted from a template. On one occasion where this was clearly the case, the nurse responded back to the patient 'Oh, we just do that to test that you've actually read it'. These documents are supposed to be specific in terms of ensuring that a patient's needs are met whilst in hospital, and also to provide an aide-memoire to all parties as a patient moves closer towards discharge, however are not being completed correctly.

- In some cases patients have been provided with a phased return back into community living, starting with say a day off the ward, then a weekend, then a week before discharge, which seems like an appropriate way not only to adjust

back to living in the community, but also to help via MDT sessions assess and address any issues that may be causing triggers or barriers that may impact in the short – medium term. This is in my opinion not only a structured approach, but one which should be recognised as a best practice approach to avoid the potential risk of cyclical re-admission cycles.

- This however is not always the case, and in other cases patients are told simply 'We'll be discharging you this time next week', or 'We'll be discharging you later this week', not allowing a patient to fully get ready to fully re-integrate themselves back into community. I am of the personal opinion that doctors in particular forget that moving from a ward environment back into the community, even after a short stay in a mental health facility can be a big shock, especially if there is no support waiting for them on the other side. In a number of cases a patient has been allocated either a Care Co-Ordinator, Community Psychiatric Nurse, Social Worker *etc.* but this is not always the case. Furthermore it is not always the case that a clear contact plan is put in place post-discharge, so that patients have a clear understanding as to how their care will continue.

- In the same way that there seems not to be any welcome literature / support onto a ward environment, there does not seem to be a uniform discharge procedure off of the ward. Often patients are left waiting for hours for medication (*Which, where a patient requires temporary / emergency accommodation can have an impact on being able to reach relevant services on time*), and there is no real sense of full, documented discharge summising with a patient. As one patient said "It's like being kicked out of a hotel room and forced to just wait in the lobby."

- Patients do not receive a discharge summary, in comparison with the vast majority of general hospitals. Upon requesting one, I personally have been told that it would be sent to my GP, whom had not received it 3 weeks later in one case, and the lack of a discharge summary both makes it more complicated in terms of being able to provide evidence to employers / benefit agencies, as well as meaning that a patient has little – no recourse in the event that actions discussed withing MDTs in particular are not acted upon.

- As a personal example, I was told that the reason for my discharge was that there would be a package of care for me in the community, which I waited 3 weeks for. After starting to make enquiries as to when this package of care would start, I found out that each of the elements discussed were not included, and that I would need to be re-referred in order to receive a new CPN. Without a discharge letter, I have had no option but to do an FOI request for my notes, in order to ascertain what was written about me, alongside the outcomes of my MDT, to which both myself and a chaperone agreed that there would be full community care in place.

- Where patients do have a care plan, it states that they will be given 14 days worth of medication upon discharge, whereas in fact often patients are only given 7 days worth of medication. This creates a sense of immediacy to get further medication from a GP, but creates issues as an electronic pharmacy record may not be sent in time to enable a GP to order said medication, send it to a pharmacy, and have it ready for collection on time, especially if a patient needs pill boxes rather than standard blister packs. This has led to some patients running out of medication that clearly states they should not stop taking abruptly, and in some cases causes the risk of severe physical injury / damage (*for example epilepsy, dementia medication etc.*).

- A lot of these issues lead to what could be known as the ‘revolving door’ process, where patients are discharged either too early, or without adequate community care in place, which impacts on their health whilst out of hospital, leading to further crisis’s, then requiring admission back to either an Emergency Department, a Section 136 place of safety, or back to an acute mental health ward. Each of these of course costs the NHS considerable outgoings in terms of ambulances and times in Emergency Departments, but at times it seems that some doctors are more concerned about patching patients and moving them on, rather than trying to look to address more of the underlying phycological and socio-environmental reasons behind an admission in the first place, which could help in reducing repeat admissions.