Essex Partnership University NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age	Basildon Mental Health Unit (MHU)	R1LY9
Acute wards for adults of working age	Broomfield Hospital Mental Health Wards	R1LX7
Acute wards for adults of working age	Chelmer and Stort Mental Health Wards	R1LX9

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We did not rate this service because this was a focussed inspection.

- Staff had not embedded lessons learned from a serious incident, into practice despite managers sharing learning. This led to another serious incident, with similar circumstances, occurring at the Basildon Mental Health Unit. There were also inconsistences with staff knowledge of general risks on Thorpe ward, where staff had no knowledge of previous incidents relating to ceiling tiles.
- All wards had periods of understaffing. Between 01 January 2019 and 31 March 2019 the provider failed to fill 98 nursing shifts and 110 health care worker shifts. Both staff and patients felt wards were understaffed particularly at the Basildon Mental Health Unit.
- The trust used two different databases across the north and the south locality but despite the trust having a platform to share patient information across both areas, not all staff used this effectively and told us of problems with accessibility
- The trust made several improvements with regards to patient safety, however there were still issues with the environment. Managers had not identified all potential ligature anchor points in ligature risk assessments. Managers had not completed mitigating action plans for some ligature anchor points on Grangewaters ward and Thorpe ward. Staff we spoke to on all three wards at the Basildon Mental Health Unit had a lack of awareness of some of the anchor points present in the environment.

However:

- Staff worked in collaboration with patients to plan their discharge and started discharge planning at the right time. We saw examples robust and detailed discharge plans. The trust employed staff specifically to support patients moving on from hospital and we saw evidence of staff supporting patients with visits to the community in relation to their housing.
- Staff showed openness and transparency when things went wrong. Staff knew what incidents to report and how to report them. Staff felt supported after incidents and received a full debrief from managers. Senior management conducted thorough investigations and shared lessons learned with all staff through bulletins, emails and monthly team meetings.
- Staff assessed, monitored and reviewed risks to patients regularly. Staff completed detailed and individualised risk assessments and care plans with patients and patients were involved in creating 'my care, my recovery' plans to manage their own risks.
- The provider conducted the appropriate checks when using bank and agency staff. The provider used a staff bank that worked with agencies that complied with pre-employment checks such as Disclosure and Barring Service, right to work, mandatory training etc. The provider also used a system to ensure staff did not work more than 60 hours per week within the trust.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of the services.

Are services safe?

We found:

- Staff had not embedded lessons learned from a serious incident, into practice despite managers sharing learning. This led to another serious incident, with similar circumstances occurring at the Basildon Mental Health Unit. There were also inconsistences with staff knowledge of general risks on Thorpe ward, where staff had no knowledge of previous incidents relating to ceiling tiles.
- The trust used two different databases across the north and the south locality but despite the trust having a platform to share patient information across both areas, not all staff used this effectively and told us of problems with accessibility. This meant that when patients transferred to different wards, staff could not always identify previous risks when patients transferred between wards.
- The décor in Thorpe ward was poor, walls had peeling paint and dormitories smelled of urine. Bathrooms on Thorpe ward had mould on the walls. Both Thorpe and Grangewaters ward had dormitories which had a strong smell of cigarette smoke.
- All wards had periods of understaffing. Between 01 January 2019 and 31 March 2019 the provider failed to fill 98 nursing shifts and 110 health care worker shifts. Both staff and patients felt wards were understaffed particularly at the Basildon Mental Health Unit.
- Chelmer, Stort, Galleywood and Finchingfield wards were all single sex and patients had their own bedrooms. However, Basildon Mental Health Unit did not comply with guidance on eliminating mixed-sex accommodation. All wards within the unit were mixed sex. Thorpe and Grangewaters ward had dormitories which the trust has plans to eliminate by 2021. During our inspection three females and one male were using the swing beds on Basildon Assessment Unit. Therefore, female patients had to walk past male bedrooms to access the shower and toilet facilities, which impacted on patient privacy and dignity.
- Managers had not identified all potential ligature anchor points in ligature risk assessments. On the Basildon Assessment Unit, managers had not identified anchor points such as; wardrobes, television boxes and light fixtures in bathrooms. On Grangewaters ward, managers had not identified taps in the ligature risk assessment and on Thorpe ward, managers had

not identified ceiling tiles or exposed lightbulbs as ligature anchor points. Both ligature risk assessments on Thorpe and Grangewaters ward were out of date, however the matron informed us that new ligature risk assessments were awaiting approval.

- Managers had not completed mitigating action plans for the television box on Grangewaters ward and for lights and taps on Thorpe ward. The staff we spoke to on all three wards at the Basildon Mental Health Unit had a lack of awareness of some of the anchor points present in the environment.

However:

- Staff showed openness and transparency when things went wrong. Staff knew what incidents to report and how to report them. Staff felt supported after incidents and received a full debrief from managers.
- Senior management conducted thorough investigations and shared lessons learned with all staff through bulletins, emails and monthly team meetings.
- Staff assessed, monitored and reviewed risks to patients regularly. Staff completed detailed risk assessments and included positive behaviour plans for patients to manage risk in the least restrictive way. Patient care plans also included management of risks and least restrictive interventions to administer care. Patients were involved in creating 'my care, my recovery' care plans to best manage their own risks.
- The provider conducted the appropriate checks when using bank and agency staff. The provider used a staff bank that worked with agencies that complied with pre-employment checks such as Disclosure and Barring Service, right to work, mandatory training etc. The provider also used a system to ensure staff did not work more than 60 hours per week within the trust.

Are services effective?
We did not inspect this domain.

Are services caring?
We did not inspect this domain.

Are services responsive to people's needs?
We found:

- Patients we spoke to, felt involved and aware of their discharge plans. Discharge plans we looked at, were thorough, robust and showed evidence of patient involvement. The discharge team

encouraged discharges to take place early in the week and not on Fridays. Discharge coordinators felt involved by the ward and had good connections to the local authority, housing and benefits services.

- Staff supported patients to maintain contact with their families. We looked at discharge plans and saw family involvement. Ward managers also ensured patient visiting times were flexible to accommodate schedules of family members.
- Most patients said the food was of a good quality and they enjoyed eating in the hospital serveries where they had a variety of choice, including vegetarian options. Patients could make hot drinks 24 hours a day and staff provided healthy snacks for patients such as fruit.
- Patients knew how to complain and felt empowered to complain. Patients we spoke with were aware of the advocacy service and felt comfortable speaking with both staff and advocates to discuss any issues on the wards.
- Patients were individually risk assessed to use their own mobile phones and access social media.

However:

- Grangewaters ward did not have enough rooms to facilitate family meetings. Family meetings took place in communal lounges or multi-faith rooms which restricted patient use of the multi-faith rooms or impacted on privacy when meetings took place in the communal lounges.
- Staff had not informed informal patients of their rights on Thorpe and Grangewaters ward. Patients informed us that they could not leave the ward without a doctor's authorisation. Staff did not record giving informal patients their rights in patient notes reviewed on Thorpe and Grangewaters ward.

Are services well-led?

We did not inspect this domain.

Summary of findings

Our inspection team

The team that inspected the service comprised two inspection managers, six inspectors and one nurse specialist advisor and one social work specialist advisor with experience of working on mental health acute wards.

Why we carried out this inspection

We carried out this unannounced inspection, following a number of concerns raised by various sources to the Care Quality Commission about the care and treatment of individuals on acute wards. The concerns included how staff managed patient risk and how staff supported patients when they were ready to be discharged from hospital.

How we carried out this inspection

We have reported on some of the key questions in safe and responsive. As this was a focused inspection, we looked at specific key lines of enquiries in line with concerning information received. Therefore, our report does not include all the headings and information usually found in a comprehensive report. In addition, any data looked at as part of this inspection, only related to the acute wards inspected.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited Basildon Assessment Unit, Thorpe, Grangewaters, Stort, Chelmer, Finchingfield and Galleywood wards and looked at the quality of the ward environments. We also briefly checked the Kelvedon unit but did not inspect this unit.
- spoke with 20 patients
- spoke with two associate directors
- spoke with 37 other staff members; including consultant psychiatrists, psychologists, occupational therapists, housekeepers, modern matrons, discharge and flow coordinators, ward managers and nurses.
- spoke with one advocate
- attended and observed five multi-disciplinary meetings
- attended and observed one joint safeguarding meeting
- attended and observed one community meeting
- attended and observed one therapy group
- observed three situation report (SitRep) phone calls
- examined in detail, 55 medication cards
- examined in detail, 50 patient records
- examined in detail one seclusion record
- spoke with the manager for the staff bank

Information about the provider

Essex Partnership University NHS Foundation Trust (EPUT) was formed on 1 April 2017 following the merger of North Essex Partnership University NHS Foundation Trust (NEP) and South Essex Partnership University NHS Foundation Trust (SEPT).

EPUT provide community health, mental health and learning disability services for a population of approximately1.3 million people throughout Bedfordshire, Essex, Suffolk and Luton. Their services include: mental health, community health, learning disabilities and social care.

There are 14 wards for this core service at five locations in Essex. In total there are 192 acute ward beds for patients.

Summary of findings

They are registered with the CQC for the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act

Acute wards visited:

Basildon Mental Health Unit

- Mental Health assessment unit is a 20 bedded, mixed sex ward
- Thorpe ward is a 20 bedded, mixed sex ward
- Grangewaters ward is a 28 bedded, mixed sex ward

Broomfield Hospital Mental Health Wards

- Finchingfield ward is a 17 bedded ward for men
- Galleywood ward 18 bedded ward for women

Chelmer and Stort Mental Health Wards

- Chelmer ward is a 16 bedded ward for women
- Stort ward is a 16 bedded ward for men

What people who use the provider's services say

- We spoke with 20 patients across the seven wards we visited. Most patients felt safe, respected and cared for by regular staff on the ward.
- Patients who were ready for discharge, felt prepared and involved in their discharge plans.
- Patients were happy with the level of communication and involvement from staff.
- Five patients felt staffing levels were too low and night staff were rude and unapproachable.
- Patients across Basildon Mental Health Unit and Chelmer and Stort wards complained about televisions not working.
- Patients at Basildon felt there was a lack of private space to see to families. Staff asked for visits to take place in the multi-faith room or communal lounge which impacted privacy and restricted patient use of the multi-faith room.
- Patients also felt there was a lack of privacy with dormitory accommodation and a lack of activities on the weekend.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure they meet their safe staffing levels across all wards.
- The provider must ensure that all blind-spots are mitigated, and all ligature points are identified and mitigated against on the ligature risk assessments.
- The provider must ensure that all wards are clean and well maintained.
- The provider must ensure that they comply with guidance regarding mixed sex accommodation.
- The provider must ensure that all learning is embedded in practice where incidents of the same nature keep occurring.

Action the provider SHOULD take to improve

- The provider should ensure that informal patients are aware of their rights to leave the ward.
- The provider should ensure staff are competent and confident using the health information exchange system, to ensure patient information is shared across services when required.

Essex Partnership University NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

- The responsible clinician discussed section 17 leave of absence with the patients in the ward rounds and at other times during the week. Leave was authorised regularly by the responsible clinicians.
- Staff knew the location of the Mental Health Act administrators but not who they were.
- Mental Health Act paperwork was discussed in morning meetings.
- Consent to treatment forms were attached to medicine cards for all patients.
- Patients had easy access to information about independent mental health advocacy and the advocate visited the wards regularly.
- Staff requested an opinion from a second opinion appointed doctor when necessary.

Mental Capacity Act and Deprivation of Liberty Safeguards

All patients were detained under the Mental Health Act. No patients were subject to a Deprivation of Liberty Safeguards application or authorisation.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Our findings

Safe and clean environment

- The layout of the of most wards allowed staff to observe all parts of the ward. However, we found additional blind spots on both Thorpe and Grangewaters wards which managers had not mitigated with convex mirrors.
- Managers needed to update ligature risk assessments on a six-monthly basis. However, both ligature risk assessments on Thorpe and Grangewaters ward were out of date. The matron informed us that new ligature risk assessments were awaiting approval.
- Managers had not identified all potential ligature anchor points in ligature risk assessments. On the Basildon Assessment Unit, managers had not identified anchor points such as; wardrobes, television boxes and light fixtures in bathrooms. On Grangewaters ward, managers had not identified taps in the ligature risk assessment and on Thorpe ward, managers had not identified ceiling tiles or exposed lightbulbs as ligature anchor points. Managers had not completed mitigating action plans for the television box on Grangewaters ward and for lights and taps on Thorpe ward. The staff we spoke to on all three wards at the Basildon Mental Health Unit had a lack of awareness of some of the anchor points present in the environment.
- Chelmer, Stort, Galleywood and Finchingfield wards were all single sex and patients had their own bedrooms. Thorpe and Grangewaters ward had separated male and female dormitory accommodation for patients. The Basildon Assessment Unit did not comply with guidance on mixed-sex accommodation. During our inspection three females and one male were using the swing beds on the unit. Therefore, female patients had to walk past male bedrooms to access the shower and toilet facilities, which could impact on patient safety.
- Staff carried keys and personal call alarms issued by reception at the start of each shift. There were call button alarms located in each of the bedrooms on the wards.
- The Basildon Assessment Unit, Chelmer, Stort, Grangewaters, Galleywood and Finchingfield wards were clean and well presented. However, Thorpe ward had paint peeling off the walls in certain areas and dormitories smelled of urine. We also found mould on the walls in the bathroom. Both Thorpe and Grangewaters ward had dormitories which had a strong smell of cigarette smoke.
- Clinic rooms were all clean and fully equipped. Staff had access to resuscitation equipment and all stickers were visible and in date. However, on Thorpe and Grangewaters ward clinic rooms were untidy and disorganised. Staff did not label a dosset box containing medication in the clinic room on Grangewaters ward.

Safe staffing

- Managers logged safer staffing data daily and took part in 'situation report' calls to discuss staffing and risk issues. All ward managers said they could adjust the staffing levels when required to take account of changing observation levels. When necessary ward managers could use agency and bank staff to maintain safe staffing levels. However, managers informed us that some shifts would remain unfilled despite best efforts.
- All wards had periods of understaffing. Between 01 January 2019 and 31 March 2019 the provider failed to fill 98 nursing shifts and 110 health care worker shifts. Patients felt wards were understaffed particularly at the Basildon Mental Health Unit and escorted leave would often be rearranged due to staff shortages.
- Managers had reviewed the staffing establishment levels and increased these by 3.72. However, the provider had changed to using 12-hour shifts and changed the skill mix of staff during the night shift. Senior unit staff informed us that due to this change they felt understaffed at points.

Are services safe?

- Between 01 January 2019 and 31 March 2019, the provider reported a total of three staff leavers, all from the Basildon Mental Health Unit mostly due to retirement.
- Between the 01 January 2019 and 31st March 2019, the provider reported an average absence level of 7%, with the highest absence level of 11% on Basildon Mental Health Unit.
- The provider had 11 full time equivalent vacancies for nurses and 7 full time equivalent vacancies for health care support workers across the wards inspected.
- Trust information from 01 January 2019 to 31st March 2019, showed average agency use per month to be 27% and average bank use per month to be 58% across all wards inspected.
- The provider conducted the appropriate checks when using bank and agency staff. The provider used a staff bank that worked with agencies that were compliant with undertaking pre-employment checks such as: Disclosure and Barring Service, right to work and mandatory training. The provider also used a system to ensure staff did not work more than 60 hours per week within the trust. Ward managers and matrons informed us that all staff received an induction and agency staff we spoke to were familiar with the wards they were working on.
- Medical staff were present in the hospital Monday to Friday during office hours. In addition, a permanent or locum doctor was on call for evening and night cover who could attend the ward quickly in an emergency. A consultant was always available on the phone for advice as were junior doctors. Consultant psychiatrists encouraged staff to contact them about patients as they were familiar with patients.
- A staff member was present in the communal areas of the ward at all times and we witnessed good interaction with patients on the ward. Staff provided reassurance to patients and tried to engage them in activities, which patients enjoyed.
- All staff received an induction to the service and regular staff we spoke with were aware of the individual patient risks and need. Agency and bank staff also received a robust induction. Agency and bank staff informed us that they had adequate time when they came on shift, to familiarise themselves with the current patients, their risks and care plans.
- The wards had site buddies and security nurses allocated each day who would respond to alarms throughout the hospital, cover the wards until agency staff arrived and assist with security issues such as searches. This meant that there were enough staff to carry out physical interventions and observations safely.
- On Thorpe and Grangewaters ward, staff informed us that despite conducting searches on patients following leave, patients were creative in bringing contraband such as cigarettes onto the ward.

Assessment of patient risk

- We looked at 50 patient risk assessments. Staff completed robust, individualised and detailed risk assessments of every patient on admission. Staff updated risk assessments regularly following incidents on most wards. Ward managers informed us that staff regularly audited risk assessments. However, we checked six risk assessments on Grangewaters ward that staff had not updated following incidents and staff copied risk assessments from previous versions.
- Staff had information in care plans about how to support patients when they relapsed or when they were in crisis and most used the 'my care, my recovery' care plans which staff co-produced with patients to best support their care. Staff robustly documented how to manage risks within these care plans.

Management of patient risk

- Staff identified and responded to changing risks in patients and staff we spoke were familiar with individual patients. All staff we spoke with, including agency staff, took time to make themselves aware of patient risks and needs by looking at care notes and receiving thorough handovers. Staff informed us that they regularly took part in 'safety huddles' to discuss patient risks.
- Staff informed informal patients on most wards of their rights. However, on the Basildon Mental Health Unit, patients could not leave at will unless a doctor had approved it. Staff were not regularly informing informal patients of their rights and patients informed us that they had never received a leaflet on their rights from staff on the ward.
- Staff imposed blanket restrictions on the Basildon Mental Health Unit. For example, two members of staff needed to be present in the servery before patients received their breakfast. This meant that breakfast was often late if staff were busy on the wards at which point the breakfast was cold.

Are services safe?

Safeguarding

- Staff described how they would identify and make a safeguarding referral. The provider trained staff in safeguarding adults and children and the wards inspected had a compliance rate on average of 96%. Staff on all wards could give examples of how to protect patients from harassment and discrimination and examples of when this had been done.

Staff access to essential information

- The trust used two different databases across the north and the south locality but despite the trust having a platform to share patient information across both areas, not all staff used this effectively and told us of problems with accessibility

Medicines management

- We reviewed 55 patient medication records and staff followed good practice in medication management storage, dispensing and administration. Pharmacists and nurses audited medication weekly. However, staff did not label a dosset box containing medication in the clinic room on Grangewaters ward.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with the National Institute of Care and Excellence (NICE) guidance particularly when psychiatrists prescribed a high dose of antipsychotic medication. We saw good practice in the monitoring of physical health particularly in cardiometabolic monitoring forms completed by doctors.

Track record on safety

- As this was a focussed inspection we did not request specific data about the number of incidents for this core service, however we looked at two specific serious incident reports and datix forms.
- Senior managers informed us that incidents of self-ligaturing without anchor points had increased due to the reduction in fixed ligature points within the environment. The provider recognised this was an issue and was in the process of setting up a working group to look at ways to reduce this.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents on the trust's electronic recording system.
- Staff were open and honest with patients after incidents had taken place and would explain and offer apologies if something had gone wrong.
- Staff discussed incidents and learning points in team meetings and through various groups. We saw evidence of lessons learned and staff involvement in the root cause analysis.
- Staff had not embedded lessons learned from a serious incident, into practice despite managers sharing learning. This led to another serious incident, with similar circumstances occurring at the Basildon Mental Health Unit. There were also inconsistences with staff knowledge of general risks on Thorpe ward, where staff had no knowledge of previous incidents relating to ceiling tiles.
- Managers held formal and informal debrief meetings with staff and patients after an incident and staff were able to access support following an incident.
- Staff informed us that they felt supported after an incident and received regular opportunities for reflective practice.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Our findings

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

Our findings

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

Our findings

Access and discharge

- All wards had an average bed occupancy of above 90% between 01 January 2019 and 31 March 2019. Galleywood, Chelmer, Thorpe and Grangewaters wards all had average bed occupancy over 100%, the highest being Grangewaters ward with an average bed occupancy of 119%, which included patients on leave. Staff ensured patients received support from the home treatment team and crisis team when they were on leave from the hospital. Staff included leave plans in patients my care, my recovery plans and patients had copies of this. Should a patient need to return to the ward in an emergency, staff sourced a bed elsewhere in the Trust if theirs was not available. This provided an interim solution until staff could move them back to the ward.
- Staff at the Basildon Mental Health Unit utilised the Section 136 Suite as a bed for patients due to a shortage of beds.
- Staff and patients informed us that beds were available in the catchment area patients were living in where possible. To avoid patients transferring out of area, the trust would try to keep them within Essex and some patients from the north of Essex transferred to wards in the south.
- Transfers between units did not always occur during working hours. Staff informed us that two recent serious incidents, involving transfers of patients to Basildon Mental Health Unit from wards in the north of Essex, happened in the middle of the night. This resulted in a poor handover between the services and lack of patient history due to the trust using two different electronic systems to record patient data.
- Patients we spoke to, felt involved and aware of their discharge plans. Discharge plans we looked at, were thorough, robust and showed evidence of patient involvement. The discharge team encouraged discharges to take place early in the week and not on Fridays. Discharge coordinators felt involved by the ward and had good connections to the local authority, housing and benefits services.
- From 01 January 2019 to 31 March 2019 there was a total of 9 delayed transfers. The wards with the highest number of delayed discharges were Grangewaters and Galleywood ward which had three delayed discharges each. Delayed discharges occurred largely due to placement availability and patients being unable to find private housing.

The facilities promote recovery, comfort, dignity and confidentiality

- The Basildon Mental Health Unit had dormitories on Grangewaters and Thorpe ward, therefore patients did not have their own bedrooms, which impacted on patient dignity and privacy. The Basildon assessment unit was a mixed sex ward, but patients had their own bedrooms. The trust is currently planning works to eliminate dormitories and mixed sex accommodation.
- Patients could personalise their bedrooms and we also saw evidence of personalisation in patients' bed spaces within dormitories.
- Staff and patients had full access to the full range of rooms and equipment to support treatment and care such as a clinic room, lounge, quiet room and dining room. Patients also had access to the serveries on site which had garden access. However, Grangewaters ward did not have enough rooms for family meetings. Patients at Basildon felt there was a lack of private space to see to families. Staff asked for visits to take place in the multi-faith room or communal lounge which impacted privacy and restricted patient use of the multi-faith room.
- Most wards had a phone on the ward corridor however, if patients required more privacy, staff would transfer phone-calls to a private office. Staff risk assessed patients to use their own mobile phones on the ward.

Are services responsive to people's needs?

- Patients at Thorpe and Grangewaters ward were subject to blanket restrictions. Patients were not able to access fresh air unless doctors granted leave for patients to go to the servery outside the ward which had a garden attached to it.

Meeting the needs of all people who use the service

- Staff did not always ensure that informal patients were aware of their rights on wards at the Basildon Mental Health Unit. Patients informed us that they only received a leaflet on informal patient rights on the day of the inspection and they could not leave without consultant permission, but doctors were sometimes inaccessible for hours. Doctors informed us this was to keep patients safe and assess risk prior to leaving.
- Patients we spoke to knew how to complain and had access to advocacy to assist with this.
- **Access and discharge**

- All wards had an average bed occupancy of above 90% between 01 January 2019 and 31 March 2019. Galleywood, Chelmer, Thorpe and Grangewaters wards all had average bed occupancy over 100%, the highest being Grangewaters ward with an average bed occupancy of 119%, which included patients on leave. Staff ensured patients received support from the home treatment team and crisis team when they were on leave from the hospital. Staff included leave plans in patients my care, my recovery plans and patients had copies of this. Should a patient need to return to the ward in an emergency, staff sourced a bed elsewhere in the Trust if theirs was not available. This provided an interim solution until staff could move them back to the ward.
- Staff at the Basildon Mental Health Unit utilised the Section 136 Suite as a bed for patients due to a shortage of beds.
- Staff and patients informed us that beds were available in the catchment area patients were living in where possible. To avoid patients transferring out of area, the trust would try to keep them within Essex and some patients from the north of Essex transferred to wards in the south.
- Transfers between units did not always occur during working hours. Staff informed us that two recent serious incidents, involving transfers of patients to Basildon Mental Health Unit from wards in the north of Essex, happened in the middle of the night. This resulted in a poor handover between the services and lack of patient history due to the trust using two different electronic systems to record patient data.
- Patients we spoke to, felt involved and aware of their discharge plans. Discharge plans we looked at, were thorough, robust and showed evidence of patient involvement. The discharge team encouraged discharges to take place early in the week and not on Fridays. Discharge coordinators felt involved by the ward and had good connections to the local authority, housing and benefits services.
- From 01 January 2019 to 31 March 2019 there was a total of 9 delayed transfers. The wards with the highest number of delayed discharges were Grangewaters and Galleywood ward which had three delayed discharges each. Delayed discharges occurred largely due to placement availability and patients being unable to find private housing.
- **The facilities promote recovery, comfort, dignity and confidentiality**

- The Basildon Mental Health Unit had dormitories on Grangewaters and Thorpe ward, therefore patients did not have their own bedrooms, which impacted on patient dignity and privacy. The Basildon assessment unit was a mixed sex ward, but patients had their own bedrooms. The trust is currently planning works to eliminate dormitories and mixed sex accommodation.
- Patients could personalise their bedrooms and we also saw evidence of personalisation in patients' bed spaces within dormitories.
- Staff and patients had full access to the full range of rooms and equipment to support treatment and care such as a clinic room, lounge, quiet room and dining room. Patients also had access to the serveries on site which had garden access. However, Grangewaters ward did not have enough rooms for family meetings. Patients at Basildon felt there was a lack of private space to see to families. Staff asked for visits to take place in the multi-faith room or communal lounge which impacted privacy and restricted patient use of the multi-faith room.
- Most wards had a phone on the ward corridor however, if patients required more privacy, staff would transfer phone-calls to a private office. Staff risk assessed patients to use their own mobile phones on the ward.

Are services responsive to people's needs?

- Patients at Thorpe and Grangewaters ward were subject to blanket restrictions. Patients were not able to access fresh air unless doctors granted leave for patients to go to the servery outside the ward which had a garden attached to it.
- **Meeting the needs of all people who use the service**
- Staff did not always ensure that informal patients were aware of their rights on wards at the Basildon Mental Health Unit. Patients informed us that they only received a leaflet on informal patient rights on the day of the inspection and they could not leave without consultant permission, but doctors were sometimes inaccessible for hours. Doctors informed us this was to keep patients safe and assess risk prior to leaving.
- Patients we spoke to knew how to complain and had access to advocacy to assist with this.
- Patients had a choice of food to meet dietary requirements and most patients liked the food and the option of having an on-site servery on the wards. Patients informed us that there was a lack of vegan options in the Basildon Mental Health Unit server.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Our findings

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose The provider had not identified or mitigated against all ligature anchor points and blind spots on Thorpe and Grangewaters ward. This was a breach of regulation 12 (2) (d) The provider had not ensured that lessons learned from previous incidents were embedded into practice at the Basildon Mental Health Unit. This was a breach of regulation 12 (2) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider did not comply with mixed sex accommodation guidance on the Basildon Assessment Unit, where bathrooms were not segregated for patients on the swing beds. This was a breach of regulation 10 (2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not maintained or cleaned the environment on Thorpe ward. The ward had mould, peeling paint and smelled of urine. This was a breach of regulation 15 (1) (a) and (e)