West London Mental Health NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Hammersmith and Fulham Mental Health Unit and community services Lakeside Mental Health Unit and Hounslow community services St Bernards and Ealing community services	RKL79 RKL14 RKL53
Rehabilitation mental health wards for working age adults	Lakeside Mental Health Unit and Hounslow community services St Bernards and Ealing community services	RKL14 RKL53
Forensic inpatient wards	Broadmoor Hospital St Bernards and Ealing community services	RKL51 RKL53
Child and adolescent mental health wards	St Bernards and Ealing community services	RKL53
Wards for older people with mental health problems	Hammersmith and Fulham Mental Health Unit and community services Lakeside Mental Health Unit and Hounslow community services St Bernards and Ealing community services The Limes	RKL79 RKL14 RKL53 RKL62

Summary of findings

Community based mental health services for adults of working age	Hammersmith and Fulham Mental Health Unit and community services Lakeside Mental Health Unit and Hounslow community services St Bernards and Ealing community services	RKL79 RKL14 RKL53
Mental health crisis services and health-based places of safety	Hammersmith and Fulham Mental Health Unit and community services Lakeside Mental Health Unit and Hounslow community services St Bernards and Ealing community services	RKL79 RKL14 RKL53
Specialist community mental health services for children and young people	Hammersmith and Fulham Mental Health Unit and community services Lakeside Mental Health Unit and Hounslow community services St Bernards and Ealing community services	RKL79 RKL14 RKL53
Community based mental health services for older people	Hammersmith and Fulham Mental Health Unit and community services Lakeside Mental Health Unit and Hounslow community services St Bernards and Ealing community services	RKL79 RKL14 RKL53

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.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Requires improvement 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Requires improvement** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Good** 
Are Mental Health Services well-led?	**Requires improvement** 

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.

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Overall summary

We have given an overall rating to West London Mental Health NHS Trust of **requires improvement.**

We have rated one of the nine core services that we inspected as inadequate, three as requires improvement and the other five as good. The services that were inadequate are the forensic and high secure services. The services that require improvement are the acute admission wards for adults, the community based mental health services (mainly the community recovery teams) and the crisis services. The latter include the home treatment teams and health based places of safety.

The forensic core service report covers both the high secure services at Broadmoor and the West London forensic services. We were most concerned about the West London forensic services.

At the start of the inspection, the chief executive of the trust gave a presentation about the areas they were proud of and the challenges faced by the trust. Our inspection findings reflect the priorities identified by the trust. This demonstrates that the senior trust managers had identified many of the problems that they needed to address. However, we believe that our inspection identified that the scale and speed of change that was needed was very significant. They must address these as a matter of urgency.

The three main areas for improvement were as follows:

- The trust had a substantial problem with staff recruitment and retention. There were too few staff to consistently guarantee safety and quality in the forensic services, high secure services and community based mental health teams (mainly the community recovery teams). There were staffing problems in some other areas but these are not as severe.
- The trust had a problem with low morale and poor engagement with front-line staff in some of its services. This particularly affected those in working in the forensic services. Poor morale can adversely affect the quality of care and make staff reluctant to show openness, transparency and honesty that are essential to safe care.
- The trust must improve its practices in relation to restrictive interventions such as the use of restraint and seclusion. They have started to tackle this problem but there is much more to be done. The problem is most serious in the forensic, high secure, adult admission and older peoples' wards. The trust must ensure that its seclusion rooms meet the required standards, that staff use restraint only as a last resort, that they minimise the use of restraint in the prone position, that they accurately document and record the use of restrictive interventions and that they make the necessary physical health observations after a patient has been given an injection to manage disturbed or distressed behaviour

Despite these problems there was much for the trust to be proud of. The problem of low morale was not endemic. In many services that we visited, staff were very positive about the work of the trust and in most places care was delivered by hard working, caring and compassionate staff. This was particularly noted at Broadmoor where staff showed a real concern for patients on an individual basis and a desire to see them progress towards recovery.

Three other areas stood out as being very positive.

- The trust actively encouraged the personal development of its staff. It supported them in this and enabled them to access training and other development opportunities. We heard of many examples where staff had been able to extend their skills and develop their career within the trust and as a result provide better care to patients.
- The trust was making real strides with user and carer engagement. An example of this was the support it offered to the West London Collaborative. We also found many examples across the services where staff involved people in their care and in the wider service.
- The trust worked closely with statutory and voluntary sector partners to improve mental healthcare in the wider community. For example it had worked with the police to better support people in a crisis. This had resulted in the police not having to take a single person detained under section 136 to a police cell for over a year.

The trust was developing a strong leadership team which had good insight into the challenges they faced and were working to create a more open and positive culture

Summary of findings

within the organisation. The management restructure into two clinical services units was leading to clearer accountability. The trust was improving the quality of its integrated performance report which it used to monitor the quality and safety of its services. The recent introduction of clinical improvement groups for each ward and team was leading to better sharing of information.

We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

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?

Requires improvement 

We rated safe as **requires improvement** for the following reasons:

In forensic inpatient wards we found that:

- Staffing levels in the West London forensic services had not been maintained consistently at levels which guaranteed patient safety.
- Also low staffing levels at Broadmoor and West London forensic services meant that patients did not always have access to therapeutic activities, individual sessions with their primary nurse and association time in high secure services. In the West London forensic services some patient leave was being cancelled.
- In West London forensic services some nursing staff were working excessive hours.
- Some ward environments, particularly the seclusion rooms in the West London forensic services were not in a good state of repair and did not afford the maintenance of patient dignity.
- There were some blanket restrictions in the West London forensic services which had not been assessed according to the type of service and individual patient needs. Examples included searches of wards and the use of protective gowns in seclusion in the womens service.
- Records for restraint and seclusion in the West London forensic services were not consistent and accurate. Some seclusion and restraint was taking place and not being recognised, or being used when it was not clear if this intervention was needed.
- In the West London forensic services some patients were being prescribed medication at levels higher than the recommended maximum dose without the national guidance for this being applied.

In acute wards for adults and the psychiatric intensive care unit we found that:

- Not all staff knew the incident reporting thresholds, therefore all incidents were not reported.
- Female patients were required to access seclusion on the male PICU ward. The location of the seclusion rooms could compromise patient safety as people had to be supported, whilst in a distressed state to move between floors.

Summary of findings

- Not all areas of the ward were included in the ligature audits. Ligature audits did not indicate timescales when works were scheduled to be carried out. Patients' personal items posed potential ligature risks on the wards.
- The use of rapid tranquilisation was not clearly recorded on patients' prescription charts on some wards and the monitoring was not always happening.
- Medication was not managed consistently well across all the wards. On Grosvenor ward the controlled drugs register was not always completed accurately.

In the health based places of safety we found:

- The health based place of safety at the Lakeside mental health unit was not suitable for purpose. At Lakeside mental health unit the place of safety was based on Kestrel ward, a male ward, at the end of the corridor with other patients. Although there was a separate entrance to the place of safety, people could not be transferred here without compromising their privacy and dignity. Females could not be admitted to the place of safety on the male ward. Women who had been detained under section 136 were taken through a separate entrance onto Grosvenor ward where they would be initially assessed in an interview room. The trust had plans to relocate the place of safety within 12 months as it was not considered fit for purpose.

In the community based mental health services for adults we found that:

- Community recovery team caseloads were very high. There were not enough staff deployed in the teams to safely meet the needs of all the patients on their caseloads.
- The premises in which some of the teams were based could present a risk to staff due to the alarm systems or the layout of the premises.
- Patient crisis plans were not always kept up to date. Plans to mitigate risks to patients in a crisis were not always in place or were not stored where they could be easily found in a crisis.

In wards for older people with mental health problems we found that:

- Staff on Meridian ward lacked a clear understanding of what constituted restraint, such as arm holding. As a result, the use of restraint was being under-reported by the ward and accurate information on the use of restraint could not be established.

Summary of findings

- Staff were trained in the safe moving and handling of patients though did not always use appropriate moving and handling techniques to assist patients to move and there was a lack of equipment for this on Meridian ward.

Trust wide:

- There was an unacceptable variation in the use of restraint, including a high use of prone restraint.

However work was ongoing to ensure incidents were reported and the number of reported incidents was increasing especially for medication errors. Staff had a good knowledge of safeguarding and when needed how to get advice within the trust.

Are services effective?

Requires improvement

We rated effective as **requires improvement** for the following reasons:

In acute wards for adults and the psychiatric intensive care unit we found that:

- All patients did not have physical health assessments completed that were thorough and were followed up in a timely manner including ongoing physical health checks where needed.

In community based mental health services for adults we found that:

- Records of patient care and treatment were not always accurate or up to date.
- Records of patient care were not always easy for staff to find.
- Staff had not received training to support them to meet the specific needs of patients over the age of 65

In mental health crisis services and health based places of safety we found that:

- The records across the teams were not consistent and accurate especially in terms of updating risk assessments, medication records and care plans. This could potentially place patients at risk of not having their current needs met. Audits were not taking place to identify when this work was needed.
- The number of staff being supported by receiving regular supervision was very low.

However the induction and ongoing training was valued by staff and improving the quality of care. Staff were mainly well supported in their teams and there were opportunities across the trust for reflective practice.

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There were many positive examples of multi-disciplinary teams working together to support patients and also of teams working together as patients moved between the services.

The trust was implementating the Mental Health Act and its code of practice well in most areas.

Are services caring?

Good

We rated caring as **good** for the following reasons:

- Staff were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard-working, caring and compassionate staff.
- People and where appropriate their carers, were usually involved in decisions about their care.
- Opportunities were available for people to be involved in decisions about their services and the wider trust.

Are services responsive to people's needs?

Good

We rated responsive as **good** for the following reasons:

- Despite there being great pressures, the services were mostly managing to respond to the needs of patients in a timely manner. Where patients had to move between wards for non-clinical reasons this occurred mainly in Hounslow, the numbers were lower and moves were not happening late at night. The trust was aware of the need to provide consistent care and where needed patients were offered a service in the independent sector if a bed in the trust was not available.
- Teams were providing appointments where possible at times that were suitable for people using the service. If patients did not arrive for their appointment there were arrangements in place to check they were alright.
- The trust provided a good range of therapeutic activities for patients using inpatient services. There were some very positive examples at Broadmoor and other services of people having opportunities to develop vocational skills.
- The trust served a very diverse population and there were many positive examples of working with local communities to try and make services more responsive.

However there is still some work to progress with complaints. Some patients did not find making a complaint easy, complaints were not all responded to in a timely manner and feedback from informal complaints was not always used to improve services.

For patients being supported by the community recovery team, there were long waits of between six months and a year to see a psychologist.

Summary of findings

Are services well-led?

Requires improvement 

We rated well led as **requires improvement** for the following reasons:

In forensic and high secure services we found that:

- Many staff across both sites, at Broadmoor and at the West London forensic service spoke of feeling disempowered and of suffering from poor morale.
- In the West London forensic services staff expressed specific concerns about the longstanding culture of bullying linked to race, religion and culture.
- Staff based at Broadmoor Hospital told us that they felt detached from the central trust based in London.
- While the trust had identified the key concerns and issues which were raised through the inspection process. Whilst action had been taken this had not yet had sufficient impact to address all the concerns which were highlighted especially with staff engagement in the West London forensic services.

In the acute wards for adults and the psychiatric intensive care unit we found that:

- Governance processes across the wards were not working well. Audits were not always identifying issues or being followed up. Some basic checks were not taking place as planned. The quality of record keeping was very variable. These could all potentially present a risk to the safety of patients.

In crisis services and health based places of safety we found that:

- Governance processes across the home treatment teams were not working well. Audits were not always taking place. There were variations for example in the quality of record keeping, the regular supervision of staff, supporting patients with their physical health and staff understanding and use of the Mental Capacity Act. These could all potentially present a risk to the safety of patients.

However, the trust was developing its integrated performance report and this meant the information from ward to board was improving. The appointment of a director & deputy director of nursing and clinical directors whilst still relatively new in some cases was bringing positive changes including professional engagement in making service improvements.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Steven Michael, chief executive, South West Yorkshire Partnership NHS Foundation Trust

Team Leader: Jane Ray, head of inspection for mental health, learning disabilities and substance misuse, Care Quality Commission

The team of **75** people included:

Fourteen CQC inspectors

Six trainee CQC inspectors

Ten allied health professionals

Two analysts

Seven experts by experience who have personal experience of using or caring for someone who uses the type of services we were inspecting

Nine Mental Health Act reviewers

Ten nurses from a wide range of professional backgrounds

One planner

Three pharmacists

Seven senior doctors

Two social workers

The chief inspector of prisons and a colleague for one day

Two people with governance experience

In addition the inspection was observed by two researchers from the University of Liverpool who were evaluating the model of inspection used by the Care Quality Commission.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of the experience of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received
- Asked a range of other organisations for information including Monitor, NHS England, clinical commissioning groups, Healthwatch, overview and scrutiny committees, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups
- Sought feedback from patients and carers through attending 9 focus groups and meetings
- Received information from patients, carers and other groups through our website

During the announced inspection visit from the 8-12 June 2015 the inspection team:

- Visited **67** wards, teams and clinics
- Spoke with**381** patients and their relatives and carers who were using the service
- Collected feedback from **605** patients, carers and staff using comment cards

Summary of findings

- Spoke with the managers or acting managers for each of the **67** wards and teams
- Spoke with **512** other staff members; including doctors, nurses and social workers
- Attended and observed **64** hand-over meetings and multi-disciplinary meetings
- Joined care professionals for **16** home visits
- Attended **14** focus groups attended by **307** staff
- Interviewed **8** senior executive and board members
- Looked at **314** treatment records of patients
- Carried out a specific check of the medication management across a sample of wards and teams
- Looked at a range of policies, procedures and other documents relating to the running of the service
- Requested and analysed further information from the trust to clarify what was found during the site visits

The team inspecting the mental health services at the trust inspected the following core services:

- Acute ward and the psychiatric intensive care unit
- Long stay rehabilitation wards
- Forensic inpatient wards including the high secure service
- Wards for older people with mental health problems
- Ward for children and adolescents with mental health problems
- Community based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Community based mental health services for older people
- Specialist community mental health services for children and young people

We did not inspect some of the specialist services including the eating disorder, gender identity, liaison psychiatry services, IAPT and the Cassel hospital for people with a personality disorder.

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the trust.

Information about the provider

West London Mental Health NHS Trust provided mental health services to a population of 700,000 people for local services and a wider population for specialist services. The trust supported adults, older people and children in the boroughs of Ealing, Hammersmith & Fulham and Hounslow. They also provided specialist community meantal health services to children and young people in the London borough of Brent. The forensic mental health services provided a medium and low secure service to male patients from North West London. The male adolescent medium secure unit and womens medium secure services had a national catchment area. The high secure services at Broadmoor located in Berkshire had a catchment of London and the South of England. Two other specialist services provided a national service.

The trust had an annual turnover of £226 million, employed just over 3560 staff who support 33,600 patients each year at 25 main sites and in the community. The trust worked in a complex commissioning environment, with services commissioned on a local and national level. The trust was applying to become a foundation trust.

At the time of the inspection two very large redevelopment programmes were taking place. The first was the redevelopment of Broadmoor due to open in 2017 and the second was the Three Bridges medium secure campus on the St Bernard's site due to be completed in 2016.

The trust had 7 locations registered with CQC. The trust had been inspected 12 times and at the time of the inspection there were no outstanding areas of non-compliance.

Summary of findings

What people who use the provider's services say

Before the inspection took place we met with **9** different groups of patients, carers and other user representative groups as follows:

- The trustwide service user and carer experience group
- A meeting of the West London Collaborative
- Ealing Voiceability user group
- Hounslow carers group
- User group at the Solace Centre
- Broadmoor hospital patients forum
- Feedback meetings with Ealing, Hammersmith & Fulham and Hounslow Healthwatch
- Service user focus group led by Hestia in Hammersmith and Fulham
- Hounslow user forum

During the inspection the teams spoke to 381 people using services or their relatives and carers, either in person or by phone. We received 605 completed comment cards of which 403 were positive, 138 negative and 64 mixed. We also received individual comments from people through our website or by phone.

Much of the feedback we received was very positive as follows:

- Most staff were kind, supportive, tried to meet peoples needs, professional and helpful.
- People commented that they found their care and treatment helpful.
- There were positive comments about cleanliness in most places.
- People valued the courses offered by the recovery college.
- The Solace Centre received several positive comments about the support it provided.
- The trust offered opportunities for user involvement for example in staff recruitment.
- Some services received particular mention such as the memory clinics.
- Some people found the help-line useful.

Some of the challenges that we were told about were as follows:

- The most negative comments were about the impact of staff shortages especially in the forensic services and Broadmoor.
- We heard about the pressures on acute beds meaning that people were being moved frequently between wards especially in Hounslow.
- There were comments about the recovery teams – they are large, there are staff changes, reception staff are very busy, people having a duty worker rather than a care-co-ordinator resulting in lack of continuity of care.
- There were a few comments about poor staff interactions with people using the service including Broadmoor, forensic services and acute wards
- Some people using the forensic services said they felt unsafe and were worried about being assaulted by other patients.
- Some environments were mentioned as being poor, including the Ealing recovery team, the Wolsey Wing and Lakeside.
- People said they were anxious about being discharged back to their GP.
- Some carers did not feel they were adequately listened to or involved.
- Some people did not feel adequately consulted about changes in the services.

Good practice

Trust wide

- Throughout the inspection we saw many examples of caring and compassionate staff. Patients also told us about their very positive experiences. For example at Broadmoor staff showed real concern for patients on an individual basis and a desire to see them progress towards recovery.
- Staff were being supported to access a range of training to support them in their specific role over and above the mandatory training. The training also offered opportunities for career progression. For example in the community based mental health services, some staff were studying for a master's degree, completing training in dual diagnosis and undertaking psychotherapy training.

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- Clinical leadership had been introduced and whilst it was still at an early stage it was facilitating staff engagement as staff felt they could have meaningful involvement in decisions about services.
- The trust was making progress with user and carer engagement. An example of this was the support offered to the West London Collaborative.
- There were many examples of the trust warking in partnership with local statutory and voluntary partners. For example work with the police about supporting people in a crisis which meant there had been no-one in a police cell under section 136 for over a year.
- The trust provided services for a very ethnically diverse population and there were many examples of the trust working with local communities to meet the needs of individuals using their services. For example the inspection took place just prior to Ramadan and we saw how wards and community teams were working with Muslim patients who wished to to follow the month of fasting.

High secure services

- Patients and ex-patients were involved through the recovery college model in developing staff and patient training programmes looking at complex issues like the principles of physical interventions.
- Patient engagement was promoted through a well-structured and embedded patients forum. Patients attended hospital wide meetings to ensure that there was a strong patient voice on issues that were discussed. The patient forum involved patients and provided action plans and timescales for responses to issues raised. There were community meetings on all the wards, including wards where it could be difficult to organise where patients were in long term segregation or seclusion.
- A pilot project on Ascot ward was leading to changes in practice and the reduction of the use of long term segregation. This had excellent feedback from staff and patients. This pilot project had involved patients in their care planning for exiting from environments of long term segregation. There was also positive work which had taken place on Epsom ward in minimising the restrictive practices within an environment where all patients were subject to conditions of long term segregation. This had shown that staff were thinking about ways to reduce restrictive practices and challenge some of the culture around the use of long term segregation.
- Therapeutic activities supported patients to learn a range of skills. The feedback we received from patients about these opportunities was universally positive, including the pottery, leatherwork, radio shop, carpentry, gym, swimming and kitchen garden.
- Safeguarding procedures were being used by staff across the wards. Staff were using safeguarding 'grab bags' which ensured they had clear and accessible information.
- Patients were having their physical health care needs met throughthe provision of a health centre on site which had a dedicated GP service and dentist as well as being supported to access to all primary health care services.

Forensic inpatient wards

- Patient engagement was being promoted by each ward having a patient who was the ward representative. These patients attended user forums on a regular basis. There were separate male and female user forums. Ward representatives told us they were listened to in the forums. One ward representative was now involved with training staff.
- The wards benefitted from access to a resource called the Atrium. This facility included a café, shop, bank, small gym and library designed to simulate a local high street. It was used for therapy sessions, leisure, work, education, physical activity and social events, designed to promote re-integration into the community.
- On Derby ward staff used a number of de-escalation techniques as supported by the safe wards initiative.
- Patients had their physical healthcare needs met through the primary healthcare service based on the site. This included access to physical healthcare link nurses who visited each ward twice a week or more frequently if needed.

Rehabilitation mental health wards for working age adults

Summary of findings

- The ward consultant at Mott House had developed a training programme for all staff in best practice in physical healthcare which was due to be published and rolled out across the trust and had been presented to the Royal College of Nursing. The consultant had also published two long term research projects on six year outcomes for patients following discharge from specialist rehabilitation at Mott House.
- The staff and patients from Glyn ward had participated in real time rehabilitation country wide research.
- Staff on Glyn ward were trained in phlebotomy to enable blood monitoring to be carried out by staff on the ward so that consistency of care was offered to patients in managing the monitoring of certain medication.
- There was active co-production on both wards. Each ward had co-produced with staff and patients their visions and values and an agreed code of conduct.

Community based mental health services for older people:

- The clinical trials unit was playing a key role in helping valuable research into aspects of dementia and giving patients the opportunity to be involved in this through the dementia research register.
- The service was providing much appreciated support for carers and users by setting up groups such as the 'newly diagnosed group.'
- Specialist support was offered to people with dementia in care homes by a recently created 'care home practitioner' role and the dementia in care homes team.

Acute wards for adults:

- The wards had identified and trained dual diagnosis champions to support patients on the wards. They worked with the local drug and alcohol services who also attended monthly meetings with the community and inpatient teams to share information and learning. Staff were encouraged to attend external dual diagnosis training; one member of staff was completing a master's degree in dual diagnosis.

Specialist community mental health services for children and young people:

- The Hammersmith and Fulham team held a weekly safeguarding session for the whole team to consider potential referrals or review young people already known to social care. The meeting was attended by members of the multi-disciplinary team and discussed issues and agreed outcomes.
- The trust wide CAMHS nurses forum brought nurses together from across sites to share information, give updates on business and share pieces of learning. Case studies were shared at the forum and used to develop good practice across the service.

Child and adolescent mental health ward:

- The ward provided the young people with a structured daily timetable and a focus on enabling patients to develop skills for self care and practical vocational skills. The joint work with the onsite education service was good.

Community based mental health services for adults of working age:

- The trust provided a "primary care plus" service which was based at GP practices. The primary care plus team worked with GPs to provide care and treatment for patients' mental and physical health needs in one place. The service helped support patients who were being discharged from secondary care mental health services, such as the recovery teams and helped prevent the need for referral to secondary care. The service was set up in September 2013 and, having successfully established itself, was in the process of recruiting additional nurses with funding from the local clinical commissioning groups.
- Recovery teams had dedicated carer support workers who carried out assessments for carers of patients using the service and provided emotional support.
- Vocational workers and peer support workers were established in the service to provide patients with support to achieve their goals.
- Ealing recovery team west provided regular mindfulness groups for staff to help support them.
- A manager in one of the early intervention services had developed a series of workshops on spirituality,

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religion and culture called 'informing our mental health interventions' along with a cultural competency tool to help staff deliver interventions to diverse groups of patients and their families.

- The trust was developing a personality disorder pathway service which was based within the Hammersmith and Fulham recovery team but operated throughout the trust. The service had a "virtual team", providing consultations for staff to enable them to provide effective interventions for patients who had complex personality issues. The virtual team included a psychiatrist, an art therapist, a senior nurse and a psychologist. For patients who were ready to engage in more in depth psychological interventions, the service also provided direct therapy sessions.
- Ealing recovery team east provided clinic type sessions to support patients to manage their housing and welfare benefit related issues.

Wards for older people with mental health problems:

- At the Limes different communication methods were used to ensure that people with a cognitive impairment had an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The services were working well with relatives and carers. A carers group took place regularly at the Limes and was valued by the people who attended.

Areas for improvement

Action the provider MUST take to improve

Trust wide:

- The trust must work to reduce the variation in the use of restraint and the high numbers of prone restraint used across the trust.

High secure services:

- The trust must ensure that staffing levels are sufficient to not only ensure safety of staff and patients but also to promote the quality of life of patients in terms of ensuring they can access therapeutic and leisure activities as agreed in their care plan.
- The trust must ensure that staff are engaged in the running of the hospital and that communication with staff at all levels and in all areas of the hospital improves. This is to ensure that better care can be provided to patients and that staff feel that the environment and culture of the hospital and trust is one that values their input and engagement.

Forensic services:

- The trust must ensure that staffing levels are maintained to guarantee the safety of patients and staff and that the lack of staff does not have a significant impact on the quality of life of patients in the service in terms of access to therapeutic activities, escorted leave and meetings with named nurses. Staff must not work excessively long hours.
- The trust must ensure that all seclusion facilities are in a state of adequate repair and consideration is given to the maintenance of the patients dignity when using the facility.
- The trust must ensure that restraint and seclusion is appropriately recognised, only used when needed and recorded so its use can be reviewed.
- The trust must review blanket practices across the wards to ensure these only take place where needed and that as far as possible practices reflect individual patient need.
- The trust must ensure that where patients are prescribed medication above the recommended dose the national guidance must be followed.
- The trust must ensure that more targeted work takes place to address the complex issues affecting staff engagement so that communication between management within the service and members of staff

is facilitiated. This is to improve morale and ensure that staff feel comfortable raising concerns with their managers and the senior managers in the organisation.

Wards for older people with mental health problems:

- The trust must ensure that staff have an understanding of what constitutes restraint so incidents can be accurately reported.
- The trust must ensure patients who need moving and handling have this done safely with the appropriate equipment where needed.

Acute wards for adults and psychiatric intensive care unit:

- The trust must ensure that the use of rapid tranquilisation medication is clearly stated on patients' medication charts and that the necessary physical health checks take place and are recorded after this medication has been administered.
- The trust must ensure all fittings in the ward are included in ligature audits and where needed that works are completed. Ensure that on the psychiatric intensive care unit patients' personal items which may present a ligature risk to other patients are appropriately stored when not in use.
- The trust must ensure that medicines are managed and administered safely.
- The trust must ensure that seclusion rooms are located so that they can be used safely and accurate records must be available when seclusion is used and of the checks done whilst the patient is in seclusion.
- The trust must ensure that staff clearly understand the incident reporting thresholds and report all incidents.
- The trust must ensure that patients have their physical health care needs assessed and ongoing checks where needed.
- The trust must ensure governance processes are working effectively to identify areas for improvement to support patient safety.

Mental health crisis services and health-based places of safety :

- The trust must ensure that the physical environment and the clinical practice relating to 136 detentions at Lakeside is in line with the Mental Health Act code of practice.
- The trust must ensure that accurate, detailed and consistent records are kept in respect of people's care including updating risk assessments.
- The trust must ensure that staff in the home treatment teams receive regular supervision.
- The trust must ensure that governance systems are implemented to ensure the home treatment teams are working consistenty and safely to meet the needs of people using the service.

Community based mental health services for adults of working age:

- The trust must ensure there are sufficient suitably qualified staff so that patients have a care co-ordinator rather than being held by duty staff and junior doctors are not holding large caseloads of patients, which creates a risk to the safety and welfare of patients. Recovery team patients must have a named clinician responsible for their care and treatment.
- The trust must ensure that patients have personalised crisis plans that reflect their individual circumstances and must ensure these are up to date. These must be stored in patient records where they can be found quickly by all staff.
- The trust must ensure that the premises used by staff and patients are safe. The provider must ensure that staff safety alarms work and can be heard in an emergency
- The trust must ensure that accurate and complete patient care records are maintained.
- The trust must ensure that staff are trained to meet the specific needs of older patients.

Action the provider SHOULD take to improve

High secure services:

- The trust should continue to work to minimise restrictive practices such as the use of long term segregation, in line with the Mental Health Act Code of Practice 2015.

Summary of findings

- The trust should ensure that ward environments, particularly in the older buildings and areas such as Cranfield ward where patients spend significant amounts of time in their bedrooms, are enhanced to ensure that environments reflect the therapeutic aims of the service, reflecting the Mental Health Act Code of Practice 2015.
- The trust should consider the appropriateness of the continued use of the seclusion rooms in some of the older buildings, such as Canterbury ward. These compromise privacy because other patients on the ward can see into them when they are being used.
- The trust should ensure that staff on the wards receive sufficient administrative support to enable nursing time to be used most effectively in supporting the patients.
- The trust should provide the framework to ensure that best practice can be shared between the West London forensic service and Broadmoor Hospital.

Forensic services:

- The trust should ensure all risk assessments are updated and reflect the individual needs of each patient.
- The trust should ensure all safeguarding alerts are made in a timely manner.
- The trust should ensure that where rapid tranquillisation is used ensure for all patients that the observations take place and are recorded.
- The trust should ensure all patients have a record to confirm their physical healthcare checks are taking place.
- The trust should ensure all care plans are up to date, clear and consistent, have a recovery focus and a discharge plan where appropriate.
- The trust should ensure Mental Health Act documentation is up to date and completed correctly.
- The trust should ensure where audits are meant to be taking place that they are completed and the findings are used to make improvements.
- The trust should support patients to be assured that they can make complaints without fear of repercussions.
- The trust should support patients to be able to raise concerns about the manner and approach of staff if they feel this is not appropriate.

Rehabilitation mental health wards for working age adults:

- The trust should ensure maintenance and repairs are carried out in a timely way at Mott House.
- The trust should ensure that arrangements for informal patients to leave Mott House are reviewed to ensure they can go out when they want.
- The trust should ensure staff have a knowledge of the Mental Capacity Act so this can be used when needed.
- The trust should ensure patients know how to contact the advocacy services if needed.
- The trust should ensure patients on Glyn ward can make telephone calls in private.
- The trust should ensure that wards monitor how many activities are cancelled as this may indicate staffing shortages.
- The trust should ensure that the safety and recovery of patients on Glyn ward is not affected by patients from the acute ward sleeping on the ward.
- The trust should continue to promote staff engagement in these services and support staff to feel able to raise concerns.

Community based mental health services for older people:

- The trust should ensure that the cognitive impairment and dementia service at east Ealing has a suitable reception and waiting area.
- The trust should ensure that caseloads for staff are manageable and reflect agreed levels.
- The trust should ensure information about the services is available in different languages as planned.

Wards for older people with mental health problems:

- The trust should ensure that there are sufficient staff working on Meridian ward to meet the needs of patient in that service whilst recognising that staff may need to help with emergencies on other wards and patients admitted to the place of safety.

Summary of findings

- The trust should ensure there is a management plan on Meridian ward to address the risks associated with ligature points.
- The trust should ensure patients on Meridian ward have access where requested to an advocacy service.
- The trust should ensure that patients have access to a copy of their care plan where appropriate.
- The trust should ensure staff on Jubilee ward have access to the specialist knowledge to help determine when it is more appropriate for a patients to be detained under the Mental Health Act or for an application for a Deprivation of Liberty Safeguard order to be made.
- The trust should ensure there is a system in place to log complaints at a ward level.

Acute wards for adults and psychiatric intensive care unit:

- The trust should review the CCTV on Avonmore ward to make it less intrusive for individual patient bedrooms.
- The trust should address the blind spots on Kestrel and Lillie wards.
- The trust should support patients to have individual behaviour support plans.
- The trust should ensure that seclusion rooms are clean and the observation glass is cleaned and maintained regularly.
- The trust should ensure medical equipment is properly maintained, repaired promptly and accessible.
- The trust should ensure that safe staffing levels are maintained and there are adequate numbers of staff when teams are supporting patients in the place of safety.
- The trust should ensure risk assessments are updated after an incident.
- The trust should ensure patients' rights under the Mental Health Act are read, understood and repeated where required.
- The trust should ensure that all staff and patients are debriefed after incidents, including post-seclusion debriefs for patients.
- The trust should ensure that patients who are less mobile have an agreed way to request staff help from their bedrooms.
- The trust should ensure that care plans are more consistent in terms of their content, recovery focused and adequately reflect patients' views and that patients are involved in the development of their care plan and offered a copy.
- The trust should review handover and multi-disciplinary meetings across the wards to ensure consistently high standards.
- The trust should ensure more consistent use and recording of the Mental Capacity Act.
- The trust should limit patients sleeping on other wards as a result of bed pressures.
- The trust should ensure ongoing staff engagement to support staff to feel part of the trust and able to raise issues of concern.

Mental health crisis services and health-based places of safety :

- The trust should ensure safe medicine management systems in the home treatment teams are in place and adhered to.
- The trust should ensure that all teams understand the duty of candour regulation. The duty of candour was introduced for providers to ensure they are open and honest with people when something goes wrong with their care and treatment.
- The trust should review the arrangements for lone working to ensure that all home treatment teams have clear systems in place.
- The trust should ensure home treatment teams complete relevant local audits to identify and improve the quality of the service they provide.
- The trust should ensure there is a clear policy which is implemented on how physical health is managed across the home treatment teams.
- The trust should ensure that staff's understanding and application of the Mental Capacity Act becomes embedded.

Summary of findings

- The trust should ensure the home treatment teams and health based places of safety consider ways to collect regular feedback from people who have used their services to improve service provision.
- The trust should ensure that staff are appropriately engaged about changes that affect them during the ongoing changes.

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- The trust should continue to work with commissioners to ensure that the 24/7 home treatment function to support people outside of working hours is more responsive to the needs of the local population accessing the service. The current provision outside of hours was limited although a business case for a 24/7 single point of access had been agreed.

Specialist community mental health services for children and young people:

- The trust should ensure that staff are appropriately supported in the light of increasing workloads and as a result of restructuring across the three boroughs.
- The trust should review the team bases to ensure staff can call for assistance where needed and rooms were sufficiently soundproofed to avoid confidential conversations being overheard.

Child and adolescent mental health ward:

- The trust should ensure that work is facilitated to address the tensions in the staff team to ensure all staff feel engaged and able to work together in an open and transparent manner.
- The trust should ensure an effort is made to work with patients to make the communal areas and entrance more inviting, age appropriate and recovery oriented.
- The trust should review the seclusion facility and ensure it meets standards. The seclusion room was based within the bedroom corridor and a person in seclusion could not use the bathroom facilities adjacent to the seclusion room as it was routinely kept locked, and only opened on request.
- The trust should take steps to improve seclusion recording and audit the length of time staff were completing observations.
- The trust should review the arrangements for patients to attend the ward round, listening to the opinions of the young people and considering if some could attend and be more involved in their care and decision making.
- The trust should ensure informal complaints are logged so that they can be reviewed and lessons learnt.

Community based mental health services for adults of working age:

- The trust should ensure that the majority of staff working in the Ealing early intervention service are permanent employees in order to provide a more consistent staff team and consistent support to patients.
- The trust should ensure that all staff carrying out trust business follow the trust's lone working policy.
- The trust should take steps to inform all patients about how they can make a formal complaint about the service.
- The trust should ensure the premises used by the Ealing early intervention service is a comfortable temperature for staff and patients using them.
- The trust should continue with its work to promote staff engagement so that staff feel able to raise issues or concerns without fear of reprisals.

West London Mental Health NHS 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.

In the 12 months prior to the inspection the trust had 31 visits from Mental Health Act reviewers. The most common issues were patients not being advised of their rights, care plans not reflecting the views of the patients and lack of assessment of capacity.

The Trust's systems supported the appropriate implementation of the Mental Health Act (MHA) and its code of practice. Administrative support and legal advice was available from the head of mental health law and clinical records from a centralised team within the trust, as well MHA administrators based at each hospital site. Broadmoor hospital had a separate MHA lead and administrative support systems.

Regular audits were completed to ensure the MHA was being implemented correctly. Responsibility for the monitoring the implementation of the MHA and MCA within the trust rests with the clinical effectiveness & compliance committee (CECC). The MHA leads provide reports on the monthly use of the MHA. The CECC reports to the quality assurance committee and to the trust board.

Training was provided to staff within local sites. Role specific training was given where required. Overall staff appeared to have a good understanding of the MHA and code of practice.

Seven full Mental Health Act review visits were completed during the inspection. Detention paperwork was filled in correctly, was up to date and was stored appropriately.

There was a good adherence to consent to treatment and capacity requirements overall. Copies of consent to treatment forms were attached to medication charts where applicable. However, on two wards where a Mental Health Act review visit was completed, we were unable to consistently see the completion of assessments of patients' capacity to consent to treatment, or a discussion about consent.

Most people had their rights under the MHA explained to them. However on five of the wards where a Mental Health Act review visit was completed, we were unable locate consistent records to confirm that all patients had been informed of their rights on admission and regularly thereafter.

A majority of the care plans we reviewed were comprehensive and individualised. On three wards where a Mental Health Act review visit was completed, there was inconsistent evidence of patient involvement and the recording of patient's views in relation to their care and treatment in line with the code of practice.

Within all of the wards visited people had access to Independent Mental Health Advocacy (IMHA) services and information on IMHA services was provided to patients. Patients and staff appeared clear on how to access IMHA services appropriately.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust established a mental health law group in November 2014 that considered the Mental Capacity Act (MCA) and Mental Health Act. There was no MCA lead within the Trust at the time of the inspection. The head of mental health law and clinical records held the responsibility for the management of deprivation of liberty safeguards within the trust.

New training was introduced by the trust in March 2015 that focused on the MCA and Deprivation of Liberty Safeguards (DoLS). This included a half day training for health care assistants and other junior staff. Specialist training from a lawyer was provided for senior staff. In depth and bespoke training took place on the Limes and Jubilee ward who support patients who are over the age of 65. Some teams such as the rehabilitation and home treatment teams acknowledged that their knowledge on how to apply the act needed further development. On Jubilee ward further input was needed to ensure staff are clear when to consider detention under the Mental health Act and when an application should be made to authorise a DoLS.

The trust had produced wall charts and screen savers to support staff with using the MCA and DoLS.

Between the 1 July 2014 and the 31 December 2014 there had been 7 DoLS applications. Four of these were from The Limes and three from Jubilee ward.

The trust had also produced a leaflet on advance decisions that had been widely distributed to patients.

Requires improvement

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

We rated safe as **requires improvement** for the following reasons:

In forensic inpatient wards we found that:

- Staffing levels in the West London forensic services had not been maintained consistently at levels which guaranteed patient safety.
- Also low staffing levels at Broadmoor and West London forensic services meant that patients did not always have access to therapeutic activities, individual sessions with their primary nurse and association time in high secure services. In the West London forensic services some patient leave was being cancelled.
- In West London forensic services some nursing staff were working excessive hours.
- Some ward environments, particularly the seclusion rooms in the West London forensic services were not in a good state of repair and did not afford the maintenance of patient dignity.
- There were some blanket restrictions in the West London forensic services which had not been

assessed according to the type of service and individual patient needs. Examples included searches of wards and the use of protective gowns in seclusion in the womens service.
- Records for restraint and seclusion in the West London forensic services were not consistent and accurate. Some seclusion and restraint was taking place and not being recognised, or being used when it was not clear if this intervention was needed.
- In the West London forensic services some patients were being prescribed medication at levels higher than the recommended maximum dose without the national guidance for this being applied.

In acute wards for adults and the psychiatric intensive care unit we found that:

- Not all staff knew the incident reporting thresholds, therefore all incidents were not reported.
- Female patients were required to access seclusion on the male PICU ward. The location of the seclusion rooms could compromise patient safety as people had to be supported, whilst in a distressed state to move between floors.
- Not all areas of the ward were included in the ligature audits. Ligature audits did not indicate timescales when works were scheduled to be carried out. Patients' personal items posed potential ligature risks on the wards.
- The use of rapid tranquilisation was not clearly recorded on patients' prescription charts on some wards and the monitoring was not always happening.
- Medication was not managed consistently well across all the wards. On Grosvenor ward the controlled drugs register was not always completed accurately.

In the health based places of safety we found:

- The health based place of safety at the Lakeside mental health unit was not suitable for purpose. At Lakeside mental health unit the place of safety was based on Kestrel ward, a male ward, at the end of the corridor with other patients. Although there was a separate entrance to the place of safety, people could not be transferred here without compromising their privacy and dignity. Females could not be admitted to the place of safety on the male ward. Women who had been detained under section 136 were taken through a separate entrance onto Grosvenor ward where they would be initially assessed in an interview room. The trust had plans to relocate the place of safety within 12 months as it was not considered fit for purpose.

In the community based mental health services for adults we found that:

- Community recovery team caseloads were very high. There were not enough staff deployed in in the teams to safely meet the needs of all the patients on their caseloads.
- The premises in which some of the teams were based could present a risk to staff due to the alarm systems or the layout of the premises.
- Patient crisis plans were not always kept up to date. Plans to mitigate risks to patients in a crisis were not always in place or were not stored where they could be easily found in a crisis.

In wards for older people with mental health problems we found that:

- Staff on Meridian ward lacked a clear understanding of what constituted restraint, such as arm holding. As a result, the use of restraint was being under-reported by the ward and accurate information on the use of restraint could not be established.
- Staff were trained in the safe moving and handling of patients though did not always use appropriate moving and handling techniques to assist patients to move and there was a lack of equipment for this on Meridian ward.

Trust wide:

- There was an unacceptable variation in the use of restraint, including a high use of prone restraint.

However work was ongoing to ensure incidents were reported and the number of reported incidents was increasing especially for medication errors. Staff had a good knowledge of safeguarding and when needed how to get advice within the trust.

Detailed findings

Our findings

Track record on safety

- NHS Trusts are required to submit notifications of incidents to the national reporting and learning system (NRLS). In total 1970 incidents were reported to NRLS between the 1 March 2014 and 28 February 2015. The majority of these incidents were classified as resulting in 'no harm' 75%, or 'low harm' 20%, with 4.5% resulting in'moderate harm' and 0.2% 'severe harm'.
- The trust was one of the lowest reporters of incidents in data published by the NHS national reporting and learning system. The 54 mental health trusts in England use this system. The trust was aware of this and was working to try and improve levels of reporting. There had been specific workshops on medication incidents and this was resulting in improved levels of reporting. Another example of this was the chief executives blog where he was encouraging staff to report incidents. Whilst staff were starting to report more incidents the inspectors found examples during the inspection of incidents recorded in patient records which had not been formally reported. This was often because staff had not recognised this as a notifiable incident. The trust had set up a working group to do some more targeted work to ensure they developed a culture where reporting incidents happened more frequently.
- The CQC intelligent monitoring system gives an indication of potential risks for the trust in preparation for the comprehensive inspection. There was a risk identified in relation to an indicator which measures proportion of care spells where a mental health patient suffered physical injury requiring an admission to A&E from April 2012 till the end of March 2013. There was also a risk identified in relation to the number of prescriptions above British national formularly limits between December 2013 and the end of November 2014. These were explored as part of the inspection and are included in the findings later in the report.
- There had been one never event in the 6 months prior to the inspection. This was a drug incident regarding the administration of methotrexate which resulted in no harm to the patient. Between March 2014 and the end of February 2015 there had been 113 serious incidents which were reported through the NRLS. Of these 24% had been the assault of an patient by another inpatient. The next most significant incident was the unexpected death of a community patient which was 9%.
- The trust provided a more detailed breakdown of the serious incidents between April 2014 and the end of April 2015. During this time there were three inpatient deaths. One was an apparent suicide and two deaths at Broadmoor were at the time of the inspection still waiting for the cause of death. There were also 17 community deaths which were apparent suicides. Of these the Ealing assessment team had the highest number of deaths of people they were supporting with 3 apparent suicides.
- From 1 April 2014 till the end of March 2015 there were 15 notified admissions of patients under 18 to an adult ward, although they were offered support to meet their needs until an appropriate placement was identified. This was reported as a serious incident due to the potential risks for the young person of being in an adult environment. The trust had highlighted this issue to the commissioners who are responsible for ensuring access to appropriate inpatient facilities.
- The NHS SafetyThermometer measures a monthly snapshot of four areas of harm including falls and pressure ulcers. This was monitored in the local services, especially on the two wards for patients over the age of 65 and there were no services where there was a particular concern.

Learning from incidents and duty of candour

- The trust was working to fulfil the regulation relating to the duty of candour. This means they operate with openness, transparency and candour which means that if a patient is harmed they are informed of the fact and an appropriate remedy offered. We heard from a number of patients, staff and external stakeholders that the trust was open and transparent in sharing details of safety incidents. We also saw the trust was taking steps to ensure incidents, complaints and other concerns were fully investigated. Most people felt satisfied with how this is happening, but a few remained unhappy with how their individual concerns had been addressed.
- The trust monitored whether it was completing the investigation of serious incidents within the expected timescales. They recognised that this was an area where

they needed to improve. They commissioned an external consultant to look at their processes for reporting, investigating and learning from incidents who reported in October 2014. They recommended improving the timescales for reporting incidents and making sure a 'risk owner' is identified to lead on the investigation. The trust was implementing these recommendations and at the time of the inspection 88% of incidents that were reported had been recorded within two hours of the incident taking pace.

- The clinical commissioning groups fed back that they felt the quality of investigating incidents had improved. Four root cause analyses were randomly chosen by the inspection team and these had been completed comprehensively.
- The trust monitored the numbers of incidents reported. The trust had an incident review group that met monthly reviewed recent incidents, identified themes and scope for organisational learning.
- The trust had a number of means of sharing learning from incidents and complaints. This included a recently introduced trust wide monthly learning from incidents newsletter called "Learning Lessons". There were also patient safety newsletters in the clinical service units. There was also an annual trust wide learning lessons conference. This had taken place shortly prior to the inspection at Broadmoor. This was felt to be very helpful and there were discussions taking place about whether this should take place six monthly and how to share the learning from this event with staff who could not attend.
- In the year prior to the inspection the trust had been organised into two clinical service units. Each clinical service unit had a central clinical improvement group which had a recently introduced a standard agenda which included learning from incidents. These groups shared information and received feedback from the clinical improvement groups for each ward and community team.
- The inspection of the trust took place at a time when these changes were relatively new and still being embedded. Already this was having a positive impact and staff had a growing awareness of incidents that had taken place across the trust and the associated learning that had taken place.
- Staff were positive in most areas about the process of de-briefing after a serious incident. This ensured that support was provided to the patient and the staff involved in the incident. Where needed staff were supported to seek medical assistance, have input from occupational health and counselling services. It also provided an opportunity for the team to reflect on learning from the incident. On the acute wards it was found that debriefings after patients had been secluded were not always taking place and patients were not always being given an opportunity to reflect on the incident.

Safeguarding

- The trust had systems in place to safeguard people from abuse. Most staff we spoke to understood the importance of safeguarding vulnerable adults and children. Safeguarding training was mandatory and took place at different levels according to the staff members role. The compliance with safeguarding training in May 2015 was safeguarding adults 91%, safeguarding children level one 99%, safeguarding children level two 93% and safeguarding children level three 86%.
- From April 2014 to the end of March 2015 there had been 363 safeguarding alerts raised by the trust. Most of these resulted in a safeguarding stategy meeting taking place. Of these 20 alerts were allegations against members of staff. The trust recognised that there were variations between wards and teams making alerts and were working with areas with low levels of alerts to ensure they were recognising safeguarding issues. The forensic wards needed to review their thresholds for making a safeguarding alert as some incidents of patients assaulting other patients were not being reported.
- The services had safeguarding leads who could support staff with raising an alert and knew the detailed arrangements in the geographical area in which the service was located. The trust safeguarding policy included a flow chart and aide memoire to remind staff of the process. There was some very good safeguarding practice, for example the use of 'grab bags' at Broadmoor providing staff with all the guidance they needed in one place to respond to potential abuse.
- Local authorities fed back that the trust was actively engaged in local multi-agency safeguarding boards and associated work such as training for investigators. Bracknell Forest specifically mentioned the good joint working with the high secure services about safeguarding children.

- Each clinical service unit had a safeguarding forum that fed into a trust wide safeguarding group. The trust arranged an annual safeguarding conference.

Assessing and monitoring safety and risk

- The trust was aware that work was needed to improve assessing and managing risk to patients. The trust had red rated on the trust risk register the risk of failing to manage clinical risk effectively, resulting in serious self-harm or suicide.
- The trust monitored as part of its integrated performance report the percentage of inpatients with a risk assessment completed within 72 hours of admission. This indicated that over 96% had a risk assessment in place and this had been sustained over the previous year. The inspection looked at the availability and content of risk assessments across the core services and found a mixed picture. Within the forensic wards and acute wards there were examples of risk assessments that did not address all the areas of risk or where they had not been updated following an incident or a change in the persons needs. In the home treatment teams risk was being carefully considered by the multi-disciplinary team but the risk assessments were not updated just notes made in the persons progress record. This meant there was the potential for staff to not be aware of the risks for that person.
- The trust had a suicide and self-harm reduction strategy 2014-18. This followed the national suicide prevention strategy 2012. The trust had implemented a number of actions in response to this. These included high secure and forensic services having a suicide prevention group; mandatory training on managing risk for front line staff; also mandatory training on recovery orientated clinical risk management; more work with partner agencies for local services such as the police; the enhanced observation policy had been reviewed with input from the coroner; a dual diagnosis strategy had been developed as well as other actions. In the high secure and forensic services a checklist has been implemented to ensure risks of suicide in hospital and post discharge are reduced as much as possible.
- The trust was one of the first trusts to take part in the piloting of a health and safety scorecard that has been developed by the national confidential enquiry into suicide and homicide for people with a mental health illness.

Potential risks

Safe staffing

- The director of nursing had carried out a review of nurse staffing levels across the services. This had included benchmarking against staffing levels in other trusts and using professional knowledge. This had identified a number of areas where staffing levels needed to be reviewed although the work on implementing this was taking place after the inspection.
- The trust had an e-rostering system in place across inpatient services. The community teams were due to start using this system in October 2015.
- Vacancies in October 2014 were 15% and just prior to the inspection were 11%. The healthcare vacancies had halved. There were 166 band 5 registered nursing vacancies. Staff vacancies remained a key area of non-compliance on the trusts performance dashboard. From January to December 2014 the staff turnover had been 16.2%. The trust sickness rates were broadly in line with other mental health trusts at 4.9%, although there were variations between services. In some areas high levels of vacancies and sickness were resulting in a high use of agency staff.
- The trust had an active programme of recruitment. In the last year recruitment was brought back into the trust after being provided by an external company. This had improved the rate of recruitment and the average number of weeks to fill a vacancy. The greatest challenge was to fill band 5 nursing posts. The trust recruitment policy was looking at how to attract staff by linking with local universities, recruiting further afield but also looking at other ways to make the jobs more attractive through offering flexible working, developing a staff benefit scheme, change of payment timescales for bank staff, reviewing the bank rate amongst other ideas. The trust was also looking at staff retention – undertaking exit interviews and also interviewing new staff 90 days into the job to see how they were doing. The preceptorship arrangements for band 5 nurses were also being developed.

- Staffing levels were monitored monthly and information made available to the board. The February 2015 2% (95) shifts were rated red to show the staffing did not meet planned requirements. From looking at staff rotas these figures especially for forensic services might not be completely accurate. This was recognised by the senior management team who were working to improve the accuracy of reporting. In line with the other high secure services Broadmoor hospital had withdrawn additional payment for working in high secure for bank staff and newly appointed staff. This had led to particular challenges in recruiting staff at Broadmoor hospital. The Royal College of Nursing, NHS England and an external governance review had all commented on the staffing levels at Broadmoor. Whilst they do not feel security is compromised they are concerned about activities being cancelled and the amount of time, patients are spending in their rooms.
- The inspection found that staffing levels were having the greatest impact in the high secure services, forensic services and community based mental health services. The area of greatest concern was in forensic services. Here vacancies especially for registered nurses were higher and whilst efforts were made to fill these shifts temporary staff did not necessarily have the skills to perform all the roles. The staffing levels were having a detrimental impact on access to therapeutic activities, escorted leave and one to one sessions with the primary nurses. In addition whilst anecdotal there were also concerns about staffing levels and skill mix affecting the numbers of incidents and use of restrictive practices on the ward. Broadmoor used night-time confinement on some wards and this was put in place where it was considered that this would maximise therapeutic benefit for patients in the hospital. For example, confining a group of patients at night released staff to facilitate greater therapeutic input for patients during the day. Where patients were subject to night time confinement, some did not have access to a minimum of 25 hours a week of therapeutic input which was recommended as the minimum. At Broadmoor the staffing levels did not reduce safety but impacted on access to association time, therapeutic and leisure activities and resulted in restrictive practices being used for longer periods of time than might otherwise be needed. In the adult community teams, especially the recovery teams high caseloads meant that there was a risk to patients that they may not receive the support they need in a timely manner. We also found in other services that staff were very stretched. For example on the acute wards staff would often have to help in the health based places of safety or with incidents on other wards which could reduce staffing levels and potentially impact on patient care.
- The NHS staff survey results in 2014 reflected some of these challenges. The trust performed better than the national average for staff suffering work related stress/ pressure and staff feeling satisfied with the quality of work and patient care they are able to deliver. The trust performed worse than average for staff feeling pressure to attend work when feeling unwell.

Safe and clean ward environments and community care

- The trust provided services from a very variable range of physical environments across 25 main sites. At the time of the inspection two large redevelopment programmes were taking place. The redevelopment of Broadmoor hospital will be completed in 2017. On the St Bernards hospital site the male medium secure accommodation is being replaced by a new 80 bed unit called Thames Lodge opening in 2016.
- During the inspection we heard from staff that there could be challenges in the timely completion of building and equipment repairs or renovations that were impacting on the quality of the service available to the patients and staff. For example at Mott House, St Bernard's a tumble drier had not been repaired for three months. Also some community team bases needed improvements to make sure they were appropriate for staff and patients such as the provision of appropriate seating in the reception area for the cognitive impairment and dementia team in east Ealing. Also across the community team bases where staff were meeting with patients, there was not always access to an alarm so that staff could call for help in the event of an incident. Whilst teams were managing this in different ways these arrangements need to be reviewed to ensure staff safety was maintained. Also on Cranfield ward at Broadmoor where patients spent a lot of time in their bedrooms more could be done to make these environments more reflective of the therapeutic aims of the service.
- We found that facilities were generally clean. Infection control and health & safety is monitored across the trust

through a system of nurse walk-abouts using safety checklists. Prior to the inspection we heard about legionella at St Bernards and issues with the use of chemicals and asbestos in workshops at Broadmoor. We were satisfied that these had been addressed or appropriate plans were in place by the trust to maintain the safety of patients and staff.

- The inpatient services had patient led assessments of the care environment (PLACE). Overall the PLACE assessments gave high cleanliness scores with Broadmoor being an outlier at 77.83%.
- The clinical service units had health and safety committees and cleanliness and infection control groups. These report through the patient safety & safeguarding committee to the quality assurance committee that reports to the board.
- Mandatory training provided by the trust included fire safety, infection control, health and safety, moving and handling and basic life support. There were high levels for staff completing this training and where targets were missed an action plan was in place to ensure training was completed.
- The trust had undertaken environmental risk assessments of ligature point risks in the mental health inpatient areas during the last year and these identified high risk ligature points. In high secure and forensic services these had mostly been removed or were being managed. In the local services especially the acute wards we found that the audits did not cover all areas of the ward accessed by patients. There was not a clear programme on acute wards of when high risk ligature point reduction work would take place. Items such as phone chargers with cables were accessible on acute wards where patients had been assessed as being at risk of self-harm. On Meridian ward which supported people over the age of 55 there was not a clear plan for how how risks associated with ligature points would be addressed.
- We looked at whether patients using mixed gender inpatient services were provided with 'same sex accommodation' to promote their privacy and dignity. The trust had reported no breaches in same gender care. In Hammersmith & Fulham the trust were working with commissioners to make these wards single gender. There were also plans to adapt the environment at the Limes and Jubilee ward to provide same gender care. At Lakeside the health based place of safety was located on a male ward. This meant the provision was not suitable for females and they were taken to a female ward and offered room in an interview room which was not appropriate. At the Hammersmith & Fulham mental health unit the only seclusion room was located on the male psychiatric intensive care unit. This could compromise the dignity of female patients who need to access the facility. The trust had recognised this and was in the process of developing a separate de-escalation suite on the female ward.

Physical interventions

- The trust had policies on violence reduction and management, seclusion, use of night time confinement (high secure) and use of mechanical restraint (high secure). All the policies talk about the need to maintain training and to use the least restrictive measures. The policies do not reflect the Department of Health guidance "Positive and Pro-active Care". The trust has written to contest this guidance and to state their position which is that prone restraint may at times be necessary.
- Between 1 July 2014 and 31 December 2014 restraint was used on 432 ocassions. Restraint was being used mostly on acute, forensic and high secure inpatient wards. In 179 (41%) of these 432 incidents, patients were restrained in the prone position which was very high. In 31 (7%) of the 432 incidents of restraint rapid tranquilisation was administered. Physical intervention training was delivered by an in-house tutor team and the model used was the prevention and management of violence and aggression (PMVA). The training reflected the needs of staff working in different services. Across the trust staff all knew that physical interventions including restraint should only be used as a last resort. In the acute wards the use of restraint was variable and there were no records of behaviour support plans. In the forensic services the use of restraint was variable and also the records of restraint did not include all the necessary details to monitor the intervention. In the wards for older people on Meridian ward the staff did not recognise that holding patients by their arms in what they called 'precautionary arm holds' was a form of restraint and as a result this was not being recorded or monitored. This means that the trust needed to ensure that staff were using this physical intervention appropriately by ensuring it was recognised, recorded and monitored. The trust must also aim to reduce the use of prone restraint which was very high.

- There were in total 361 incidents of use of seclusion across 37 wards at the trust (1 July - 31 December 2014). Seclusion was being used mostly on acute, forensic and high secure inpatient wards. There were 37 patients in long term segregation at Broadmoor at the time of the inspection. The trust was aware of variations in the use of seclusion across the sites. At the time of the inspection the terms of reference were being finalized for Nottinghamshire Healthcare NHS Foundation Trust to carry out a review of the facilities and practice around seclusion.
- We were concerned about the use of seclusion for a number of reasons. First of all some of the facilities were not located suitably or appropriately maintained for people who had to use them. For example in each of the mental health units with acute wards, patients were being moved between wards and in some cases between floors to access seclusion rooms. Some seclusion rooms at Broadmoor were located so that other patients on the ward could see the person who was secluded which did not promote their privacy or dignity, such as on Canterbury ward. Also some needed environmental improvements such as the seclusion facilities in some of the acute units where the room was not very clean or needed some maintenance work. Second, the records of seclusion were not all fully completed, which meant it was not always possible to know if patients had received appropriate medical and nursing monitoring during their time in seclusion. Third, there were also some practices which were not appropriate. For example on Parklands ward which is a female forensic services all the patients had to wear protective clothing in seclusion whether they individually needed this or not. Also in forensic services, some patients were being asked to remain in rooms as part of their planned care without it being recognised that seclusion was taking place and therefore without the necessary safeguards. This was raised and addressed at the time of the inspection.
- Prior to the inspection there had been work taking place at Broadmoor to reduce the use of long-term segregation. A pilot project on Ascot ward was leading to changes in practice and the reduction of the use of long term segregation. This had excellent feedback from staff and patients. This pilot project had involved patients in their care planning for exiting from environments of long term segregation. There was also positive work which had taken place on Epsom ward in minimising the restrictive practices within an environment where all patients were subject to conditions of long term segregation. This had shown that staff were thinking about ways to reduce restrictive practices and challenge some of the culture around the use of long term segregation.
- West London forensic services established in December 2014 a restrictive interventions reduction committee. This monitors and reviews the use of restrictive interventions and supports innovative programmes to reduce the use of interventions. The trust has made one of its priorities for its 2015-16 quality account to reduce the use of restrictive interventions including physical restraint, seclusion and long-term segregation. This work was progressing well in the high secure services, work was underway in forensic but local services including the acute wards still needed to progress. Six wards at Broadmoor four wards at West London forensic services and one ward in local services were participating in the 'safe wards' initiative.
- Within the forensic services at St Bernards there were examples of blanket restrictions. For example patients carried books that were signed when they completed an activity and leave would only take place once the book was signed to confirm five activity sessions had taken place. This was a blanket approach and not based on individual care plans.

Safe equipment

- Medical devices across the trust were mostly regularly maintained and checked regularly to ensure they were fit for purpose. They were also appropriately located to ensure they could be accessed when needed. On some of the acute wards and Meridian ward some emergency equipment had not been checked on a weekly basis and equipment was broken and if needed would have to be brought from another ward which could be dangerous in an emergency situation.
- On Meridian ward which supported people over the age of 55 there was no equipment to help with moving and handling patients who had mobility issues. The acute wards provided an 'ageless service' so some patients would be older and potentially have reduced mobility. It was observed that not all the bedrooms had call bells so that patients could call staff for help if needed.

- In February 2015 the trust had rolled out having defibrillators in all its services (80 across 20 sites). This was part of the London Ambulance Service 'shockingly easy' campaign. The trust was the first of its kind to be accredited by the London ambulance service.

Medication

- There were a number of areas where medicines were not managed safely. In some cases the necessary physical monitoring was not always carried out after people received medicines for rapid tranquilisation. Some staff did not document the rationale and monitoring when people were prescribed high dose antipsychotic medicine. Documentation of medicines supervised by the home treatment teams, and the patients agreement for the use of unlicensed and off-licence medicines was not always in place. There were other areas of unsafe medicines management which we noted, which had already been picked up by the trust's own medicines audits, such as recording of people's allergy status, ensuring medicines reconciliation is carried out within 72 hours, according to trust policy, management of controlled drugs, and addressing missed doses of medicines. Directly following our inspection, the trust wrote to us to say they had begun to take action to address the additional issues we had identified.
- The trust carried out a wide range of medicines related audits to assess how they were performing, and to identify areas for improvement. These included audits of controlled drugs, missed doses, recording of allergies, medicines reconciliation, and safe and secure handling of medicines. These audits showed that improvements were being made, but further improvements were needed to ensure medicines were managed safely. The trust already has action plans in place to address the issues they had identified prior to our inspection. The trust wrote to us directly after our inspection to say it had begun to take action to address the additional issues we noted.
- Medicines errors and incidents were reported quarterly. The trust had identified that it was under reporting medicines incidents and were encouraging the reporting of medicines incidents to encourage learning. A medicines safety officer had been in post since September 2014 to improve patient safety related to medicines.
- Throughout the trust, staff told us that the pharmacy team were a valuable resource in identifying issues with medicines and encouraging improvement. In all of the areas we inspected there was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety.
- Arrangements for the supply of medicines were good. There were effective arrangements in place for medicines supplies and advice out of hours.
- The pharmacy team had developed a junior doctor's induction handbook which provided a quick reference summary of important medicines management issues for ward doctors, had launched a medicines management and optimisation exchange page on the trust intranet, provided in house and external teaching on a number of medication related topics and had developed and implemented a medicines safety study day. There was a monthly 'medicines matters' bulletin that was disseminated to all staff. This bulletin provided an update including new guidance on medicines in mental health, audits carried out on medicines in the trust, news and reviews on medicines and learning lessons from medication incidents. Pharmacy has also responded to and, where appropriate, taken action on medicines alerts, including developing posters and stickers to highlight patients safety alerts related to medicines. We found that the pharmacy team at Broadmoor provided a well-established clinical service to ensure people were safe from harm from medicines, and the CQC pharmacist inspector noted that medicines were managed safely on this site. The trust holds regular medicines safety meetings to improve medicines use and patient safety.
- The trust audited the use of injectable rapid tranquilisation. 15 incidents were reported on the trusts incident reporting system in March 2015. During our inspection we identified that the use of injectable rapid tranquilisation was being under-reported, as incident forms were not always completed following the use of rapid tranquilisation, and we could not find evidence that the physical monitoring necessary for peoples safety was always carried out after people were administered rapid tranquilisation.
- Improvements were needed to the management of controlled drugs. The trusts controlled drugs audit for

2014/2015 identified that out of 54 areas audited, 19/54 required further improvements to ensure controlled drugs were managed according to the trust controlled drugs policy. Ten of these were identified as 'red', 9 as 'amber' and 35 as 'green'. Action plans were put in place for the areas requiring improvement. Improvements were needed to the identification and recording of allergies. The trusts last audit identified that only 15% of active patients had an allergy or adverse reaction recorded in their electronic patient record.

- The trusts medicines reconciliation audit 2014/2015 showed that only 74% of patients admitted to the trust had a medicines reconciliation completed during their stay. The purpose of medicines reconciliation is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission and therefore minimising medication errors. The trust already had an action plan in place to address this.
- The trust carried out a safe and secure handling of medicines audit across all wards/units/departments where medicines are kept (70 sites). Areas of concern highlighted from the audit were temperature monitoring for stored medicines, management of FP10 prescriptions and completion of inpatient prescription charts for administration. Action plans had been put in place following this audit, and improvements had been made.
- The trusts carried out an omitted doses audit in February 2015. 681 patients were included in the audit, on 51 wards. During a 7 day period, there were 2112 omitted doses, out of which 159 were for medicines not unavailable, there were 189 gaps, so it was unclear whether medicines had been omitted or administered, and 1320 were for refusals. The trust was taking action to reduce the number of omitted doses.
- When people were detained under the Mental Health Act, the appropriate legal authorities for medicines to be administered were in place and were kept with prescription charts in most areas, so that nurses were able to check that medicines had been legally authorised before they administered any medicines.

Requires improvement

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

We rated effective as **requires improvement** for the following reasons:

In acute wards for adults and the psychiatric intensive care unit we found that:

- All patients did not have physical health assessments completed that were thorough and were followed up in a timely manner including ongoing physical health checks where needed.

In community based mental health services for adults we found that:

- Records of patient care and treatment were not always accurate or up to date.
- Records of patient care were not always easy for staff to find.

In mental health crisis services and health based places of safety we found that:

- The records across the teams were not consistent and accurate especially in terms of updating risk assessments, medication records and care plans. This could potentially place patients at risk of not having their current needs met. Audits were not taking place to identify when this work was needed.
- The number of staff being supported by receiving regular supervision was very low.

However the induction and ongoing training was valued by staff and improving the quality of care. Staff were mainly well supported in their teams and there were opportunities across the trust for reflective practice.

There were many positive examples of multi-disciplinary teams working together to support patients and also of teams working together as patients moved between the services.

The trusts systems supported the appropriate implementation of the Mental Health Act and its code of practice.

Our findings

Assessment and delivery of care and treatment

- Most of the areas we visited completed comprehensive assessments of the people they were supporting. The assessments varied dependent on the needs of the individuals. For example in high secure services, admissions were planned and assessments took place prior to admission and a multi-disciplinary admissions panel considered the referral. In the CAMHS community services the assessments included the young person and their family. Information came from other involved bodies such as education.
- The trust had set a target that all patients would have a recorded physical health check within 72 hours of admission. In the last integrated performance report in May 2015, this was achieved for 99% of patients. This level of achievement had been consistent across the previous year. Improving physical healthcare had been a specific target in the quality account from 2013-14 and this had been achieved. In 2014-15 the quality account had set a target in the high secure, forensic and local inpatient services to improve the detection and management of long term conditions. The data was showing that for high secure services the trust was providing as least as good care as an individual would expect in the community. For forensic and local inpatient services the recording in the patient record system made it hard to assess progress. On some wards the inspection confirmed the poor record keeping and so it was not possible to know if patients were being supported to have their physical healthcare needs monitored.
- The National Audit of Schizophrenia found in 2014 that the trust was below what should be provided in terms of monitoring physical health for patients with this diagnosis. We looked at whether patients were having their physical health monitored and appropriate support with physical health care conditions. There were different arrangements in place across services to support people with their physical healthcare. In local inpatient services people were assessed by a ward

doctor on admission. It was recognised that the ward based nursing staff needed further development in terms of their knowledge and skills to support patients with their physical healthcare needs. A clinical nursing structure was being implemented by the director of nursing including matrons with the skills to develop this work. For patients with long term mental health needs on the forensic wards, the trust had appointed a liaison physician to improve their overall physical health. The forensic wards were also working with Imperial Healthcare NHS Trust with diabetes consultants visiting the wards to provide better diabetes care.

- In the Care Quality Commission community mental health patient experience survey 2014, the trust performed poorly on the question to patients about whether the mental health services gave them help or advice with finding support for their physical healthcare needs. In the home treatment teams the inspection found there was a lack of consistency about how staff were supporting people to address their physical health care needs.
- The trust was making progress on its smoking cessation programme. The high secure services were smoke –free. In forensic and local services the aim was to encourage patients to take part in the smoking cessation programme. Clinics had been established for patients and training provided for patients and staff. Some patients had stopped smoking. The trust was moving towards smoke free sites.
- The trust acknowledged that the quality of care planning as variable across the trust. We found that there was a lot of work taking place to improve care planning and in many of the areas we visited the quality of care planning had improved and they were more personalized. In some teams the care planning was very good such as the cognitive impairment and dementia teams where the care plans were very person-centred and focused on supporting people to retain their independence. In forensic and acute wards it was particularly noted that the care plans needed to improve, with more patient involvement and a greater focus on recovery. In inpatient wards for older people more people should have been offered a copy of their care plan.

Outcomes for people using services

- The trust had a wide range of measures in place agreed with commissioners, other stakeholders such as NHS England and in partnerships with social care with the aim of improving the outcomes of people who use their services.
- The commissioning for quality and innovation (CQUIN) framework for 2014/15 had incentivised the trust to deliver improvement. A number of targets were set for local, forensic and high secure services. For local services examples of these included communication with GP's, developing integrated care pathways and transfer of young people from CAMHS to adult services at their 18th birthday. In forensic services these included improving physical healthcare, inproving care pathways for CAMHS and collaborative risk assessments. In high secure these included improving physical healthcare, involving carers and recovery orientated practice. These were mostly met in local and high secure services, but work was ongoing in forensic services.
- The trust ensured it maintained the care it provided and the associated procedures in line with the latest NICE guidance. A trust wide group oversees this process and shared the work with clinical service units.
- The trust had a dedicated clinical effectiveness and audit team to provide advice, support and training. They recognised that clinical audit was an essential part of improving quality.
- The trust in 2014-15 had participated in all of the national clinical audits that it was eligible to participate in. This included the National Audit of Schizophrenia and the Prescribing Observatory for Mental Health (POHM-UK). The POMH – UK included specific topics , anti-psychotic prescribing for people with a learning disability, prescribing for people with a personality disorder and prescribing for substance misuse: alcohol detoxification.
- The trust identified that there were 41 internal and local clinical audit projects taking place. These had been agreed by the trust or clinical service unit as a priority as part of their quality improvement processes. Examples of the 5 trust wide audits included infection control hand hygiene audits, monitoring the monthly senior nurse walkabout checklists, a quarterly observation and engagement audit. Locally generated clinical audits covered a wide range of areas including patient records, community meetings, mental health act compliance, transition from CAMHS to adult services. In addition there were 12 trust wide non-financial audits monitoring

key areas of work. These included use of temporary staff, learning lessons from serious incidents and monitoring data quality. In the home treatment teams the audits were not being completed to improve service delivery. In the forensic services some wards were struggling to complete the audits.

- In terms of measuring outcomes for individuals the trust was using the health of the nation outcome scales to measure the health and social functioning of people with a severe mental illness and over time the patient outcomes. Services also used a range of other outcome measures to see how patients were progressing.

Staff skill

- The trust provided a corporate induction for all staff. We heard from a range of staff that this training was very helpful. Staff said they valued meeting the chief executive and also having training from service users and carers.
- In addition staff received a local induction that supported them to understand their specific role in the services. We heard that in services that were very stretched such as the forensic and high secure wards, that these local inductions were not always completed and signed off.
- The trust had core mandatory training requirements with attendance defined for qualified and unqualified staff working in different parts of the trust. This included fire awareness, moving and handling, basic life support and automated external defibrillation, health and safety, infection control, safeguarding adults and children, breakaway, clinical risk training, information governance, mental health law, equality and diversity, information governance. At the time of the inspection 87% of staff had completed the mandatory training and information was available for each clinical service unit and wards or teams that were outliers could be identified. In addition there were other statutory and essential to role training courses. For example staff working in high secure services had additional training on security.
- Staff talked positively about the training opportunities they received. For example the trust had launched in April 2015 a care certificate for healthcare assistants to support them to develop relevant skills, values and behaviours. Staff also talked about accessing training through the recovery college. An external governance review in January 2015 commented favourably on the ongoing training, especially for nursing and medical staff. Examples include training on restorative justice and training on how to support people with a personality disorder. The staff working in the community recovery teams which provided an 'ageless' service said they would welcome more training on meeting the needs of older people.
- The junior doctors particularly commended the good links with the post-graduate office. A trainee forum had been established for trainee staff and this was well received.
- The trust expected all staff to have completed an annual appraisal. In March 2015 85% of staff had received an in year appraisal. From April 2015 onwards the trust had changed the key performance indicator and was measuring the percentage of staff who had objectives set for the financial year. In May 2015 this was 31% of staff and the trust were actively encouraging these objectives to be set.
- The trust had an expectation that staff will have access to monthly clinical and managerial supervisions. Most staff we talked to said they were receiving clinical and managerial supervision and many told us that this had improved, although the frequency was variable between services. The home treatment teams were not providing staff with regular supervision.
- The trust expected staff to have access to regular team meetings and we found that these were usually taking place and in most services there were also meetings providing opportunities for reflective pratice which was well received.
- We found examples of where managers were working to address staff performance issues. Staff said this can sometimes take far too long and the trust acknowledged that the process needed to be streamlined and this work was underway.
- The trust complied with the medical revalidation statutory requirements. In 2014-15 98% of the trust doctors had completed their appraisal.
- The trust aimed to celebrate the success of staff who lived the trust's values while delivering excellent care. They had an annual staff awards scheme, employee of the month scheme and also recently a team of the month award to thank staff and show they value outstanding performance at work.

Multi-disciplinary working and inter-agency work

Requires improvement

Are services effective?

- Staff spoke favourably about internal multi-disciplinary work. We observed multi-disciplinary meetings and staff handovers. This reflected some good practice and we saw staff working well together in a respectful manner making the most of each others skills and experience. It was noted that handover and multi-disciplinary meetings across the acute wards were very variable and some needed to improve.
- We also saw many examples of how different teams in the trust worked together to support patients as they moved between services. This was particularly evident for patients who were moving from inpatient services to receiving support from community teams. We heard about how information was shared and staff from community teams attended meetings on the ward.
- We heard from stakeholders that the trust faced ongoing challenges in working with GPs and sending them timely information. In most teams this was progressing positively and in one community recovery team where the performance of one professional needed to improve this was being addressed.
- We found some examples of good inter-agency work and also some challenges. For example we heard about the partnership with Ealing Council and Accession Social Enterprise to develop a number of work rehabilitation units which have helped people to find meaningful employment opportunities. We also heard through the focus groups about the work of the forensic outreach service where staff from a wide range of professional backgrounds work with a patient at least six months before discharge. This therapeutic work continues and can intensify after the patient is discharged to maintain their progress outside hospital. We were also told by staff about the impact of reductions in social care funding on access to social workers to support the discharge planning process.
- The trust had also worked affectively with other trusts in partnership with other agencies. The North West London mental health programme board was the first in London to publish a crisis care concordat action plan which was a national initiative aimed at improving the response of different agencies to people in a mental health crisis. The medical director led the work in agreeing new mental health crisis commissioning standards aimed at increasing the accessibility and consistency of services. Through joint working with the police there have been no patients in a police cell under section 136 of the Mental Health Act for over a year.
- In the last year there was also the development of a primary mental health service across the three main local service boroughs. This involved community nurses working in close collabaoration with GPs and other colleagues in primary care to support patients who would previously have required treatment from traditional community mental health teams.

Information and Records Systems

- Staff told the inspection team that the trusts IT, patient records and telephony systems had improved.
- The trust was investing in technology to support the delivery of care and operational efficiencies. This has included investment in an electronic document management system. In 2014 the trust went live with RiO7, a new version of the patient record system. It was hoped that this system would not only support existing work, but offer opportunities to facilitate new ways of working such as integration with GP systems and support e-prescribing and mobile working. The trust was also now using Windows 7 and Microsoft 2010 which had resulted in more reliable and faster network access.
- In the Ealing recovery teams there was particularly disorganised and inconsistent record keeping. This meant that it was hard to find the correct information about patients and so there was a potential risk that this could impact on the care provided. The home treatment teams also had some inaccurate and inconsistent records including care plans that were limited in detail and risk assessments which had not been updated. In forensic services the quality of patient records needed to improve in terms of consistency and detailed information.

Consent to care and treatment

- The trust established a mental health law group in November 2014 that considered the Mental Capacity Act (MCA) and Mental Health Act.
- New training was introduced by the trust in March 2015 that focused on the MCA and Deprivation of Liberty Safeguards (DoLS). This included a half day training for health care assistants and other junior staff. Specialist training from a lawyer was provided for senior staff. In depth and bespoke training took place on the Limes and Jubilee ward who support patients who are over the age of 65. Some teams such as the rehabilitation

and home treatment teams acknowledged that their knowledge on how to apply the act needed further development. On Jubilee ward further input was needed to ensure staff are clear when to consider detention under the Mental health Act and when an application should be made to authorize a DoLS.

- The trust had produced wall charts and screen savers to support staff with using the MCA and DoLS.
- Between the 1 July 2014 and the 31 December 2014 there had been 7 DoLS applications. Four of these were from The Limes and three from Jubilee ward.
- The trust had also produced a leaflet on advance decisions that had been widely distributed to patients.

Assessment and treatment in line with Mental Health Act

- In the 12 months prior to the inspection the trust had 31 visits from Mental Health Act reviewers. The most common issues were patients not being advised of their rights, care plans not reflecting the views of the patients and lack of assessment of capacity.
- The Trust's systems supported the appropriate implementation of the Mental Health Act (MHA) and its code of practice. Administrative support and legal advice was available from the head of mental health law and clinical records from a centralised team within the trust, as well MHA administrators based at each hospital site. Broadmoor hospital had a separate MHA lead and administrative support systems.
- Regular audits were completed to ensure the MHA was being implemented correctly. Responsibility for the monitoring the implementation of the MHA and MCA within the trust rests with the clinical effectiveness & compliance committee (CECC). The MHA leads provide reports on the monthly use of the MHA. The CECC reports to the quality assurance committee and to the trust board. There was no MCA lead within the Trust at the time of the inspection. The head of mental health law and clinical records held the responsibility for the management of deprivation of liberty safeguards within the trust.
- Training was provided to staff within local sites. Role specific training was given where required. Overall staff appeared to have a good understanding of the MHA and code of practice.
- Seven full Mental Health Act review visits were completed. Detention paperwork was filled in correctly, was up to date and was stored appropriately.
- There was a good adherence to consent to treatment and capacity requirements overall. Copies of consent to treatment forms were attached to medication charts where applicable. However, on two wards where a mental health act review visit was completed, we were unable to consistently evidence the completion of assessments of patient's capacity to consent to treatment, or a discussion about consent.
- Most people had their rights under the MHA explained to them. However on five of the wards where a mental health act review visit was completed, we were unable locate consistent records to confirm that all patients had been informed of their rights on admission and regularly thereafter.
- A majority of the care plans we reviewed were comprehensive and individualised. On three wards where a Mental Health Act review visit was completed, there was inconsistent evidence of patient involvement and the recording of patient's views in relation to their care and treatment in line with the code of practice.
- Within all of the wards visited people had access to Independent Mental Health Advocacy (IMHA) services and information on IMHA services was provided to patients. Patients and staff appeared clear on how to access IMHA services appropriately.

Good

Are services caring?

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

Summary of findings

We rated caring as **good** for the following reasons:

- Staff were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard-working, caring and compassionate staff.
- People and where appropriate their carers were mainly involved in decisions about their care.
- Opportunities were available for people to be involved in decisions about their services and the wider trust.

Our findings

Dignity, respect and compassion

- The staff we spoke to across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard working, caring and compassionate staff.
- We observed many examples of positive interactions between staff and patients throughout the inspection visit. For example when on all the wards at Broadmoor and in our visits to the recreation, training and therapeutic services, staff were treating patients with care, kindness and respect. This was also evident in the conversations we had with staff, that, without exception they spoke about patients with respect and understanding.
- There were a few places where there were a cluster of negative comments about the attitude of staff from people who have used the services. This was particularly noted for the West London forensic services where about half the patients we spoke to raised concerns about the attitude of some staff. It was also noted that an analysis of complaints completed by the trust had also highlighted staff attitude as the second highest theme. We could see that this was being addressed in a variety of ways including through supervision and the use of training to promote positive behaviours. For example customer care training had taken place for reception and administrative staff trust wide
- with service user involvement. Where needed the trust was also investigating individual concerns and taking action.
- We also found in some areas that there was room for improvement. For example on Grosvenor ward some staff could improve in terms of their interactions with patients particularly when they were showing signs of distress.

Involvement of people using services

- On most wards there were regular community meetings taking place which enabled patients to have some involvement in the services they were receiving.
- Some specific work that was taking place on four wards in the high secure services looking at the co-production of care plans. It was proposed that this would be expanded.
- Patients were supported to attend meetings about their care and support and to be actively involved in planning their ongoing care and treatment. The exception to this was the Wells unit a child and adolescent mental health ward. Here the young people were not encouraged to join the ward round but this could be considered on an individual basis.
- There were eight different advocacy services operating across the geographical areas covered by the trust. People who used the services told us that had information available about the advocacy services and could access these as needed. The only exception to this was on Meridian ward where ward staff were not clear on how to access advocacy services.
- The trust had involvement leads / carer support worker posts across their services. Some of these posts had staff directly employed by the trust. Other post-holders were employed by the local authority or third sector organisations.
- The different clinical service units had separate arrangements for engaging with people who use the services and carers. For example forensic services had reviewed user and carer involvement. They had

Good

Are services caring?

established a monthly women's service user forum, monthly men's service user forum, monthly carers forum, quarterly service user and carer experience forum and quarterly carer event. The high secure services had a patient forum and carers meetings. The arrangements in local services were less well developed.

- There is also a trust wide service user and carer experience board. This reflected on and provided updates on how user and carer engagement was happening within the trust.

- Most of the inpatient areas we visited had arrangements in place to introduce patients arriving on the ward in a thoughtful manner that enabled them to be shown around. We saw different examples of information being given to patients and their relatives and carers to introduce them to the service

Good

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

We rated responsive as **good** for the following reasons:

- Despite there being great pressures, the services were mostly managing to respond to the needs of patients in a timely manner. Where patients had to move between wards for non-clinical reasons this occurred mainly in Hounslow, the numbers were lower and moves were not happening late at night. The trust was aware of the need to provide consistent care and where needed patients were offered a service in the independent sector if a bed in the trust was not available.
- Teams were providing appointments where possible at times that were suitable for people using the service. If patients did not arrive for their appointment there were arrangements in place to check they were alright.
- The trust provided a good range of therapeutic activities for patients using inpatient services. There were some very positive examples at Broadmoor and other services of people having opportunities to develop vocational skills.
- The trust served a very diverse population and there were many positive examples of working with local communities to try and make services more responsive.

However there is still some work to progress with complaints. Some patients did not find making a complaint easy, complaints were not all responded to in a timely manner and feedback from informal complaints was not always used to improve services.

For patients being supported by the community recovery team, there were long waits of between six months and a year to see a psychologist.

Our findings

Right care at the right time

The high secure, forensic and a number of other specialist services provided by the trust were commissioned by NHS England. The trust also worked with clinical commissioning groups, local authorities, people who use services, GPs and other local providers to understand the needs of the people in the three boroughs where local mental health services were provided.

Mental health acute care pathway:

- Patients were admitted where there was a bed available across the trust. They were not always admitted to a bed in their catchment area if one was not available. At the time of our visit, there were eight patients from Ealing on Kestrel ward in Hounslow. Staff tried to work with patients and families and facilitate a transfer between units where possible.
- Staff felt challenged due to the pressure on beds. St Bernard's did not have a female recovery ward, which meant patients were transferred to Hounslow or Hammersmith & Fulham. Finch ward an assessment ward in Hounslow had 26 patients admitted to 20 beds with six of these patients on leave at the time of our visit. Twenty-four patients were admitted to 20 beds on Kingfisher in Hounslow, with five on leave. Four patients on Horizon in Ealing were on leave and the ward had not had any contact with one of these patients for over two weeks. Staff said patients were sometimes admitted to the assessment wards due to a PICU bed not being available. During the inspection, there was a patient being supported in the seclusion room on Grosvenor ward while waiting to be admitted to a PICU.
- Non-clinical moves occurred between the wards as a result of the pressure on acute beds. This was most likely to happen with an assessment ward moving a patient to a recovery ward. Recovery ward managers said that they tried to work with the assessment wards to identify patients who might be most suitable. Both recovery ward managers commented that at times they could be receiving transfers who were still acutely unwell. There were nine recorded patient transfers for non-clinical reasons between wards due to bed pressures in April 2015.

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Are services responsive to people's needs?

- When a patient went on leave, their bed was sometimes used for a new admission. If the patient returned from leave and there was no bed available on the ward, the unit coordinator would identify an empty bed elsewhere within the trust as a temporary measure. Staff said that if a patient needed to return early from leave, efforts were made to increase support in the community to keep the patient at home rather than arrange a transfer to another ward.
- There were patients sleeping on other wards at night. The trust reported that in April 2015 there were 58 sleepovers took place within Hounslow. The trust avoided moving people late at night and were discussed with patients. Patients and staff on the wards where patients slept commented that this could cause disruption to the receiving wards. Staff did not always feel informed about how to meet the needs of the patients sleeping on the ward.
- Kestrel and Kingfisher wards in Hammersmith & Fulham had eleven patients who were experiencing delayed discharges as they were waiting for accommodation. Some patients' discharge had been delayed for three months. Discharge planning began upon admission. Leave periods were routinely tried prior to discharge and supported by the home treatment team and care coordinator.
- Where needed the trust was placing patients in the independent sector. Fewer than10 patients had been placed in the independent sector at the time of the inspection.
- During the inspection a 17 year old had been admitted to Finch ward as there was no bed available within a specialist adolescent unit. This had been reported as a serious incident and the patient was nursed under one-to-one observation on the ward. Staff managed this appropriately and located an appropriate placement and the patient was transferred. The trust had highlighted this admission to the commissioners who were responsible for commissioning appropriate inpatient services.

Other mental health inpatient services:

- None of the wards for older people operated a waiting list and there were beds available for people in their catchment areas. Meridian ward had four delayed discharges over the previous six months that were due to difficulties accessing social care, and patients waiting for a care home placement. The staff worked with the community recovery teams to ensure patients were moved into suitable accommodation as soon as clinically appropriate.
- The rehabilitation wards also said that at times it can be hard to identify suitable discharge placements for patients who had complex needs.
- For forensic services admissions and discharges took place during working hours. Referrals were discussed in fortnightly meeting. Discharge was occasionally delayed due to bed shortages in the identified move on ward, or in the community. However close working with the forensic outreach team helped reduce delayed discharges back into the community.
- The high secure services had a 94% occupancy rate. Some beds were left vacant as part of the contract arrangements with NHS England in order to accommodate emergency situations and incompatibilities between patients. The average length of stay was around 7 years. However, this figure needed to be considered in the context that there were a few patients who had been in the hospital for very long periods of time which lengthened the average length of stay.
- The child and adolescent mental health ward only had planned admissions that did not take place at the weekend. There was no waiting list for children waiting to be admitted to the unit and the average length of stay in the service was 9 months. Discharge meetings were held prior to discharge. Discharge plans and summaries were produced in advance of a child leaving the service. The majority of patients were discharged to the community.

Community mental health services:

- The trust had an urgent advice line that was available out of hours. This provided advice, support and signposting to other services.
- Most of the home treatment teams were not 24 hour. During the hours the teams worked they would receive referrals directly. Out of hours, people would be referred to the psychiatric liaison teams. The home treatment

teams were responsible for 'gatekeeping' all admissions to inpatient beds. Most teams were achieving, or close to achieving, 100% for this indictor that all referrals that may need admission to hospital were seen by the team.

- The assessment teams received around 200 referrals every month. The trust risk register dated June 2015 recorded that the team were not achieving their target for seeing new referrals (emergency - 4 hours; urgent - 24 hours; routine plus - 7 days; routine – 4 weeks). This risk register recorded this as a red risk. It also recorded as a red risk that patients and other professionals were experiencing difficulties accessing the team by telephone during normal working hours. Referrals to the assessment teams were generally made by GPs and were prioritised according to risk. The teams aimed to keep two emergency appointments available every day so that patients could be seen promptly. Most assessments were carried out face to face. However, the service was flexible and assessments were sometimes completed on the telephone, especially if a person had not attended their agreed appointment. Assessments could also be carried out in a patient's home if this worked best for them.
- About 40% of patients seen by the Hounslow assessment team were referred on to the recovery teams. The assessment team and early intervention teams reported delays in transferring patients to the recovery teams because of the pressure on the recovery teams caused by large caseloads. The Hounslow early intervention team described delays of between six and eight months waiting to transfer patients to the recovery teams. Between 30% and 40% of patients were transferred to the recovery teams from the early intervention service. Recovery teams triaged all referrals in order to determine who was at higher risk and should be seen quickly. Less urgent referrals waited four or five weeks to be seen by a doctor. The duty worker provided support to patients in the interim if they needed help.
- The Ealing early intervention service had a mean of 23 days from patient referral to assessment, for Hounslow it was 19 days and Hammersmith & Fulham it was 14 days. The service target for new admissions to the early intervention service was 45 each year. About 60% of early intervention service patients were discharged to primary care after three years with the service.
- As part of the 'shifting settings of care agenda' recovery teams were trying to move patients who had ongoing mental health conditions, but were stable enough, back to primary care so that they could be monitored and supported by their GP. Shifting settings of care aims to promote patients' independence, social inclusion and recovery and allow GPs to 'join up' physical and mental health care more effectively. For example, Hounslow recovery team east had a target to discharge 54 patients back to their GP or to the primary care plus team, who acted as a step down between primary care and the recovery teams, every month. Since 1 April 2015 they had been achieving this target. Links between the primary care plus team and the community teams were good.
- Waiting times for patients referred to psychology by the early intervention teams was four to eight weeks. In Ealing recovery team west the waiting time to see a psychologist was six months and there were 62 patients on the waiting list at the time of our visit. The waiting time for psychology was seven months in Hounslow recovery team east. The team had tried to shorten waits for psychological interventions by increasing the number of psychology led therapeutic groups provided. Hammersmith and Fulham assessment teams and recovery teams reported that patients had to wait between one and two years to see a psychologist.
- The cognitive impairment and dementia service had target times that varied slightly from team to team but were generally within four weeks from referral to initial assessment and from nine weeks from assessment to diagnosis and treatment. Teams were often able to see people well within these times, although there could be delays between assessment and diagnosis, often for reasons outside the control of the team. For example, the Hammersmith and Fulham team sometimes experienced delays in relation to MRI scans at Charing Cross Hospital - they were currently reviewing their service level agreement with them. Teams were able to see urgent referrals within 24 hours.
- Young people could access the specialist CAMHS service through a referral from their GP, school or social services. All referrals were screened and triaged by the duty worker with urgent cases allocated to a team and the young person and their families informed. The trust-wide target from referral to initial assessment was 77 days (11 weeks) and CAMHS had an internal target

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Are services responsive to people's needs?

across teams of five to six weeks. All teams were currently meeting the internal target with the exception of neurodevelopmental teams. There had been an increase in demand for the service in the last few years of 35% in Ealing and Hounslow which was believed to be due to a general awareness of young people's mental health needs.

Accessibility of appointments:

- We found that services were aware of the need to engage with patients who might find it hard to attend appointments and follow up patients who missed appointments.
- Most services tried to offer flexible appointments and were aware of the need not to cancel urgent appointments and to be on time for appointments.

The facilties promote recovery, comfort, dignity and confidentiality

- Most of the services where care was provided were clean and comfortable environments. Most inpatient services had access to quiet lounges, rooms for therapeutic activities and outside space.
- Some services, where people were staying for a longer period of time encouraged people to bring with some personal possessions and personalise their rooms.
- On some wards there was less privacy. For example on Glyn ward patients did not have access to a phone where they would make calls in private.
- The feedback about meals in inpatient services varied. Most people said they were satisfied with the food. The main exception were the forensic services. When these services move to the new building, there will be facilities for fresh food to be cooked on the site.
- On most wards there was access to hot drinks and snacks.
- Access to therapeutic activities were generally very good for people using inpatient services. There were a good vaiety of activities available at Broadmoor and these provided opportunities for people to gain skills. In the hospitals and community people spoke positively about the courses available at the recovery college. A few people commented about the lack of activities at the weekend and others said activities could be cancelled if there were not enough staff.

Meeting the needs of all people who use the services

- The trust served a very diverse population across each of the areas it covered. The trust demonstrated a real commitment in terms of meeting people's equality, diversity and human rights.
- The trust had a head of diversity and a diversity unit. The trust completed an annual diversity profile report. Equality and diversity training was mandatory and most staff were up to date with this training. Staff had access to copies of information leaflets in a wide range of languages and formats that could be printed off to give to patients.
- The trust had taken a number of actions to meet it's public sector equality duty. Examples of this included attending focus groups with the local Tamil and Somali communities to look at how services can be more responsive; a year long programme of diversity related celebrations in high secure services; progress with creating an LGBT friendly environment across the trust and the launch of LGBT staff forums.
- The trust has links with a wide range of chaplains who provide support. Many of the chaplains joined a focus group and said they felt a valued part of the trust and that they worked well with the ward staff and had access to multi-faith rooms.
- In the high secure services there was an equality and diversity forum which ran regularly to ensure that issues relating to equality and diversity were raised and discussed throughout the hospital. Two patients attended these meetings and were able to contribute. The equality and diversity forum had produced a booklet to help patients and staff understand and know about the different events which had been run. Over the last year, there had been events acknowledging Burns night, St Patricks day, an LGBT social event, Eid celebrations, black history month celebrations and Christmas.

Learning from concerns and complaints

- Information on how to complain was provided on in-patients wards and in community services. The trust website also had information on how to make a complaint. This was written in English. It was not clear how to access information in other formats.

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Are services responsive to people's needs?

- Feedback from some patients and carers said that they did not feel confident about making a complaint for reasons that included; the process was too difficult, they did not feel it would lead to change; they were concerned it could have a negative effect on the care being received. Many of the complaints made were informal and these were not recorded just logged in the patients daily notes. These informal compaints should be used to inform improvements.
- Complainants were offered an opportunity to meet with staff and discuss and resolve their complaints locally.
- Complaints were managed and responded to in each of the clinical service units, with responses being reviewed and signed by the clinical director.
- The trust received 366 complaints from 1 April 2014 to 31 March 2015. This was fewer than the previous year when 444 were received. Local services received 157 complaints, West London forensic services received 52 complaints and high secure services received 151.
- The trust had not upheld 16% of the formal complaints that were made 1 January 2014 to 31 December 2014. There had been 11 referred to the Parliamentary and Health Service Ombudsman (PHSO). None were upheld by the PHSO (one was still pending outcome).
- The trust's policy for the management of complaints, concerns, comments and compliments was ratified in December 2012. It was due for review in July 2015. The policy notes that when the trust received a complaint it aimed to acknowledge it within three days. At this point a timeframe for the response was set with the person. This would depend on the complexity of the complaint, but would usually be around 25 working days. The trust was not responding to all complaints promptly. 87% of complaints during the year were resolved within the timeframe agreed with the complainant. The trust target is 90%. In May 2015, 12 complaints were closed outside of the agreed timeframe. This was 46% of the total. This was due to the late submission of investigation reports and final responses needing to be amended due to poor quality or the need for further investigation.
- Information on complaints was stored on the trust's intranet computer system. The trust was not monitoring the total amount of time taken to respond to complaints. The trust did not systematically look at complaints in terms of the ethnicity or other personal characteristics of complainants in order to see whether there were more or less complaints from any particular group of people using the services. In addition the trust did not specifically look at whether complainants were reflective of the population using trust services.
- Some staff had undertaken a pilot training sessions on interviewing and responding to complaints. The trust was reviewing this training before potentially making it available for more staff.
- We reviewed six complaint files and responses provided to complainants by the trust. All files demonstrated that the complaint had been acknowledged and an initial timeframe set. Staff had written to three of the complainants to extend the timeframe. There was variation between the information contained in the files. The files for complaints from high secure services contained full details of the investigation and interviews. For the other clinical service units it was difficult to see how the conclusions in the responses had been reached by the investigator as the information was not in the file. The six complaints files addressed the concerns raised and offered a clear response with regards to these concerns.
- The trust collected data on complaints, compliments and the patient advice and liaison service. It is reported monthly to the board, bi-monthly to the service user & carer experience subcommittee and quarterly to the quality assurance committee. The trust integrated performance report contained three complaints related key performance indicators: the number of new complaints received in period (trust); the number of complaints still open outside agreed timeframe; and the number of complaints closed outside agreed timeframe.
- The trust produced a quarterly report and annual report called 'learning from experience'. This included the lessons learnt.
- Actions from complaints will be monitored by the clinical service unit. It was not clear how the trust gained assurance that all actions for complaints had been completed. Staff working in complaints acknowledged this was an area the trust was looking to improve its robustness.
- The trust had started a complainant satisfaction survey recently. At the time of the inspection only five responses had been received.

Requires improvement

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

We rated well led as **requires improvement** for the following reasons:

In forensic and high secure services we found that:

- Many staff across both sites, at Broadmoor and at the West London forensic service spoke of feeling disempowered and of suffering from poor morale.
- In the West London forensic services staff expressed specific concerns about the longstanding culture of bullying linked to race, religion and culture.
- Staff based at Broadmoor Hospital told us that they felt detached from the central trust based in London.
- While the trust had identified the key concerns and issues which were raised through the inspection process. Whilst action had been taken this had not yet had sufficient impact to address all the concerns which were highlighted especially with staff engagement in the West London forensic services.

In the acute wards for adults and the psychiatric intensive care unit we found that:

- Governance processes across the wards were not working well. Audits were not always identifying issues or being followed up. Some basic checks were not taking place as planned. The quality of record keeping was very variable. These could all potentially present a risk to the safety of patients.

In crisis services and health based places of safety we found that:

- Governance processes across the home treatment teams were not working well. Audits were not always taking place. There were variations for example in the quality of record keeping, the regular supervision of staff, supporting patients with their physical health and staff understanding and use of the Mental Capacity Act. These could all potentially present a risk to the safety of patients.

However, the trust was developing its integrated performance report and this meant the information from ward to board was improving. The appointment of a director & deputy director of nursing and clinical directors whilst still relatively new in some cases was bringing positive changes including professional engagement in making service improvements.

Our findings

Vision values and strategy

- The trust had a refreshed mission, behaviours and objectives following a major piece of engagement work in summer 2014. The trust's mission is 'promoting health and wellbeing together'. The vision is 'to be an outstanding healthcare provider, committed to improving quality and caring with compassion'.
- The trust had three objectives. The were to 'be outstanding' (collaborate and innovate), 'improve quality' (we invest, we listen and we learn) and 'care with compassion' (we work together and are recommended).
- In the short term the trust had a one year business plan. This identified areas to progress and included, clinical leadership, staff engagement, redevelopment, quality governance and risk management.
- The trust had developed its quality priorities for 2015-16. This identified three main areas of work. The first was patient safety; to reduce the use of physical interventions, including physical restraint, seclusion and long term segregation. Also to create a positive and open culture of reporting incidents and ensure any lessons that are learnt are acted on and embedded across the trust. The second was patient experience; to improve communication with service users by giving them timely information about their care and clearly identifying people who will support them. Also to treat service users in the best possible clinical environments which should be clean, safe and therapeutic at all times.

The third was clinical effectiveness; to improve the physical health of our service users, patients and staff by making services smoke-free and improving physical health monitoring and awareness.

- The trust has also developed a quality strategy 2013-18. The trust commissioned an external governance review and this said that the strategy needed further development 'to create a more pro-active approach to quality with better engagement and clarity around the initiatives and where they fit in relation to key priorities'.

Governance

- At the start of the inspection, there was a presentation from the trust to the inspection team. This highlighted the work of the trust that was a success, the challenges and the areas for improvement. These reflected the findings of the inspection and showed that the trust knew where work was needed. What the inspection did however identify was that the scale and speed of change that was needed was very significant especially in terms of ensuring the staffing levels were safe and met the needs of the people using the services.
- The trust used a range of indicators. These were brought together in an integrated performance report. In May 2015 an updated integrated performance report was introduced to the board and this was much more concise and easier to understand. It was positive to note that the indicators reflecting areas for improvement aligned with the inspection findings such as the red rag for staff vacancies. It was also useful to see the introduction of performance trends in some key areas. It was noted that there was further work taking place to agree the metrics being reported.
- At the time of the inspection there were four main committees that were sub-committees of the board. These were the trust management team, audit committee, finance and investment committee and the quality assurance committee. There were also other programme boards, forums and committees reporting into the board. The quality assurance committee provided the board with assurance in relation to clinical quality. They received reports from three quality governance sub-committees reflecting service user and carer experience, clinical effectiveness & compliance and patient safety & safeguarding.
- The trust had a risk register updated on a monthly basis and this is monitored by the quality assurance committee. The two highest risks were associated with achieving cost improvement plans especially in local services. The third highest risk was the failure to manage clinical risk effectively resulting in serious self-harm or suicide. Changes in risk levels were tracked and there were actions to mitigate risks. The register did not say how long risks had been open. On local risk registers there were some risks without a clear owner who was responsible for addressing the concern.
- The organisation of the trust into two clinical service units and the appointment of seven clinical directors was still relatively new and these directors were learning about their roles and managing a large agenda for change. The clinical director in the high secure services was also developing proposals to improve internal governance arrangements and committee arrangements for the trust. These changes are being implemented at Broadmoor with a view to them being more widely used across the trust.
- The clinical service units had clinical improvement groups for each ward and team. These were multi-disciplinary and had representation from patients. They had recently started to use standard agenda's incorporating patient feedback, complaints and incidents.
- The inspectors found that at a ward or team level the use of this information to monitor the service or make improvements was very variable. Some wards and teams were making good use of information about staffing, feedback from patients, results of local audits to ensure the service was operating well. In other areas this was not happening effectively. For example across the acute wards and home treatment teams, the gathering and use of information such as audits was not happening consistently. This meant that the management of medication, the checking of medical equipment, the recording of risk assessments was not up to date which was potentially unsafe. These were systemic failings of the ward and team based governance processes.
- Commissioners, local authorities and other partners were largely positive about their working relationships

with the trust. They found senior staff very responsive. They felt the changes in the governance systems will take time to embed and that the challenge was achieving ward to board connectivity.

Leadership and culture

- The executive board consisted of seven executive directors who were the most senior managers responsible for the day to day running of the trust. There had been some recent changes of executive directors. The chief executive had been in this post for just under three years and shortly after the inspection announced his pending retirement in November 2015. The director of nursing and patient experience joined the trust in November 2014 and the director of finance and business in January 2015.
- The trust also had a new chair, who started on the 1 April 2015. He had previously been the chair of a local acute NHS trust. There were 7 other non-executive directors. A board development programme was in place and regular away days took place.
- The feedback from stakeholders was that the board and senior management changes were positive, that there was a good relationship with stakeholders and the clinical leadership was also viewed positively.
- The executive and non-executive directors made visits to services, but further work was needed to decide how these can best take place and how the information can be used.
- The trust recognised that there was still more work to do to create a healthy culture in the organisation that promoted the safety and well being of staff. The NHS staff survey in 2014 had a higher response rate of 55% than the previous year. This survey showed that there were improvements in staff feeling that their managers are listening to the team members and making sure that decisions are made as a result of feedback and discussions. There were however still 12 areas where the trust was below the national average and in the worst 20% of all mental health trusts. For example only 54% of the staff surveyed said they would feel secure raising concerns about unsafe clinical practice, which is less less than the national average of 69%. The scores were even lower for staff in forensic and high secure services. This reflected what staff were telling us during the inspection. Another example was that 25% of staff surveyed said they experienced physical violence from patients and relatives (although in forensic services this was 49-56%) compared to the national average of 18%. This again reflected what we heard during the inspection and was one of the reasons why staff said staffing levels were unsafe. Another example was that 8% of the staff surveyed said they had experienced physical violence from other staff (although in forensic and high secure this was 11-19%) compared to the national average of 3%. A final example was that 28% of staff who were surveyed said they experienced harassment, bullying or abuse from other staff (although in parts of forensic, high secure and the gender identity clinic this was 31-47%) compared to a national average of 21%. This was again an ongoing theme from our interviews with staff.
- The inspection team did hear many examples of how people felt well led at a team level and about their positive experiences of team working. We heard how senior managers were very supportive but it can be much harder to work with middle managers.
- The trust had a variety of leadership development opportunities in place. The staff survey had shown that 72% of the staff surveyed believed the trust provided equal opportunities for career progression or promotion, which was below the national average of 86%. This year the trust had launched a leadership programme especially for BME staff, building on the new leadership programme which had started the previous year to invest in staff and develop management from within the trust. To date 19 BME staff had joined the scheme. We also heard about how leadership training was being provided for the clinical leads, consultants and other professionals. Junior doctors also told us about how they had access to leadership training and were feeling more engaged with the trust.
- Most staff we spoke to said they knew about the whistle-blowing procedure but would generally prefer to speak to their line manager in the first instance. The numbers of people using the trust whistle-blowing processes were low. There were 4 internal whistle-blowing alerts in 2014. In addition there were 3 whistle-blowing alerts from staff at Broadmoor that came directly to the Care Quality Commission. These were forwarded to the trust so they could be addressed and used to inform the inspection.

Requires improvement

Are services well-led?

Engagement with people and staff

- The senior team in the trust were all aware that to address the need for cultural change within the trust, ongoing engagement with people who use the services and staff was essential.
- The most significant development in user engagement was the lauch in the last year of the West London Collaborative. This is an independent organisation with its own board, funded by the trust. The Collaborative arranged a conference this year that brought together service users, carers, staff and partner organisations to hear speakers debate the issues surrounding the prescribing of medication with the aim of promoting better collaboration between staff and patients. The Collaborative is also working with the trust to make improvements such as reducing the use of restrictive practices.
- In addition the trust involved patients and carers in many aspects of its work. Examples of this include, helping with staff recruitment, having input into staff training and conferences, helping to assess services using patient led assessments of the care environment, participating in operational and strategic meetings such as the local service transformation programme board. The trust also used an electronic patient feedback system called Meridian, although there were plans progressing for this to be replaced with an alternative system. The trust also employed peer support workers. Patients and carers act as co-developers and co-facilitators for courses provided by the recovery college such as the carers training programme. Leadership courses were being developed for patients through the recovery college.
- The new friends and family test was rolled out by the trust in 2014 although the response rate was very low at 4.2%. Overall 48% of respondents would recommend the trust as somewhere to work and 50% would recommend care at the trust. The trust scored lower than the average on both questions where the respondents answered 'extremely likely'.
- The trust had a staff engagement plan which had five key strands. These were to keep staff safe and healthy, support equal opportunities and career progression, support staff to raise issues of concern, value staff and maintain staffing levels.
- They had also introduced a range of staff engagement initiatives. These had included 'speak up Friday' where staff can contact the chief executive. This had produced a low response rate. There was also a staff reporter scheme where volunteer staff enlisted other staff to give feedback. New staff had been interviewed to find out how their jobs are going. Senior staff were working shifts in services. There were also listening events. In addition there were schemes providing facilitated support to staff teams. To reduce bullying the befriending schemes had been extended and the dignity at work policy was being reviewed.
- The trust also had a range of measures to communicate with staff including on-line bulletins and the chief executives blog. Staff spoke very highly of 'the exchange' which was the trusts intranet system for staff to access the information they needed for their work and to keep updated with developments. We heard from staff that communication in the trust had improved.
- Despite the initiatives the inspection found that there were some areas where staff morale and engagement was a significant concern. The most serious of these were the West London forensic services. Staff and managers spoke of a complex longstanding staff culture of bullying and blame. We were told bullying involved managers bullying staff, staff bullying managers and colleagues bullying each other. A feature of this bullying concerned staff's ethnicity, religion and culture. These issues were also reflected in the child and adolescent mental health ward at the Wells unit which was located with the forensic services. A new clinical director had recently come into post. In addition the trust were engaging external facilitators to work with the services. These fundamental problems have to be actively addressed for the service to move forward in a healthy state.
- Other services also had issues that affected morale but to a lesser extent than the forensic services. In the high secure services some staff did talk about a 'blame culture' and bullying but most talked about pay and the remoteness from the rest of the trust. Again the trust needs to continue the engagement work and address the issues that are important to the team at Broadmoor such as recruitment.
- In other services such as the recovery teams, the acute wards and rehabilitation wards some staff still said they

felt worried about raising issues of concern, but many also talked about wanting to have better communication and feel involved in decisions about the services.

Fit and Proper Person Requirement

- The trust was in the process of meeting the fit and proper persons requirement (FPPR) to comply with Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This regulation ensures that directors of health service bodies are fit and proper persons to carry out the role.
- A new fit and proper persons policy was approved by the trust board in March 2015. It was ratified by the trust's management team in April 2015. The trust also updated its recruitment and selection policy in April 2015. The policies outlined the checks required for directors on appointment and on-going annual checks of fitness. These included checks of criminal record where appropriate, identity, right to work, employment history, professional registration, qualifications and an internet search to check for insolvency and bankruptcy.
- The trust had undertaken a review of the information they held for all their executive directors to ensure they were meeting the standard.
- We reviewed the personnel files of eight directors on the trust board. Six of these were executive directors and two were non-executive directors. Most of the checks on current directors required by the policy had already been carried out or were in process. There were some gaps, which the trust had identified. For one director there were no written references, as verbal references had been sought. The trust had identified this gap and was in the process of sourcing written references.
- The trust was in the process of reviewing the information it held for non executive directors (NEDs). The trust had determined that they did not require a disclosure and barring check for all NEDs.
- The Chair and NEDs were appointed by the Trust Development Authority (TDA). The trust did not have records of references and employment history for these directors, as these checks would be undertaken by the TDA. A copy of the person's appointment letter from the TDA was kept on their file. The trust was in the process of undertaking checks for NEDs, including reviewing evidence of professional qualifications and formal identification. These were completed shortly after the inspection.

Quality improvement, innovation and sustainability

- We heard about many areas of innovation across the trust. An example of this was the programme to improve mental health and well-being on the White City estate, one of the most deprived areas of Hammersmith & Fulham. Working with a local charity using a co-production approach the improving access to psychological therapies team used a variety of techniques to support people with their anxiety and depression.
- The trust undertakes a range of research and would like to see this grow. The trust was one of the first in the country to open a clinical trials facility specifically for mental health research. The new purpose built facility on the Lakeside site in Isleworth was used to carry out the clinical trials work into dementia, psychosis and personality disorder. The facility was a specialist service that provides assessment, treatment and support for people experiencing memory problems and all patients are offered the opportunity to be part of the clinical trials or research programmes. At the time of the inspection there were more than 100 active research projects, ranging from testing new drugs to studies to improve the understanding of mental health issues. The trust was working with Buckinghamshire New University where there was a partnership and the institute of mental health had been established in 2013. The trust was also linked to Imperial College Health Partners and had provided clinical academic leadership to produce best practice guidelines for patients who need a psychosis care pathway.
- The trust also participated in external peer review and service accreditation. This included the accreditation for inpatient mental health services where Finch and Grosvenor wards were accredited and Kestrel and Kingfisher were accredited as excellent. Also the quality network for inpatient CAMHS where the service at the Wells Unit had completed a peer visit and the quality network for community CAMHS which had also led to peer visits. Other accreditations included the memory services national accreditation programme where the services were waiting to be assessed. The

electroconvulsive therapy accreditation service where the Broadmoor and Southall services were accredited as excellent. The forensic inpatient services had completed peer visits as part of their accreditation. Broadmoor hospital is accredited through the national offender management service audit. This audit is carried out by an assessment team from HM Prison Service who for the past few years have scored it in the top 5th percentile.

- The trust clearly understood the need to deliver better care in a challenging economic environment. In order to achieve this they were working with commissioners and other partners across North West London to continue redesigning the local services. Whilst working on this longer term transformation programme the trust was also making cost improvements. The trust had a programme management office to oversee all the projects. All the savings plans had a quality impact assessment. They always included senior clinical input and where relevant input from people who use the service, carers and wider stakeholders.We looked at the quality impact assessments and found evidence of clinical involvement.

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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 18 HSCA (RA) Regulations 2014 Staffing The trust had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patients. This is because in the high secure and forensic services patients were regularly not having access to therapeutic activities, escorted leave, and in high secure services association time. In forensic services some staff were working very long hours. This was also because in the community recovery teams there were not enough staff to safely meet the needs of patients on their caseloads. Also staff had not received training to meet the specific needs of patients over the age of 65. This was a breach of regulation 18(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The trust had not ensured that systems and processes were established and operated effectively to prevent abuse of patients and care and treatment which included acts intended to control or restrain a patient that was not necessary to prevent or not in an proportionate response to risk of harm posed to the patient or another individual if the patient was not subject to control or to restraint. This was because the trust there was a high use of prone restraint. This was because in the West London forensic service restraint and seclusion had not always been

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Requirement notices

appropriately recognised, only used when needed and recorded. Some seclusion facilities were not in a state of adequate repair and did not maintain the dignity of patients using the facility.

This was also because in the acute wards the trust did not have seclusion facilities located so that they could be used safely. Also accurate records of the use of seclusion and physical checks of patients in seclusion were not always available to confirm this had been provided in a safe way.

This was a breach of regulation 13(1)(2)(4)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust did not have effective systems in place to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of a regulated activity, for the purposes of continually evaluating and improving such services. This was because staff in the high secure services did not feel adequately engaged and improvements in communication were needed. In forensic services more work was needed to address the complex issues affecting staff engagement to improve morale, ensure staff engagement and ensure staff feel comfortable raising concerns with managers and senior managers in the trust. This is in breach of regulation 17(1)(2)(e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust had not provided care and treatment that was appropriate and met the needs of patients.

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This was because in the West London forensic services there were some blanket rules and restrictions that were taking place. An example of this was patients having books signed to say they had completed activities before their leave was agreed.

This is a breach of regulation 9(1)(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust had not ensured that care and treatment was provided in a safe way for patients in terms of the proper and safe management of medicines. This was because where patients in the West London forensic services had been prescribed medication above the recommended dose and national guidance had not been followed. This was also because the acute wards did not ensure that use of rapid tranquilisation was always recorded on patients' prescription charts. Patients did not always have their physical health monitored following administration of rapid tranquilisation. Also medication was not consistently managed safely across all the acute wards. This was a breach of regulation 12 (1)(2)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way and the trust done all that was reasonably practicable to mitigate the risks. The trust did not ensure that all ligature risks were included in the wards' ligature audits. Ligature audits did not include timelines for works to be completed and were not updated when works had been completed.

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The trust did not ensure that patients' personal items that could present as a ligature risk to other patients were stored securely when they were not in use.

This was a breach of Regulation 12 (1)(2)(a)(b)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust had not provided care and treatment that was appropriate and met the needs of patients. The trust did not ensure that all patients had their health fully assessed and that where health concerns were identified that these were monitored and treated. This was a breach of Regulation 9 (1)(2)(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust did not have systems and processes which were operated effectively to ensure compliance and address areas where improvements needed to take place to mitigate risks to the health, safety and welfare of patients. Governance processes across the home treatment teams and acute wards were not working well. Audits were not always taking place. There were variations for example in the quality of record keeping, the regular supervision of staff and supporting patients with their physical health. The trust did not maintain an accurate, complete and contemporaneous record for each patient and other records necessary for the management of the regulated activity. The records across the community recovery teams and home treatment teams were not consistent and accurate

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especially in terms of updating risk assessments, medication records and care plans. This could potentially place patients at risk of not having their current needs met. Records were not always easy to find.

In the acute wards and on Meridian ward the use of restraint was not always being recognised and reported so that potential risks to the people who use the services are escalated within the organisation. The trust did not ensure that all staff clearly understood the incident reporting thresholds and reported all incidents.

This was a breach of Regulation 17 (1)(2)(a)(b)(c)(d)

This was a breach of Regulation 17 (1)(2)(a)(b)

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 People were not being protected against the risks associated with unsuitable premises. At Lakeside mental health unit the health based place of safety was based on Kestrel ward, a male ward, at the end of the corridor with other patients. Although there was a separate entrance to the place of safety, people could not be transferred here without compromising their privacy. In addition females could not be admitted to the place of safety on the male ward. Female 136 admissions were taken through a separate entrance onto Grosvenor ward at Lakeside where they would be taken to an interview room as an alternative setting to the place of safety. The place of safety was not suitable for the service provided. This was a breach of Regulation 15 (1) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

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Staff were not receiving the appropriate support and supervision as is necessary to enable them to carry out their duties they are employed to perform.

The trust did not ensure that staff employed in the home treatment teams had received regular supervision.

This was a breach of regulation 18 (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 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust had not ensured that care and treatment was provided in a safe way for patients in terms of the moving and handling of patients. This was because staff on the wards for older people were not moving and handling patients safely and did not always have access to the appropriate equipment for this purpose. This was a breach of regulation 12 (1)(2)(c)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. This was because in the community based mental health services: • Patient crisis plans were not always kept up to date. Plans to mitigate risks to patients in a crisis were not always in place or were not stored where they could be easily found in a crisis. • Premises used by the community teams were not all safe to use for seeing patients and families. This was in breach of regulation 12 (1)(a)(b)(d)