

Inadequate 

# West London Mental Health NHS Trust

## Forensic inpatient/secure wards

### Quality Report

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#### Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RKL51	Broadmoor Hospital	Ascot ward Cranfield ward Harrogate ward Leeds ward Sheffield ward Newmarket ward Sandhurst ward Sandown ward Woburn ward Canterbury ward Dover ward Folkestone ward Epsom ward Kempton ward Chepstow ward	RG45 7EG
RKL53	St Bernard's and Ealing Community Services	Benjamin Zephaniah ward Brunel ward Tagore ward Tom Main ward Avebury ward	UB1 3BU

# Summary of findings

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Barron ward  
Bevan ward  
Derby ward  
Rollo May ward  
Solaris ward  
Tennyson ward  
Aurora ward  
Garnet ward  
Pearl ward  
Melrose ward  
Parkland ward

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This report describes our judgement of the quality of care provided within this core service by West London Mental Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement 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.


Where applicable, we have reported on each core service provided by West London Mental Health NHS Trust and these are brought together to inform our overall judgement of West London Mental Health NHS Trust.

# 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 the service

Inadequate 

Are services safe?

Inadequate 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Inadequate 

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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated forensic/secure wards overall as **inadequate** because:

- 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.
- 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.

However, we found that patients at Broadmoor Hospital were very positive about the quality of care which they received. There were many excellent examples of patients being engaged in their care and the work of the trust. Staff were aware of how to report incidents and there were systems in place to ensure that learning from incidents was shared through the services and the trust.

# Summary of findings

## The five questions we ask about the service and what we found

### Are services safe?

We rated safe as **inadequate** because:

- 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.

However, environmental and ligature risk assessments had been completed and where there were risks identified, staff were aware of them and managed risk through observation and knowledge of individual patients' clinical needs. Clinic rooms were well-equipped with emergency medicines and medicines were stored appropriately. Risk assessments were up to date and comprehensive in high secure services. There were some gaps in the risk assessments in the West London forensic service. Staff were aware of the ways to report incidents and there were mechanisms in place for staff to learn from incidents.

Inadequate



### Are services effective?

We rated effective as **good** because:

Good



# Summary of findings

- Staff had made comprehensive assessments of patients and created care plans. There was good access to physical healthcare. With very few exceptions in the West London forensic service, staff had assessed patients' physical health care needs and they monitored and recorded the patients' physical health.
- Patients had access to a range of psychological therapies and were provided with care from a range of staff from different disciplines, including occupational therapists, psychologists and social workers.
- Staff had access to mandatory and specialist training opportunities and staff received regular supervision as well as reflective practice sessions on the wards.
- Staff received training on the Mental Health Act and Mental Capacity Act. We saw evidence of some good use of the Mental Capacity Act at Broadmoor and at the West London forensic service.

However, some Mental Health Act paperwork at the West London forensic service was not up to date. Also in the forensic services the care plans needed further work to ensure they were reviewed, consistent and had a recovery focus.

## Are services caring?

We rated caring as **good** because:

- The majority of feedback we received from patients was positive. We observed care being delivered with care and kindness. This was particularly evident in feedback from Broadmoor Hospital. Staff had a good understanding of patients' needs.
- We saw that patients were involved in care planning with some exceptions in the West London forensic services.
- All patients had regular access to advocates and there were opportunities for patients to feed back to the service through regular community meetings and patients' forums which involved ward representatives. There were carers' groups for patients on both sites.

However, some patients at the West London forensic services did not give positive feedback about the attitude and approach of a few staff members.

Good



## Are services responsive to people's needs?

We rated responsive as **good** because:

Good



# Summary of findings

- Most people were admitted through established processes and there were few transfers which were unplanned. At Broadmoor there were processes to prioritise urgent referrals.
- Wards had access to a range of rooms and spaces to meet the needs of patients and support treatment and care. Most wards had access to outdoor space. The trust was able to meet the needs of people from a range of backgrounds and religions and ensured that food choices included religious diets such as kosher and halal food. There was access to interpreters and patients were aware of complaints processes.

However, some areas where the trust should improve were:

- There were some delays in the system when people at Broadmoor were waiting for a bed in a medium secure service, which meant that due to high occupancy people could not always be provided with care in the least restrictive environment which would safely meet their needs.
- In the West London forensic service, some patients were not provided with support in the ward which provided the least restrictive environment due to the availability of beds.
- Patients in the West London forensic service raised concerns about not being able or feeling comfortable making complaints about the service, although the trust reported a steady increase in complaints being made and those being upheld.
- Some patients in the West London forensic service raised concerns about the choice and quality of food, particularly vegetarian options.

## Are services well-led?

We rated well-led as **inadequate** because:

- 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.

**Inadequate**





# Summary of findings

However, the trust had identified key issues which were reflected on the relevant risk registers. A quality improvement lead had been appointed at Broadmoor Hospital. The trust had leadership development programmes in place, including one which specifically focused on people from black and minority ethnic backgrounds.

# Summary of findings

## Information about the service

The forensic services at West London Mental Health Trust is managed as one clinical services unit (CSU). The inpatient services are located on two sites.

### **Broadmoor Hospital**

Broadmoor Hospital is a high secure service for men and on the day of our inspection there were 198 patients in the service. The services are configured to meet the needs of patients with a mental illness and personality disorder as follows:

Mental illness services:

Ascot ward - high dependency unit – 12 beds

Cranfield ward – intensive Care – 11 beds (across mental illness and personality disorder services)

Harrogate ward – assertive rehabilitation – 20 beds (including one bed specifically for people with physical healthcare needs)

Leeds ward – assertive rehabilitation – 20 beds

Newmarket ward – admission – 12 beds

Sandhurst ward – assertive rehabilitation – 12 beds

Sandown ward – admission – 12 beds

Sheffield ward – assertive rehabilitation - 20 beds

Woburn ward – high dependency unit – 15 beds

Personality disorder services:

Canterbury ward – assertive rehabilitation – 14 beds

Dover ward – assertive rehabilitation – 14 beds

Folkestone ward – assertive rehabilitation – 14 beds

Epsom ward – high dependency unit – 12 beds

Kempton ward – admission – 12 beds

Chepstow ward – medium dependency unit - 12 beds

### **West London forensic services**

There are 18 forensic inpatient wards at St Bernard's Hospital, Ealing. They consist of enhanced medium

secure, medium secure, and low secure wards for men and women. There are three main buildings. Three Bridges and the Tony Hillis Wing provide services for men. The Orchard provides services for women.

We inspected the following wards:

Three Bridges:

Benjamin Zephaniah ward – 18 beds, male medium secure admissions

Brunel ward – 6 beds, male medium secure for patients with physical health problems

Tagore ward – 17 bed, male medium secure admissions

Tom Main – 16 beds, male medium secure high dependency

Tony Hillis Wing:

Avebury ward – 16 beds, male medium secure rehabilitation

Barron ward – 17 beds, low secure slow stream rehabilitation

Bevan ward – 18 beds, medium secure rehabilitation

Derby ward – 18 beds, male low secure admissions and rehabilitation

Rollo May ward – 25 bed, male medium secure rehabilitation

Solaris ward – 18 bed, male low secure admissions and rehabilitation

Tennyson – 7 bed low secure, male pre-discharge

The Orchard:

Aurora ward – 10 beds, female medium secure admissions

Garnet ward – 10 beds, female medium secure rehabilitation

Melrose ward – 10 bed, female enhanced medium secure treatment

Parkland ward – 10 bed, female enhanced medium secure treatment

# Summary of findings

Pearl ward – 15 beds, female low secure rehabilitation

## Our inspection team

### **Broadmoor Hospital**

The inspection team that inspected high secure services at Broadmoor Hospital consisted of ten people – one CQC inspector, one expert by experience, two mental health nurses, one consultant forensic psychiatrist, two Mental Health Act reviewers, one speech and language therapist, one pharmacist inspector and a social worker. There were two observers from Her Majesty's Inspectorate of Prisons for one day and a CQC analyst joined the team for one day.

### **West London forensic services (The Orchard, Three Bridges, Tony Hillis Wing)**

The inspection team that inspected the West London forensic services consisted of fourteen people - three CQC inspectors, two experts by experience, two mental health nurses, two consultant psychiatrists, two Mental Health Act reviewers, two psychologists and a pharmacist.

## 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 fully understand the experience of people who use services, 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 this inspection visit, we reviewed information that we held about these services and asked a range of organisations for information. We also attended a patients' forum at Broadmoor Hospital. During the inspection visit, the team spoke with the executive director for high secure and forensic services.

### **Broadmoor Hospital**

During the inspection visit, the inspection team which visited Broadmoor Hospital:

- Visited 15 wards and observed the quality of the ward environments and observed how staff were providing care to patients.
- Carried out an out of hours evening visit to two wards.

- Spoke with the clinical nurse manager (ward manager) or nurse in charge on 10 of the wards we visited.
- Spoke with 104 patients individually either on the wards or at the workshops, kitchen gardens or activities. We reviewed 58 comments received from comments boxes left in the ward and main reception areas of the hospital.
- We spoke with the deputy director for high secure services, the deputy director of nursing for high secure services and the clinical director for Broadmoor Hospital.
- We also spoke with 139 other members of staff including senior managers, nursing staff, consultants, junior doctors, nurses, health care assistants, technical instructors, occupational therapists, social workers, advocates, psychologists, administrative staff, domestic staff and security staff.
- We carried out seven focus groups which 104 staff attended in total. These included focus groups for administrative staff, junior doctors, nurses at different grades, allied health professionals including social workers, consultants and non-clinical support staff and health care assistants.

# Summary of findings

- Visited the health centre and spoke with the GP, practice nurses and the dentist.
- Observed 5 handovers between shifts including 2 handovers in the evening.
- Attended two clinical team meetings.
- Attended one community meeting.
- Attended the hospital wide patients forum .
- Attended the meeting which oversees seclusion and long term segregation.
- Visited the recovery college, workshops, shop and kitchen garden.
- Visited the general and childrens visiting areas and observed two visits.
- Visited the gym and sports facilities.
- Met with security staff and visited the control room.
- We checked 46 patient records.
- We checked 47 medication charts and spoke with the lead pharmacist for the hospital.
- Looked at a range of policies, procedures and documents related to the running of the service.
- Spoke with the ward manager or deputy ward manager on 11 wards.
- Spoke with 65 patients individually or in groups. Reviewed 93 comment cards that had been placed in comment card boxes on each ward.
- Spoke with the interim deputy director, deputy director of nursing and clinical director for the services.
- Spoke with 115 other members of staff including senior managers, consultants, junior doctors, nurses, healthcare assistants, activities co-ordinators, occupational therapists, social workers, psychologists, the user involvement lead, a family therapist, and security staff.
- Held a focus group for occupational therapists and activities co-ordinators working in these services.
- Attended three ward rounds.
- Attended two nursing handover meetings.
- Attended one referrals meeting.
- Attended one ward-based activity group.
- Attended one ward community meeting.
- Attended one Section 117 meeting where plans for a patients aftercare were being discussed.
- Looked at 53 patient records.
- Looked at medication charts and medicines management on five wards.
- Looked at community meeting minutes on two wards.
- Looked at a range of policies, procedures and documents relating to the running of the services.

## West London forensic service

During the inspection visit, the inspection team that visited West London Forensic Service:

- Visited 11 wards and observed the quality of the ward environments and how staff were providing care to patients.
- Carried out a night visit.

## What people who use the provider's services say

### Broadmoor Hospital

Most of the patients we spoke with during the visit were positive about the care and support which they received at the hospital. Twenty five patients specifically mentioned concerns about shortages of staffing levels and explained the impact that this had on them regarding the cancellation of activities, escorts and association time. Most patients told us that they felt listened to and respected.

We also collected 58 comment cards from the ward areas which had been left in advance of the inspection. Forty seven of the comments were negative, 8 were positive

and 9 were mixed having both positive and negative comments on the same card. The main themes related to staff shortages and allegations of a bullying culture among staff.

### West London forensic services

Some patients told us there were not enough staff on the wards. A number of patients reported that activities and leave were often cancelled.

Many patients were very pleased with the care they received. Patients spoke of being treated with dignity and respect. Some felt involved in their care and that their needs were understood. There was some recognition that staff had a hard job.

# Summary of findings

Around half of the patients we spoke with during the inspection had some negative views about the approach of some staff. This usually related to nursing staff. Some patients told us some staff were rude and had a poor attitude. A small number of patients felt that some staff deliberately provoked them. A number of patients spoke about the quality of food being poor.

We also collected 92 comment cards from the ward areas which had been left in advance of the inspection. Forty of

the comments were negative, 37 were positive and 15 were mixed having both positive and negative comments on the same card. The positive feedback mainly said that people found staff caring, were happy with their care and treatment and that the wards were clean. The negative feedback said there needed to be more staff, that some staff attitudes were not caring or respectful and that the food needed to improve.

## Good practice

### **Broadmoor Hospital**

- 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 patient 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 market 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 through the 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.

### **West London Forensic Services**

- Patient engagement was being promoted by each ward having a patient who was the ward representative. These patients attended patient forums on a regular basis. There were separate male and female patient forums. Ward representatives told us they were listened to in the forums. One ward representative was now involved with training staff.
- The wards in the Orchard unit 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.

# Summary of findings

## Areas for improvement

### **Action the provider MUST take to improve Broadmoor Hospital**

#### **Action the provider MUST take to improve**

- The trust must ensure that staffing levels are sufficient 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.

### **West London Forensic Services**

#### **Action the provider MUST take to improve**

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

### **Action the provider SHOULD take to improve Broadmoor Hospital**

#### **Action the provider SHOULD take to improve**

- 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.
- The trust should ensure that prior to the move to the new hospital in 2017 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.

### **West London Forensic Services**

#### **Action the provider SHOULD take to improve**

- 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.

# Summary of findings

- 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.

# West London Mental Health NHS Trust

## Forensic inpatient/secure wards

### Detailed findings

#### Locations inspected

##### Name of service (e.g. ward/unit/team)

##### Name of CQC registered location

Ascot ward  
Cranfield ward  
Harrogate ward  
Leeds ward  
Newmarket ward  
Sandhurst ward  
Sandown ward  
Sheffield ward  
Woburn ward  
Canterbury ward  
Dover ward  
Folkestone ward  
Epsom ward  
Kempton ward  
Chepstow ward

Broadmoor Hospital

Benjamin Zephaniah ward  
Brunel ward  
Tagore ward  
Tom Main ward  
Avebury ward  
Barron ward  
Bevan ward  
Derby ward  
Rollo May ward  
Solaris ward  
Tennyson ward  
Aurora ward

St Bernards and Ealing Community Services



# Detailed findings

Garnet ward  
Melrose ward  
Parkland ward  
Pearl ward

## Mental Health Act responsibilities

### **Broadmoor Hospital**

Ninety three per cent of staff had completed the mental health law training. Staff showed a good understanding of the relevant areas of the Mental Health Act. We found that documentation relating to the Mental Health Act was available and up to date.

There was a Mental Health Act office on site which was fully staffed and able to provide input and advice to ward teams. Staff on the wards were aware of how to access support if required.

Medication charts had relevant consent documentation attached.

Patients received regular updated information about their rights under the Mental Health Act and this was recorded. On Cranfield ward, we saw that this was not always recorded. This was resolved shortly after our inspection visit. All patients had access to advocacy services commissioned by NHS England.

### **West London Forensic Service**

Staff had training on the Mental Health Act (MHA). Patients had their rights explained under the MHA on admission. These rights were discussed with patients every three months. However, there were some cases where there was no recorded evidence that patients were made aware of their rights on admission.

Capacity to consent to treatment forms were attached to corresponding medication charts. There was evidence of regular reviews of patients' consent to treatment. However, we were unable to consistently see a record of assessments of the patients' capacity to consent to treatment, or a documented discussion about consent in the patients records.

Staff in the Mental Health Act office were available to provide advice and support with administration to ward staff. Ward staff were aware of how to contact them. Detention paperwork was generally filled out correctly but we found some examples of missing and out of date detention paperwork.

The service had recently started working with a new independent mental health advocacy provider. There were posters and leaflets displayed advertising the service. A number of staff we spoke with were unable to tell us about the service. Some patients had an awareness of the service although eight patients on one of the male wards did not know that this service was available to them.

Section 17 leave was appropriately authorised and recorded on standardised forms. Conditions of leave were clearly stated. In one case the number and type of escorts required was not recorded. We observed discussions about risks associated with leave on the day of our visit. Not all section 17 leave forms were signed by patients. On some occasions, old forms were not clearly marked as void.

On Parkland ward some old treatment certificates were not marked as void. There was a risk of confusion, particularly for staff not familiar with the patients. We were unable to locate the history of treatment authorisation for one patient. Two patients had a Section 62 emergency treatment certificate. One was a month old, the other was two months old. There was no evidence that a second opinion appointed doctor had been requested. There was no updated consent or treatment certificates with the medicines included.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

### **Broadmoor Hospital**

Staff had received training specifically about the use of the Mental Capacity Act. This was a part of the mandatory training which was delivered as adult safeguarding training. This was completed by 99% of clinical staff in the mental illness directorate (which included the physical health care and occupational therapy vocational departments) and 97% in the personality disorder directorate.

We saw some excellent examples of the use of the Mental Capacity Act where decisions had been taken where patients were assessed as lacking capacity. Where best interest decisions had been made there was comprehensive documentation around physical health issues and treatment.

Short prompts and information about the use of the Mental Capacity Act was available on each ward.

We observed that discussions around mental capacity took place in clinical team meetings. For example, on Epsom ward, there was a discussion around physical health care and the need and consideration of unwise decisions.

We saw that some patients had been supported to make advanced decisions which were recorded in their notes. Significant work had been undertaken by the manager of

the social work team and the lead social worker for forensic services across the trust to ensure that mental capacity issues were on the clinical agenda and the hospital had a specific mental capacity protocol.

### **West London Forensic Service**

Staff had received training in the MCA (Mental Capacity Act) and were able to describe examples where patients' capacity had been assessed in accordance with this.

Capacity assessments were undertaken by members of the multi disciplinary team as appropriate.

Staff gave us an example of the capacity assessment they undertook with a patient who wished to give a family member a large amount of money. The patient was assessed as having capacity but was advised by staff of the potential risks and repercussions of making such a gift, so that they were able to make an informed decision.

We saw evidence of best interest meetings taking place in line with the MCA across the service.

One patient was prevented from buying protein shakes as staff informed us he did not have the capacity to make this decision. However, there was no record of any capacity assessment being carried out for this patient for this specific issue.

# 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 **inadequate** because:

- 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.

However, environmental and ligature risk assessments had been completed and where there were risks identified, staff were aware of them and managed risk through observation and knowledge of individual patients' clinical needs. Clinic rooms were well-equipped with emergency medicines and medicines were stored appropriately. Risk assessments were up to date and comprehensive in high secure services. There

were some gaps in the risk assessments in the West London forensic service. Staff were aware of the ways to report incidents and there were mechanisms in place for staff to learn from incidents.

## Our findings

### Broadmoor Hospital

#### Safe and clean environment

- The hospital was made up of a number of buildings. Some of the estate was roughly 150 years old and some of the wards were built much more recently such as the Paddock Centre (where Ascot, Newmarket, Sandown, Chepstow, Kempton and Epsom wards are located) which was opened in 2005. These were more suitable to meet the current needs of patients for example providing ensuite facilities. There was a significant variation in the ward environments depending on the age of the buildings in which they were located. A new hospital was being built and this is due to open in 2017. The Paddock Centre will remain a part of the new hospital but the other wards will be relocated to a modern purpose-built site.
- There were variations in the ward layouts. Some wards had blind spots or areas which were more difficult for staff to see. This was mitigated by staff being aware and present in the areas where there were blindspots. On Ascot, Newmarket, Chepstow, Kempton and Epsom wards, there were some limited blind spots in the wards which the staff were aware of but there were generally good lines of sight. The risk in areas where there were blindspots was mitigated by staff knowledge of the areas and staff being present to observe the blindspots.
- Ligature risk assessments had been carried out on all the wards. These assessments were available on all the wards we visited and staff had a good awareness of the risk areas on the wards. The risk was mitigated by staff observation. Staff we spoke with on the wards we visited were aware of the ligature risks on the wards and the need to mitigate them on an individual patient basis. During the course of our inspection visit, we were made aware of a ligature point risk which had been identified

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on Sheffield ward. We saw that this had been raised internally through the incident reporting process and that an immediate action plan had been put into place which had led to a change in practice on the ward in response to this. The learning from this was also disseminated speedily to similar wards in the hospital and through the trust.

- We checked the clinic rooms on ten wards which we visited. They were well-equipped with necessary equipment and they were clean. All the wards had access to defibrillators. These were shared between wards in the Paddock but were easily accessible to both wards. Staff had been trained in their use. Medical equipment was checked annually and calibrated regularly. There was a system in place where stickers identified when the checks needed to take place to ensure that this was followed up. Some clinic rooms did not have examination couches. However, in these wards, patients had ensuite facilities and were able to be examined in their bedrooms by medical and nursing staff as necessary.
- There were records of hand hygiene training and audits and this information was recorded on 'the Exchange', the trust intranet system, and fed through to the trust infection control lead.
- Seclusion rooms in the Paddock Centre were clean and well-maintained. They were in a separate ward area which ensured people's dignity. They had ensuite facilities including a sink, toilet and shower. There was a clock visible to patients who were in the seclusion room and the rooms had televisions and access to natural daylight. However, seclusion rooms in some of the older buildings, such as Harrogate ward and Canterbury ward, did not have access to an ensuite shower. They were located along the ward corridor where people passing could see the patient who was in the seclusion room. This had an impact on the privacy and dignity of those in the room. Whilst the seclusion room had not been used frequently on the assertive rehabilitation wards, there was a risk that should they be used, patients' dignity could not be preserved.
- On some wards, seclusion took place in patients' bedrooms. This was the case on Cranfield ward where most of the patients were in long term segregation (LTS) on the day that we visited. Long term segregation is defined in the Mental Health Act (1983) code of practice

(2015) 26.150 as "a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long term basis". At Broadmoor, when a patient was secluded for a period of more than seven days, they were defined as being in 'long term segregation' and subject to the protections provided by that framework. Bedrooms on Cranfield ward, where patients were being kept alone, sometimes for long periods, had toilets and sinks but did not have showers. In some rooms in Cranfield ward, patients slept on mattresses on the floor rather than beds. There were clocks outside the rooms so that patient's knew what time it was. However, on the day of our visit, one clock in Cranfield ward was not working and the patient raised this as a concern as he was disorientated to time. The MHA code of practice (2015) chapter 26.151, when referring to patients being nursed in long term segregation, states "It is permissible to manage this small number of patients by ensuring that their contact with the general ward population is limited. The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow. Facilities which are used to accommodate patients in conditions of long term segregation should be configured to allow the patient to access a number of areas, including, as a minimum bathroom facilities, a bedroom and a relaxing lounge area. Patients should also be able to access secure outdoor areas and a range of activities of interest and relevance to the person". The bedroom areas in Cranfield ward were sparse and while accounting for the risk levels of patients, consideration should be given to providing an environment as advised in the code of practice.

### Safe staffing

- The trust had undertaken a review in November 2014 of nurse staffing levels across the trust. This had included benchmarking with similar services around the country. This review took into account the physical ward environments as well as the needs of the patients using the service. There was also consideration of the staff skill mix and gender mixes on the ward.

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- The trust had been working to improve recruitment at Broadmoor Hospital. We saw that specific campaigns had taken place to recruit staff.
- Staffing levels was top of the level 2 risk register for Broadmoor Hospital. This meant it had identified as an area of concern by the trust. Senior managers we spoke with acknowledged that whilst the staffing levels ensured safe environments, there was a risk that patient experience was affected by a difficulty to recruit and retain staff. The hospital collected data regarding off ward activities cancelled due to staff needing to be redirected on wards. Between March 2015 and May 2015, sports and leisure activities were cancelled for 47.5 hours which would have affected a minimum of 74 patients. Vocational services were cancelled for a minimum of 32.5 hours which would have affected 63 patient sessions.
- Night time confinement, where patients on some wards were locked in their rooms between the hours of 9.15pm and 7.15am was implemented in line with the security directions for high secure hospitals (2013). This stated that providers may make arrangements which include night time confinement within their policies “but these should only be put in place where it is considered that this will maximise therapeutic benefit for patients, as a whole, in the hospital. For example, confining a group of patients at night may release 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. For example, during May 2015 on Cranfield ward, three patients were offered less than 25 hours a week input and on Epsom ward, 12 patients were offered less than the minimum recommended 25 hours a week therapeutic input. This showed that the implementation of night time confinement on these wards did not always facilitate sufficient therapeutic activities during the day.
- ‘Association time’ is time in which patients who are being provided with care in long term segregation, are able to leave their rooms to mix with other patients or members of staff, depending on their needs and the risks associated both to themselves or others. We asked the hospital to provide us with information about when association time was limited where shortages of staff was an issue. We looked at this data for the three months prior to our inspection visit and counted the shifts where this had been identified as an issue. Between March 2015 and May 2015, association time had been limited on Ascot ward on 8 shifts, on Epsom ward over the same period, it had been 6 shifts, on Woburn ward it had been 9 shifts and on Cranfield ward it had been 48 shifts. We looked specifically at the rotas for the past three months on Cranfield ward. Cranfield ward was the intensive care ward and the establishment staffing level is 9 staff during the day and 4 staff at night with a ratio of 5 registered nurses to 4 unqualified nurses during the day and 2 registered nurses and 2 health care assistants at night. There was also an established ratio of 6 male staff to 3 female staff during the day with 2 male staff and 2 female staff at night. Out of 122 day shifts (am and pm) and 61 night shifts in a two month period, 12 night shifts had been staffed below 4 members of staff. On 16 shifts the numbers had been four members of staff but only had one qualified nurse on duty rather than two. Of the 122 shifts during the day, 70 had been below the recommended 9 members of staff on the ward. This included 9 shifts where the staffing numbers had been 6 members of staff. Thirty eight shifts had been covered during the day with only 2 qualified members of staff on duty. Ten members of staff working on Cranfield ward identified concerns to us regarding staffing levels and the frequency which they were redirected to other wards. Three members of staff reported to us that the impact of this on patient care was that it can affect patient activities and association time. Two members of staff told us that there had been occasions where they had not been able to take breaks during shifts due to the levels of staffing on that ward. We saw this was reflected in the rotas we looked at.
- Incidents related to staffing levels raised by staff themselves were at a consistent level across the hospital. There were 39 incidents between February and May 2015 and 35 between Nov 2014 and Jan 2015. Some members of staff told us that they would not consistently report low staffing as an ‘incident’ through the trust reporting system.
- Staff told us that they were not sufficiently staffed. Fifty two staff members from different parts of the hospital specifically raised shortages of staff as a concern. Twenty five patients raised concerns to us about

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shortages of staff and gave examples of the impact that this had on them. For example, a patient on Canterbury ward told us the garden had been closed due to staff shortages, a patient on Harrogate ward told us they could not have 1:1s with their named nurse when they want to and that booked telephone calls were delayed. A patient on Ascot ward told us they sometimes had to wait a long time for staff to attend calls but they did eventually come. We received a letter written to us and signed by five patients on one ward which expressed concern about the pressures that staff were being put under due to staffing levels.

- There was a risk that conditions of LTS were continued beyond the period where they may have been clinically appropriate in order to ensure that safety was maintained when staffing levels were not at their full establishment number. Some groups of clinical staff told us that they were concerned that there was a risk averse culture in the hospital, particularly following previous incidents and that this, together with some reductions in staff levels, had led to use of long term segregation when it may not be clinically necessary for each patient involved.
- Staff told us that the staff rotas did not reflect the actual number of staff on the shifts as staff were often 'redirected' to other wards during shifts. This was reflected in our observations of staff rotas and safe staffing information from the trust.
- We looked at staff turnover in all areas between Jan 2015 and June 2015. Information provided by the trust stated that in relation to registered nurses, 8 had started work at Broadmoor and 27 had left. There was sufficient medical cover during the day and night times. At the time of our inspection, there were 67 full time equivalent (FTE) vacancies for nurses or health care assistants across the hospital wards. Twenty three posts had been recruited to and were awaiting start dates. Across the wards, for the six months prior to the inspection visit, 4429 shifts had been covered by bank staff and 1136 shifts available shifts had not been covered. This was particularly notable on Kempton ward where there had been 222 shifts which had not been covered by staff and on Folkestone ward where there

had been 151 shifts which had not been covered. The highest use of bank staff had been on Epsom ward (530 shifts), Chepstow ward(436 shifts) and Cranfield ward (420 shifts).

- At the time of our inspection, a restructure of administrative staff was being undertaken which meant that there was a 24% vacancy rate. Five members of staff told us that they had concerns about the level of administrative support being provided to wards as staff had left those posts and the vacancies had not been recruited into. There were 10% vacancy rates for allied health professionals and security staff. There was a social worker assigned to each ward. At the time of our inspection, all the posts were filled by permanent or locum staff with one senior practitioner post vacant. Security staff told us that they had been concerned about staffing levels. We saw that over the six months prior to the inspection, 533 shifts in security had been filled by bank staff and 98 shifts had not been filled. Domestic staff told us that there were five who covered nine wards and they felt that this had not given them the opportunity to ensure they were able to do their jobs effectively.

### Assessing and managing risk to patients and staff

- Patients were assessed before their admission by a team from the hospital. We looked at a range of clinical records including risk assessments. The hospital used standard risk assessments known as HCR-20 (historical clinical risk) which have widespread use in forensic services. Risk assessments were completed comprehensively. Risk information was clearly identifiable in records and was updated appropriately after incidents on the wards. During handovers risk information was shared about every patient on the ward.

Staff had a very good understanding of risk. Care plans reflected identified risks.

- Observation records were comprehensively completed, recorded and checked. Each ward had a specific operational policy which explained some of the restrictions in place due to the different needs of patients on the particular types of wards. For example, on some wards, such as the assertive rehabilitation

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wards, patients had open access to kitchen areas. However, on some of the wards, such as the high dependency units, staff offered patients hot drinks at specific times.

- We looked at the use of physical interventions over the six months prior to our inspection visit. There had been no use of restraint followed by rapid tranquillisation. There had been 134 incidents of restraint used across the hospital in this time period of course of which 72 had been in the prone (face down) position. The highest levels of restraint were on Cranfield ward (intensive care) with 38 uses of restraint with 21 in the prone position, Newmarket ward (admission) with 18 uses of restraint, 15 in the prone position, Ascot ward (high dependency unit) with 16 uses of restraint, 6 in the prone position, Woburn ward (high dependency unit) with 15 uses of restraint, 10 in the prone position and Epsom ward (high dependency unit) with 13 uses of restraint, 4 in the prone position. There had been no use of restraint on Folkestone, Dover or Canterbury wards for six months. Audits carried out by the trust showed a low use of 'rapid tranquillisation' treatment for agitation or aggression compared with other services in the trust. Staff told us that de-escalation and other interventions were tried first. On Cranfield ward, staff told us that each patient's care plan for the administration of medicines was based on their experience with that patient. In line with these care plans it was necessary to restrain some patients in a face down position while injections authorised under the Mental Health Act (1983) were administered, to protect them and the staff from injury.
- Over the six months prior to the inspection, there were 68 recorded incidents of seclusion. The highest numbers of seclusion was on Ascot ward (High dependency unit) where there were 14, Kempton ward (admission) where there were 13 and Woburn ward (high dependency unit) where there were 13. On Folkestone, Dover and Canterbury wards there had been no use of seclusion or long term segregation for six months. Seclusion was used for short periods up to seven days. Long term segregation (LTS) was used when patients for their own safety or for the safety of others, were required to be provided with nursing care in isolation for longer periods. We checked records for restraint, seclusion and long term segregation. We found that the required checks were carried out by doctors and nursing staff and this information was collated centrally to ensure it took place and that patients were protected from potential harm caused in restrictive environments.
- At the time of our inspection there were 37 patients who were being nursed in LTS. Of those, 20 had been nursed in LTS for 12 months or more. This was a decrease from 54 patients being nursed in LTS in November 2014. All patients who were nursed in LTS were reviewed regularly by nursing and medical staff. There were monthly meetings for clinicians to review together, the reasons and need for LTS to continue. Clinicians from different wards in the respective pathways reviewed each patient being provided with care in LTS and established whether this needed to continue. In line with the changes in the Mental Health Act code of practice in 2015, there were plans in place for three monthly external reviews of LTS to take place from clinicians who were based in the trust's London forensic services.
- There was one ward, Epsom ward, where all the patients were nursed in LTS. There were specific reasons that this was the case on this particular ward due to incompatibilities between patients and the ward environment. Members of staff told us that the ward environment meant that this had been done to ensure patient safety and to address incompatibility issues. While we saw that this practice was safe and efforts had been made to ensure that there was a principle of least restriction, patients were having restrictions placed on them for reasons other than individual clinical need and if the patients were on a different ward, they might not be subject to the same restrictions. We saw that work had and continued to be carried out on Epsom ward to ensure that patients who were restricted in this way had association time facilitated so within a restrictive environment the ward and hospital staff were ensuring that practices were as person-centred as possible.
- On Ascot ward we saw that a short project had been undertaken to reduce LTS. This had reduced patients being nursed in LTS from 8 to 2. This work involved patients and ensuring that patients' voices and views were heard and that they were fully engaged in the care planning around the restrictive practices in place to look at consistent and clear 'exit strategies' from LTS. There was also work being done to address a 'culture of LTS' use.

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- Cranfield ward, Woburn ward and the wards in the Paddock Centre (Ascot, Epsom, Chepstow, Kempton, Newmarket, Sandown) have implemented 'night time confinement' (NTC) which means that between 9.15pm and 7.15am, the patients in these wards are locked in their rooms. There are regular observation checks by night staff. We attended Newmarket and Sandown wards at the evening handover period to observe the process of locking patients into their rooms at night. One patient we spoke with raised a concern about not liking night time confinement. Another patient we spoke with told us that they did not feel affected by it as they were used to this practice having come from prison. Many staff reported to us that they understood the reasons for introducing NTC was financial. However, in general, patients did not raise NTC as a concern to us. There is a plan to extend night time confinement to the whole hospital when the new build hospital is completed. This reflects practice at the other high secure hospitals in England, (Rampton Hospital in Nottinghamshire and Ashworth Hospital in Merseyside). The hospital carried out a review of night time confinement in September 2014 looking at the implementation of night time confinement between June 2013 and July 2014. This included looking at incidents both during the day and during the night, evaluating complaints related to night time confinement and looking at activities offered and taken up during the day by patients subject to night time confinement.
- We found that the pharmacy team provided a well established clinical service to ensure people were safe from harm from medicines. Medicines were stored in clean clinic rooms at suitable temperatures to maintain their quality. They were transported and stored securely within the hospital. Nursing staff told us that in addition to regular ward visits, the pharmacy team were available to provide advice including out of hours. We saw that pharmacists reviewed new prescriptions, were involved in ward clinical meetings and worked with the GP service to support safe prescribing. The pharmacy team told us they offered an annual medication review to every patient, and provided information via leaflets or face to face discussion on request to support patients to understand and make decisions about their medicines.
- The hospital used a comprehensive prescription and medication administration record chart which facilitated the safe prescribing and administration of medicines.
- We saw that nursing staff took people's preferences into account when developing care plans for administering medicines, as well as considering the risks to staff and other patients on the ward. Where possible patients came to the ward treatment hatch to take their medicines. Others were given their medicines in their rooms. The number of staff involved varied according to the risk, and we saw that measures were in place to check that people were taking their medicines and to reduce the risk to staff and patients in transporting medicines within the ward. We saw prescriptions which gave staff the flexibility to offer regular medication at any time during the day, so that they could choose a time acceptable to the patient. One person on Woburn ward, who had regular insulin injections was supported to do his own blood tests and administer the insulin himself whenever possible, and we saw that a risk assessment had been drawn up to make sure the process is safe. The health centre, supported by ward and pharmacy staff, ensured that patients on certain medicines had regular blood tests to check that they were safe. Staff told us that people brought their hospital prescription chart with them to the health centre so that additional medicines for physical health conditions could be prescribed safely.
- For people detained under the Mental Health Act (1983) we found that the required documentation for treatment for mental disorder was in place. Some patients were prescribed psychotropic medicines above the usual maximum dose. We saw that in some cases these doses had been authorised for short periods only, in line with guidance. A clinician on Chepstow ward told us, and records confirmed, that when prescribing medicines 'off-label' or outside their licensed indication, they discussed it with the patient. A clinician told us that when patients were reluctant to try alternative medicines he had little option but to try higher doses of their current medicines, in line with guidance.
- The hospital had a robust system in place to ensure safeguarding concerns were raised and there was information available on each ward, in the form of a concise file of information called a 'safeguarding grab



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pack. This had information on the trust's safeguarding policy and definitions of safeguarding. It also had contact information for the hospital and ward leads on safeguarding and referral information and forms to be completed as well as contact numbers for the local authority and those who would be able to provide advice. Most staff we spoke with had a good understanding of safeguarding thresholds and raising safeguarding concerns. We saw some excellent examples of where safeguarding concerns had been raised by staff on the wards and cohesive safeguarding plans were put into place. The hospital had a quarterly safeguarding monitoring meeting with external agencies such as the local authority (Bracknell Forest). There was a lead for safeguarding who was the manager of the social work team, based in the hospital and wards had their contact details as well as each ward having an attached social worker. Significant work had been undertaken through the safeguarding lead to ensure that 'safeguarding as everyone's business' was embedded in staff understanding on the ward levels. There was a police link officer for the hospital. Radicalisation was being addressed in core safeguarding business.

- We saw that wards had information up for patients to see about raising concerns about bullying and wards had an easy read 'bullying' referral form where patients could raise concerns if they had them. Most patients we spoke with told us that they felt safe at the hospital. Some patients told us that they felt safer than they had in other settings in which they had been provided with care.

## Track record on safety

- Under the national reporting framework for reporting and learning from serious incidents requiring investigation (SIRIs), incidents are graded at level 1 or level 2 depending on the nature of the incident.
- Between 1st December 2014 and 31st May 2015 there were 5 SIRIs at either level 1 or level 2. A further 9 serious incidents took place in the same time period which were investigated locally. Near misses were reported as well as incidents.

## Reporting incidents and learning from when things go wrong

- Staff were aware of reporting processes through incident reporting forms online. These incident reports were signed off by immediate management and more senior management. There were additional checks in place, for example, if an incident was reported as a safeguarding concern, it was flagged to the adult safeguarding lead in the social work department to check as well as line managers. Throughout the hospital, we found a good understanding of the processes to report incidents and the thresholds which triggered reporting.
- Staff were aware of recent incidents both on the wards they worked in and across the hospitals. Incidents were discussed at the clinical improvement groups which took place on each ward. 'Lessons Learnt' bulletins were distributed across the hospital by email to staff. There had been a 'learning lessons' conference which had taken place at Broadmoor in the month prior to our inspection. Staff gave us positive feedback about this event and felt it had been positive in promoting incident reporting and ensuring that staff knew that incident reporting led to actions being taken to improve practice and procedures where they have been identified as an issue. We were given a number of examples across the hospital of practices that had changed as a result of incidents. For example, on Woburn ward, incident reports highlighted that one patient regularly refused his medication and became agitated when it was repeatedly offered. Staff agreed with the patient that they would give him one medicine which was important to him, but not repeatedly offer the other medicines. Another patient's treatment had been reviewed by the clinical team in response to him regularly refusing some of his medicines. We heard from the trust infection control lead that after an outbreak of norovirus in 2012, action had been taken to change practices and awareness around this. A 'learning lessons' event was held regarding this and subsequently, there had been an improvement in reporting and recording symptoms.

## West London Forensic Service Safe and clean environment

- Wards were in three separate buildings. The Tony Hillis Wing was over a hundred years old. Three Bridges was approximately twenty five years old. The Orchard was the newest building, built around ten years ago. All of the buildings were some distance from each other and

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were not within the same secure perimeter. A new medium secure campus is due to open in 2016 providing 80 beds. Each ward had an environmental risk assessment.

- All of the wards were clean. Wards had cleaning schedules. The wards in The Orchard were bright and spacious. Most of the other wards were spacious.
- There was variation in the ward layouts. Wards in all of the buildings had blind spots or areas which made some area difficult for staff to see. Mirrors were used in most of these areas. On some wards there were some blind spots without mirrors such as the annexe area on Rollo May ward. Staff were aware of these and observed the areas more closely.
- Ligature point risk assessments had been carried out on all wards and were updated annually. Staff on all wards told us that the entire ward environment was checked every 30 minutes. There was also a suicide prevention steering group. Managers had identified finance to carry out some ligature point reduction work. In the meantime ligature point risks were managed based on individual patients' clinical risk.
- The clinic rooms on the wards inspected were well equipped and clean. Equipment was maintained regularly, including defibrillators. Staff had been trained in their use. Emergency medicines were checked regularly. On Tom Main ward glucose testing strips and emergency drugs for patients with diabetes had passed their expiry date.
- In the womens medium secure services, most of the wards had their own seclusion room. Parkland and Melrose wards had a seclusion room and a de-escalation room. Some of the seclusion rooms had full en-suite facilities and allowed for clear observation. There was a two way intercom, and a clock visible from inside the room. The seclusion rooms on Benjamin Zephaniah ward and Rollo May ward were on the bedroom corridors. This meant privacy for the patient in seclusion was difficult to maintain. There was no clock visible from seclusion rooms on Tom Main and Rollo May wards. Observation was difficult on Benjamin Zephaniah ward as the observation panel was scratched. The seclusion toilet was observed through a spyhole on Rollo May ward. This made observation very difficult. There was also a blind spot in the Rollo May

seclusion room, with no mirror in place. The window blind in the seclusion room on Rollo May ward could not be closed as it was broken. The seclusion room in Tom Main ward had water leaks. The toilet was not functioning. There were also water leaks in the Benjamin Zephaniah seclusion room. On Brunel ward the seclusion room had an ant infestation on the day of our inspection. There was uneven flooring in the seclusion room area on Derby ward.

- Some wards had low stimulation rooms where patients could choose to go if they required a quieter environment. These rooms had soft furnishings to better manage potential risks.
- There were alarm buttons in all wards. This was so patients could get staff assistance when necessary. Staff also carried personal alarms at all times. When this alarm was pressed staff on other wards were also alerted. In the three months prior to the inspection the personal alarm system had failed several times which meant that the wrong ward was indicated. This meant staff responding to the alarm call could go to the wrong ward. A number of staff told us that the alarms didn't work properly. A personal alarm had failed to operate during a serious incident four months earlier. During the inspection, we observed an alarm test. The alarm indicated a different ward to where the test was being carried out. This was rectified during the inspection.

## Safe staffing

- The West London forensic service had 299 registered nurse posts, of which 54 were vacant at the time of the inspection. This meant almost one in five registered nursing posts (18%) were vacant. Over 13% of healthcare assistant posts were vacant. In the previous year 12% of registered nursing staff had left the service. Several wards had over 20% of nursing posts vacant. One ward had 35% of registered nursing posts vacant. In the six months prior to the inspection seven nurses had started work in the service and 20 had left. During the same period, 10 healthcare assistants had started work and 11 had left.
- Bank and agency nursing staff were used on all wards. They covered staff vacancies, sickness and absence. They were also required for other activities such as escorting patients and additional observation. Out of 8330 shifts across the services in the month prior to the

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inspection, most shifts were filled with permanent, bank or agency staff. 891 (10%) shifts were not filled. Over 65% of the shifts not filled were shifts for nurses. Benjamin Zephaniah, Tom Main and Garnet wards were unable to fill around 15% of their shifts in the month prior to the inspection.

- On 172 shifts in the previous month there was only one nurse on the ward when there were due to be two. Eighty nine of these shifts were night shifts. There was a potential risk that by only having one nurse on the ward could affect the administration of medicine and the observation of patients in seclusion. On 33 shifts in the month, wards were below the trust standard of two nursing staff per shift. Eight of these were night shifts. Staff and patients told us the wards were always short of staff.
- On some occasions agency staff were not able to carry out all the roles that a permanent or bank member of staff was able to. They had not received some of the security training. This meant they could not hold keys or escort patients. They also could not respond to emergency calls or use physical interventions if required. This meant that when there were agency staff on duty, this could increase the work load for permanent and bank members of staff.
- Permanent staff often worked additional bank shifts on their own or other wards. Some staff were working excessive hours. Some staff were at work at some point during the day for up to 28 consecutive days. The rotas showed some staff were working up to seven 14 hour days without a day off. Staff also told us that they weren't able to take their breaks on the shift.
- Seventeen staff told us that levels of staffing were too low. Six staff told us that a lack of staffing had contributed to incidents happening. Many staff who attended the focus groups said they were concerned about safe staffing levels particularly on the forensic wards.
- Twenty one members of staff told us that they did not feel safe on the wards. A member of staff told us they had avoided a ward for two days. This was because they felt the ward was unsafe. This was directly related to staffing levels.
- Several weeks before the inspection, there was a two day period of time where, in order to ensure safety on

the wards, all therapeutic activities were ward based. This was because occupational therapists and activities co-ordinators had to work on the wards. This lasted for two days. Staff and patients told us about the impact that low staffing levels had. They told us patient leave was regularly cancelled. Ward based activities were regularly cancelled. Patients told us they were not always able to attend the gym, or off ward activities. This included attending the on-site GP clinic. This was due to a lack of staff to escort them. In those cases the GP could attend the patient on the ward. Patients were unable to have regular 1:1 time with their primary nurse.

- Outside of normal working hours there was a junior doctor on call, with two junior doctors on call till 10pm. The doctor not only covered the wards but they were also on-call for the emergency department in the acute hospital and home treatment team. A doctor was sometimes required to be on the ward when medicine was administered in an emergency. Some staff reported that the doctor was very stretched and this sometimes resulted in delays in the doctor attending at night. During the inspection, the trust told us they were aware of this issue and it was being resolved.
- Some of the low secure and rehabilitation wards did not have a social worker assigned specifically to the ward. This meant some social workers worked on more than one ward. The social workers were employed by Ealing local authority. Psychologists worked across two wards. They told us this restricted the amount of time they could spend with patients and they found it difficult to meet with patients as regularly as they felt the patients required. They were unable to provide as many groups and workshops for patients and staff as they felt necessary. Some patients told us they didn't see a psychologist very often.

## Assessing and managing risk to patients and staff

- All patients had a risk assessment on admission into the service. These were discussed by the multi-disciplinary team (MDT). The hospital used standard risk assessments known as HCR-20 (historical clinical risk) which have widespread use in forensic services. On the female wards the Becks suicidal intent scale was also used to assess the risk of suicide. A number of patient risk assessments were detailed and comprehensive. The patient had been involved in their development and they were updated after any incidents. However, half of

## Are services safe?

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

the risk assessments that were inspected lacked some detail. For example, dates of incidents were not recorded and they lacked specific information. Six risk assessments had not been updated after incidents. We saw some risk management plans were not always specific to the individual needs of patients. For example, some of the risk management plans for women relating to self harm had not been individualised.

- There were a number of blanket rules associated with the services regardless of whether the ward was medium or low secure. There were three set times in the day when all patients could access fresh air. Patients could stay outside for 30 minutes on each occasion. Every ward was routinely searched once per month. This involved every room, including bedrooms, being searched. It also meant that patients had to stay in certain areas of the ward as directed by staff. Every patient also had a personal search during this time. These restrictions applied in enhanced medium secure, medium secure and low secure wards. They applied equally to admissions, high dependency and rehabilitation wards. There were no individual risk assessments of patients saying why such restrictions were considered necessary. This meant that some patients were subject to blanket restrictions which had not been individually assessed. On one ward patients carried a book with them. This was to record the activities they had undertaken and was signed by staff. Patients understood that they must attend five activities a week or they would not have leave. This is another example of a blanket rule that had been applied.
- There were many examples of staff using de-escalation techniques appropriately in response to patient aggression and violence. At the Orchard, some care plans described the techniques to be used with individual patients. One patient with communication difficulties held up a 'flash card' to staff indicating they were feeling angry. Staff then accompanied the patient to the quiet room to calm down. In some situations, staff used 'precautionary holds', when there was a risk that a patient may become aggressive. At the Orchard some staff did not consider 'precautionary holds' to be restraint and so they were not consistently recorded in that way. There was no statement about 'precautionary holds' in the provider's policy on violence reduction and management. However, this policy was being updated to reflect the Mental Health Act Code of Practice 2015 at the time of our inspection.
- In the six months prior to the inspection there were 85 incidents of restraint that had been reported. These were highest on Parkland (23), Aurora (13) and Benjamin Zephaniah (11) wards. There were 47 prone restraints. These were highest on Parkland (11), Benjamin Zephaniah (9) and Aurora (8) wards. Staff told us that patients were in the prone restraint position for as little time as possible. Approved restraint techniques were taught by qualified trainers. Eighty five per cent of staff in West London forensic services had been trained in the previous two years. When incident forms were completed they regularly did not include all the necessary details. For example they did not all record the position of the restraint, the staff involved and their roles. Rapid tranquilisation was rarely used on the wards. In the previous six months it had been used 14 times. We looked at five cases of rapid tranquilisation on Benjamin Zephaniah ward. The medicines, dose and route were recorded. In one case there was no record of physical observations having been undertaken. On Aurora ward there were two incidents of rapid tranquilisation and documentation for one of these incidents was not available.
- In the six months before the inspection, there were 171 reported incidents of seclusion. These took place the most on Parkland (34), Benjamin Zephaniah (32) and Aurora (29) wards. Most records indicated that seclusion was used as a 'last resort'. One record said that a patient at The Orchard had requested staff to support her as she was feeling aggressive. There were not enough staff to do so and she was placed in seclusion. A patient returned from absence without leave. Her behaviour was said to be 'chaotic and unmanageable' and she was placed in seclusion. There was no record that any other interventions had been attempted. Two patients had placed paper on the observation panels to their bedrooms. Their behaviour was not recorded as being aggressive. Both patients were secluded. At the Orchard a patients' care plan did not discuss de-escalation interventions. It said as soon as the patient took part in risk taking behaviours they should be secluded. Seclusion reviews did not always take place when required. We saw some nursing reviews were

# Are services safe?

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undertaken three hours after the previous review. In one case the review was after five hours. On one ward we observed a nursing review had not taken place. Medical reviews were also delayed, particularly in the evenings and at weekends. In one case there had been no medical review for nine hours. On some wards there was not a complete record of staff observations throughout the seclusion episode. This meant that some seclusion records were not maintained appropriately. On Parkland ward patients in seclusion could not wear their own clothes. All patients had to wear 'seclusion gowns'. Some patients' care plans detailed the need for seclusion gowns in certain circumstances, however, this was a blanket decision affecting all patients.

- In Three Bridges and the Orchard some patients were restricted to a room or small area to manage risk. This prevented them having contact with other patients. This was de facto seclusion. However, the monitoring and review arrangements for a patient in seclusion were not in place. The leadership team were aware of this practice and had taken steps to address this over a number of months. All clinical staff had been made aware of this type of seclusion being de facto.
- All staff had been trained in level one safeguarding children, 94% of staff had received level two training and 84% of staff level three training. Ninety two per cent of staff had been trained in safeguarding adults. In the previous three months there had been four safeguarding children referrals. Local authority children's services were involved wherever children were visiting patients in the services.
- There had been a number of incidents where safeguarding adult referrals were not made when it may have been appropriate to do so. These involved patients bullying or assaulting each other. We heard that potential safeguarding adults referrals were discussed within the multidisciplinary team. We saw that a recent safeguarding concern had not been referred as it happened at the weekend. The social worker became aware of the incident on the following Monday. We saw that some safeguarding adults referrals were made they were not always within the timescale set out in the provider's safeguarding policy. Seven patients told us that they had not felt safe on the wards. Two patients said staff were not always visible. Patient feedback in the previous three months showed that some patients

didn't feel safe. Over 38% of patients who provided feedback said they sometimes or never felt safe. Patients felt most unsafe on Aurora, Avebury, Parkland and Rollo May wards. During the inspection most of the patients we spoke with told us they felt safe.

- Medicines were stored at the correct temperature and were within their expiry date. Pharmacists checked the medicines on each ward regularly. Wards also conducted their own audits of medicine records. On some prescription charts, some patients were prescribed doses of medicines higher than the recommended maximum dose. There was no record of the reasons for this. Also some of these patients did not have the recommended levels of physical health monitoring. Both of these areas did not follow national guidance. Some medicine charts showed medicines prescribed outside of their licence. This is known as 'off label' prescribing. National guidance state when 'off licence' medicines are prescribed, this should be discussed with patients and they should consent. We found no record of such discussions having taken place.

## Track record on safety

- Thirteen serious incidents had occurred in the year prior to the inspection. We reviewed three investigations into serious incidents. The investigations and reports were of a good standard. It was, however, noted that two incidents involved bank and agency staff. A contributing factor to these incidents was that these staff were unaware of procedures. One of the reports found staffing levels and staff shortages to be a contributing factor.

## Reporting incidents and learning when things go wrong

- All staff understood how to report incidents using the provider's reporting procedure. A wide range of incidents were reported. The senior management team were aware of, and concerned by, the under reporting of incidents. There had been a recent focus on ensuring that medicine errors were reported. In the three months prior to the inspection 28 medicine errors had been reported. A further nine incident reports recorded a patients refusal to accept medicines.
- Where mistakes or incidents had occurred staff were provided with feedback regarding these. In addition, the provider produced a quarterly update for high secure

## Are services safe?

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and forensic services. This update provided summaries of incidents and complaints. This included recommended actions from these incidents. There were also links to the providers 'learning lessons from medication incidents'. Incidents and complaints were discussed in team meetings including any actions that were needed. There were also monthly 'lessons learned' sessions.

- Following incidents, staff usually had a debriefing. We observed one of these during the inspection. However, staff told us of a potentially serious incident on one ward. There was no debriefing after this incident and staff felt unsupported.

# Are services effective?

Good 

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 **good** because:

- Staff had made comprehensive assessments of patients and created care plans. There was good access to physical healthcare. With very few exceptions in the West London forensic service, staff had assessed patients' physical health care needs and they monitored and recorded the patients' physical health.
- Patients had access to a range of psychological therapies and were provided with care from a range of staff from different disciplines, including occupational therapists, psychologists and social workers.
- Staff had access to mandatory and specialist training opportunities and staff received regular supervision as well as reflective practice sessions on the wards.
- Staff received training on the Mental Health Act and Mental Capacity Act. We saw evidence of some good use of the Mental Capacity Act at Broadmoor and at the West London forensic service.

However some Mental Health Act paperwork at the West London forensic service was not up to date. Also in the forensic services the care plans needed further work to ensure they were reviewed, consistent and had a recovery focus.

## Our findings

### Broadmoor Hospital

#### Assessment of needs and planning of care

- Admissions to Broadmoor Hospital were planned. People were assessed before admission and a nursing care plan and multi-disciplinary risk assessment were completed prior to admission. Care plans were updated on admission. There was a multi-disciplinary admissions panel which considered referrals for admission. There was a process for referrals of exceptional urgency which required assessment immediately on admission.

- All the care plans inspected were comprehensive and provided up to date information which reflected the multi-faceted needs of the patients. Care plans covered a number of domains including mental health, physical health, social and psychological needs.
- Records regarding physical health were collated on the wards both in separate physical health folders which recorded checks and monitoring. This information was also on electronic case records. The information was up to date.
- On Kempton ward, which is an admission ward, there were easily accessible 'at a glance' records on one A4 sized laminated card. This was available for all patients so that staff who were not familiar with the patients on the ward would have immediate information about the care needs, preferences and risk information about the patients on the ward.
- The hospital was in the process of moving to electronic records. At the time of our inspection, there were both paper records and electronic records available. Records were stored securely and there were procedures in place so that access to electronic records could be restricted to members of staff for whom they were necessary in order to protect the confidentiality of patients. This meant that there were systems in place to ensure information was securely stored.
- There was a strong recovery focus in the care planning documentation. Wellness recovery action plans were used. They had been redesigned for work specifically on the high dependency units. They ensured that recovery was a focus of care planning for patients at all stages of their admission. Staff were very clear about the recovery focus and hope which they carried for patients to move on within the hospital from more acute wards to rehabilitation and to move on from rehabilitation to discharge. Most staff we spoke with, referred to seeing patients recover and move on as the key positive factor. This culture of hope was embedded in staff throughout the hospital which reflected the trust's values.

#### Best practice in treatment and care

- Patients had access to a wide range of psychological input including 1:1 psychology and a number of groups

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which were offered depending on individual needs. One member of staff in the psychology service told us that sometimes staffing levels on the wards could affect patients' access to 1:1 psychology.

- The hospital had a dedicated health care centre which provided a GP service. As well as a GP, there was also a dentist who had a surgery in the health centre. There was a physical health care matron and two general nurses based in the health centre who were able to provide advice and support regarding physical health care needs. A podiatrist and optician also visited regularly and had facilities within the health care centre to provide treatment and care to patients. When patients were not able to come to the health centre, this care was provided on the ward. The hospital GP was enthusiastic and committed to providing a comprehensive service to patients. They had carried out physical health audits of patients to ensure their specific needs were being met and to ensure that additional support could be provided to patients with long term health conditions. Specialist consultants and nurses from local acute and community health trusts visited regularly on a schedule. For example, a nurse practitioner with a specialist knowledge of diabetes visited regularly as did a consultant. There was access to a dietician once a week and physiotherapy twice a week. Clozapine clinics were run from the health centre and one of the practice nurses had a specialist interest in diabetes management. Practice nurses based in the health centre were able to provide wound care and pressure care management (when necessary) on the wards and advise nurses on the wards regarding physical health care issues.
- There was one bed specifically for patients with physical health care needs which was designated on Harrogate ward. This provided an environment which allowed more space for assistance to be given with personal care. For example, if someone was discharged from an acute hospital and required more assistance before moving back to their designated ward. This room was equipped with a hospital bed and provided an ensuite toilet and shower. It also allowed space for staff to sit in the room with the patient using it. Patients were admitted to this ward from any other ward in the hospital. In the six months prior to the inspection visit, this bed was used for 12 nights.

- The hospital used the health of the nation outcome scale. This was recorded on care records. Other outcome measures used were individualised based on the needs of individuals and targets were planned using a range of psychometrics. For group work in psychology, standardised outcome measures were used depending on the type of group but outcomes were also measured in terms of looking at reductions in incidents occurring.
- Clinical nurse managers were involved in a range of audits including care plan audits, audits of 1:1 time with nursing staff and audits of medication records.

## **Skilled staff to deliver care**

- Multi-disciplinary teams worked across all wards. This included nursing staff, medical staff, occupational therapists, psychologists, activity coordinators and social workers. As well as clinical staff, there were other staff members across the hospital who contributed significantly. These included the staff in the recreation and training services, security staff, domestic staff, catering staff and administrative staff.
- We checked the rates of completion for mandatory training in the hospital. This was reported through the trust intranet system. Mandatory training included basic life support, fire awareness training, promoting safer and therapeutic services (PSTS) training, safeguarding children and adults, mental health act update training and infection control as well as other relevant training courses. There were high levels of compliance with mandatory training. For example, 100% staff who were required to complete PSTS training had done so, 94% of staff had completed safeguarding adults training and 97% had completed basic life support training.
- Staff told us that they had opportunities to access specialist training and were supported to do so by the trust. For example, one occupational therapist told us that they had been supported to qualify as an occupational therapist by the trust and another occupational therapist told us that they were being supported to access specialist training through the trust. However, three members of nursing staff told us that while opportunities existed, they have had to be postponed due to staffing issues on the wards they work on.
- There is a comprehensive induction programme for new staff including a mix of classroom sessions and ward-



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based induction sessions. However, one new member of staff who had recently finished their induction told us that some of the additional support on the ward could be affected by staffing levels on the ward they were working on.

- All clinical staff told us that they had access to monthly managerial and clinical supervision. They also had annual appraisals. This reflected the information which was provided to us by the trust.
- Wards had weekly reflective practice session which staff told us were helpful to encourage learning and sharing practice issues and concerns. However, two allied health professionals told us that sometimes these sessions were less accessible to them due to timings and covering a number of wards.
- Ward management teams told us that performance management processes ensured that staff were provided with support at the first stage and that they were provided with further support if they needed to escalate a matter.

## Multi-disciplinary and inter-agency team work

- Strong multi-disciplinary working took place across the hospital. Each ward had a weekly clinical team meeting with multi-disciplinary input and patients, where possible were involved in these meetings.
- There were handovers between morning, afternoon and night shifts. These were documented and each patient was discussed in detail. All relevant information was shared and noted and duties were assigned for the next oncoming shift. Physical and mental health was considered and risks and incidents were discussed comprehensively.
- The trust had developed links with Bracknell Forest regarding safeguarding processes and staff from Bracknell Forest were involved in safeguarding strategy meetings and regular meetings with the safeguarding lead at Broadmoor to discuss ongoing safeguarding issues.

## Adherence to the MHA and the MHA Code of Practice

- Ninety three percent of staff had completed the mental health law training. Staff showed a good understanding of the relevant areas of the Mental Health Act. We found that documentation relating to the Mental Health Act was available and up to date.
- There was a Mental Health Act office on site which was fully staffed and able to provide input and advice to ward teams.
- Medication charts had relevant consent documentation attached.
- People received regular updated information about their rights under the Mental Health Act and this was recorded. On Cranfield ward, we saw that this was not always recorded. This was resolved shortly after our inspection visit.
- All patients had access to advocacy services which were commissioned by NHS England.

## Good practice in applying the MCA

- Staff had received training specifically about the use of the Mental Capacity Act. This was a part of the mandatory training which was delivered as adult safeguarding training. This was completed by 99% of clinical staff in the mental illness directorate (which included the physical health care and occupational therapy vocational departments) and 97% in the personality disorder directorate.
- We saw some excellent examples of the use of the Mental Capacity Act where decisions had been taken where patients were assessed as lacking capacity. Where best interest decisions had been made there was comprehensive documentation around physical health issues and treatment.
- Short prompts and information about the use of the Mental Capacity Act was available on each ward.
- We observed that discussions around mental capacity took place in clinical team meetings. For example, on Epsom ward, there was a discussion around physical health care and the need and consideration of unwise decisions.
- We saw that some patients had been supported to make advanced decisions which were recorded in their notes. Significant work had been undertaken by the manager of the social work team and the lead social

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worker for forensic services across the trust to ensure that mental capacity issues were on the clinical agenda and the hospital had a specific mental capacity protocol.

## West London Forensic Service

### Assessment of needs and planning of care

- Care plans for all patients were drafted and reviewed within the initial 72 hour assessment period with input from the multidisciplinary team. Comprehensive plans included assessments of each patients' mental state and physical health. Where a physical health issue was identified, care plans demonstrated this was being monitored through regular checks. However on the male wards we found three examples of patients' physical health needs not being regularly monitored.
- All patients had a care plan in place. Most of these were developed collaboratively by the patient and their primary nurse. We saw examples of individualised, person centred care plans with evidence of patient involvement in the process.
- Care plans were stored electronically. There were a number of different care plans, as appropriate for the patient. Some care plans had up to eighteen different domains. Not all care plans had been reviewed or updated, and there was contrasting information within the care plans. For example, for one patient, their care plan covered smoking cessation. In one section the care plan stated 'patient has stopped smoking'. In another section is stated 'patient continues to smoke.' It was unclear which was the most recent record.
- Care pathways and recovery goals were not always clear across care plans. While some care plans clearly laid out the patient's individual treatment journey and the steps they needed to take towards their recovery and eventual discharge, we also saw some very sparse care plans which did not touch upon long term recovery and were more focussed on addressing immediate needs. On one rehabilitation ward of six patients only one had a discharge plan in place. The quality of the recovery focus within the care planning process was inconsistent across the wards and we saw evidence of lack of recovery focus on both the medium secure and the low secure wards.
- Patient information was recorded electronically but paper records were also used to record care

information. It was not always clear which form of recording held the most recent record. Information regarding restraint, incidents, and safeguarding were not easily accessible to ward staff.

### Best practice in treatment and care

- There were a number NICE (National Institute for Health and Care Excellence) recommended psychological therapies being offered to patients with psychotic illnesses including cognitive behavioural therapy, family therapy and art therapy. The female medium secure unit wards ran a weekly psychodynamic group, attended by patients and staff, as a forum for sharing difficult feelings and concerns in a safe, non-judgmental space. Attendees were supported to explore issues psychodynamically to understand the causes of difficult feelings and behaviours which may be manifested on the ward. Anger management and psychology groups were facilitated across the wards.
- Patients in the Orchard had access to a physical healthcare suite on the ground floor within the Atrium complex. Male patients were able to access the on site GP surgery. Patients were accompanied to Ealing Hospital for any emergency medical treatment required. Physical healthcare link nurses visited the wards twice a week or more frequently as required.
- Staff used the health of the nation outcome scores assessment tool for measuring patient progress. The Glasgow anti-psychotic side effect scale was used across the service. This ensured the side effects of medicines that patients experienced were regularly monitored.
- Clinical staff actively participated in audit across a range of clinical areas including the following: monthly audits of detention paperwork, consent to treatment forms and medicines auditing. Primary nurses were responsible for conducting audits around care plans, frequency of one to one meetings, assessments, physical healthcare checks, mattress checks, hand hygiene, infection control and flushing water for legionella checks. We observed examples of audits carried out across the wards and some of these were not up to date. Ward management told us they sometimes struggled to complete audits regularly due to staff shortages.

### Skilled staff to deliver care

# Are services effective?

Good 

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- There was a range of skilled practitioners working across the wards. These included psychologists, occupational therapists, social workers and pharmacists. A dietician was available if required and there was some input from speech and language therapy. All of the wards had activity coordinators to support patients with ward based and external activities.
- Training records held on the ward showed that staff were generally up to date with their mandatory training which included safeguarding adults and children, infection control, suicide prevention and safe restraint training. Staff who are not up to date with their mandatory training were not allowed to work bank shifts.
- Monthly supervision for nurses, health care assistants and other allied health professionals was carried out across all wards visited. Family therapists undertook peer supervision and consultants received weekly clinical supervision. Staff told us supervision was rarely cancelled and they found it helpful and supportive. Team meetings were held weekly and attended by nursing staff and other allied health professionals. Fortnightly reflective practice sessions facilitated by a psychologist took place across the wards. During these sessions staff had the opportunity to share experiences and concerns.
- Staff had the opportunity to attend specialist training relevant to their role including treatment for fire setting, relational security, prevention and management of violence and aggression and substance misuse awareness and psychosocial interventions. We spoke to two staff who had recently completed the six week psychosocial interventions training. They were sharing their learning with colleagues through team meetings and reflective practice sessions.
- There were opportunities for career progression available including a band 5 development programme, healthcare assistant development programme and nurse preceptorship scheme.

## Multi-disciplinary and inter-agency team work

- Handovers took place three times a day. These were attended by nursing staff and some multi-disciplinary team members. The handover provided a clear update to staff on patients health and wellbeing. Multi-disciplinary team meetings happened regularly across

the service. We observed a ward round attended by a psychiatrist, occupational therapist, clinical psychologist, pharmacist and nurse. Staff demonstrated warmth and respect for the patient, with a clear understanding of the patient's needs and their care pathway. There was however limited discussion around one patient's complex risks.

- Staff spoke positively about the multi-disciplinary team working and felt that everyone was working together to meet patients' needs. They felt listened to and could approach colleagues for advice when needed. Allied health professionals and social workers told us they worked well with nursing staff but recognised how short staffed the nursing teams were and the impact this had on both nursing staff morale and safety on the wards.
- Staff spoke of positive links with patients' care coordinators. Staff had effective working relationships with other agencies. This included a dedicated police liaison officer. Some of the social workers worked closely with multi agency public protection panels.

## Adherence to the MHA and the MHA Code of Practice

- Staff had training on the Mental Health Act (MHA). Patients had their rights explained under the MHA on admission. These rights were discussed with patients every three months. However, there were some cases where there was no recorded evidence that patients were made aware of their rights on admission.
- Capacity to consent to treatment forms were attached to corresponding medication charts. There was evidence of regular reviews of patients' consent to treatment. However, we were unable to consistently see a record of assessments of the patients' capacity to consent to treatment, or a documented discussion about consent in the patients records.
- Staff in the Mental Health Act office were available to provide advice and support with administration to ward staff. Ward staff were aware of how to contact them. Detention paperwork was generally filled out correctly.
- The service had recently started working with a new independent mental health advocacy (IMHA) provider. There were posters and leaflets displayed advertising the service. A number of staff we spoke with were

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unable to tell us about the service. Some patients had an awareness of the service although eight patients on one of the male wards did not know that this service was available to them.

- Section 17 leave was appropriately authorised and recorded on standardised forms. Conditions of leave were clearly stated. In one case the number and type of escorts required was not recorded. We observed discussions about risks associated with leave on the day of our visit. Not all section 17 leave forms were signed by patients. On some occasions, old forms were not clearly marked as void.
- On Parkland ward some old treatment certificates were not marked as void. There was a risk of confusion, particularly for staff not familiar with the patients. We were unable to locate the history of treatment authorisation for one patient. Two patients had a Section 62 emergency treatment certificate. One was a month old, the other was two months old. There was no evidence that a second opinion appointed doctor had been requested. There were no updated consent or treatment certificates with the medicines included.

## Good practice in applying the MCA

- Staff had received training in the Mental Capacity Act (MCA) and were able to describe examples where patients' capacity had been assessed in accordance with this.
- Capacity assessments were undertaken by members of the multi disciplinary team as appropriate.
- Staff gave us an example of the capacity assessment they undertook with a patient who wished to give a family member a large amount of money. The patient was assessed as having capacity but was advised by staff of the potential risks and repercussions of making such a gift, so that they were able to make an informed decision.
- We saw evidence of best interest meetings taking place in line with the MCA across the service. One patient was prevented from buying protein shakes as staff informed us he did not have the capacity to make this decision. However, there was no record of any capacity assessment being carried out for this patient for this specific issue.

# 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** because:

- The majority of feedback we received from patients was positive. We observed care being delivered with care and kindness. This was particularly evident in feedback from Broadmoor Hospital. Staff had a good understanding of patients' needs.
- We saw that patients were involved in care planning with some exceptions in the West London forensic services.
- All patients had regular access to advocates and there were opportunities for patients to feed back to the service through regular community meetings and patients' forums which involved ward representatives. There were carers' groups for patients on both sites.

However some patients at the West London forensic services did not give positive feedback about the attitude and approach of a few staff members.

## Our findings

### Broadmoor Hospital

#### Kindness, dignity, respect and support

- On all the wards we visited and in our visits to the recreation, training and therapeutic services, we observed staff to be 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.
- The feedback we received from patients regarding the attitudes of staff towards them was very positive. 37 patients we spoke with particularly mentioned staff positively in terms of being treated with respect, kindness and dignity.
- It was particularly notable that the 14 patients we spoke with in the workshop and kitchen garden areas were positive about the staff input and valued these opportunities. One patient described the kitchen garden as 'a true asylum'.

- Many of the patients are admitted to the hospital have long lengths of stay. At the time of our inspection, the average length of stay for patients was just over 7 years. This meant that staff knew the patients on the wards very well. Staff we spoke with were very aware of the needs and preferences of patients on the wards in which they were working.

#### The involvement of people in the care they receive

- There were a number of initiatives and programmes to ensure that patient participation and voice was reflected through the hospital and the way it was run. There was a well-established patients' forum. This had representatives from each ward, if they were able to attend and there was a good representation from senior managers within the hospital. It ensured that patients had the opportunity to raise issues of concern to them and they brought issues from wards. It also gave the hospital management a coherent process to consult, engage and inform patients in the hospital. Issues which were raised and discussed were documented and outcomes were tracked. This information was shared with patients. During the meeting we attended, patients were given feedback and an update from the clinical director about a serious incident which had occurred within the hospital. The patients' forum was co-chaired by a patient.
- Each ward had weekly community meetings. Patients were encouraged to attend. When this may be difficult, for example, on wards where there were patients who were being nursed in seclusion or in long term segregation, they were given the opportunity to contribute. For example, on Cranfield ward, the meeting took place in the ward corridor where patients could participate from their rooms. Changes had been implemented following ward community meetings. For example, on Canterbury ward, there had been changes to the ways that the dining area was designed and meals took place and an 'enhanced dining experience' had been developed with patients on the ward, including the removal of staff 'observation' chairs and adding theme nights such as curry and steak evenings. Feedback from these changes were shared at the patients' forum.

# Are services caring?

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

- Care plans had included the views and input from patients in them. On Woburn ward, we saw that a safety management planning tool was being used with patients which was a format by which patients discussed information around risk with staff and were able to give feedback and input into their risk assessments.
- Specific work had taken place to involve patients and ensure that their voices were heard. For example, on Ascot ward, the occupational therapist had provided information about groups and activities in easier language to help people on the ward understand the options available to them.
- Each ward had a specific operational policy. On Kempton ward information was given to patients when they were admitted to the hospital to help orientate them to the ward and the way it operated.
- There was a quarterly carers' forum which was held at weekends and assistance was given to family members to travel. Family members were invited to care programme approach meetings. These were regular six monthly meetings where patients' care is reviewed.
- There was a recovery college on site. This included access to educational facilities but also involved specific recovery courses which were co-produced and delivered with patients. These included a course called 'positive communication and collaborative working' which looked at the principles of 'positive and safe' and the use of physical interventions and forced medication. It ensured that the patient view was encapsulated and was delivered to patients and staff members. This was a co-produced and co-delivered course and we received very positive feedback about this from staff and patients.
- The hospital employed a service user consultant who was an ex-patient who had been at Broadmoor for 6 ½ years and now came into the hospital to deliver training including a session called "Broadmoor and beyond" to current patients. This post included management supervision by the staff in the hospital and the consultant was supported in his role. He was very enthusiastic about the support he was given by the hospital and the trust.
- There was a hospital magazine, called "The Chronicle" which was produced by patients attending the recovery college.

## West London Forensic Service

### Kindness, dignity, respect and support

- We observed staff speaking with patients. They were respectful and supportive. The patient feedback survey asked patients if they were treated with kindness and compassion. Overall patients felt this was the case. On Brunel and Melrose wards patients felt staff were particularly caring.
- Most patients told us that staff knocked on their bedroom doors. A small number of patients said this did not happen, or only sometimes.
- Some patients were very pleased with the care they received. There was recognition that staff had a hard job. Patients spoke of being treated with dignity and respect.
- Around half of the patients we spoke with had negative views of some staff. This usually related to nursing staff. Some patients told us some staff were rude and had a poor attitude. A small number of patients felt that staff deliberately provoked them.
- On Derby ward patients did not queue for their medicines. Each patient had their medicine separately from other patients. This demonstrated that patients were being respected and afforded some dignity.
- On most wards it was clear that staff had an understanding of the patients and their needs. This was particularly the case on Melrose and Parkland wards.

### The involvement of people in the care they receive

- When patients were admitted or transferred to wards they were shown around. Sometimes a patient already on the ward did this. The patient was also provided with information about the ward. On Tennyson ward patients visited the ward for a meal prior to transfer. When they arrived there was a welcome meeting. This was attended by the staff team and patients. Patients were also given an induction pack.
- Overall patients were involved in planning their care. Most patients told us this. The majority of care plans showed that the patient had expressed their views. Many of the care plans were personalised, meeting the

## Are services caring?

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

needs of individual patients. On the female wards in particular, some care plans specifically dealt with aggression. These showed how the patient wanted to be treated when they felt angry. This meant that care could be delivered in some of the most difficult times, in a way that involved patients and acknowledged their preferences. In some cases it was unclear what the patients' view of their care plan was. It was written in language which they were unlikely to have used. There were a small number of care plans where the patients' views were not recorded.

- Patients told us they also took an active role in ward rounds. We observed this during one ward round. Staff spoke without using jargon and the patient was listened to and involved. However, we also heard of ward rounds on another ward where patients weren't involved.
- Overall the majority of patients had a copy of their care plan. They understood what their care plan was. A small number of patients didn't have a copy of their care plan. Some did not know what their care plan contained.
- Advocacy was available on all wards. This meant patients were supported to express their views. Staff and the majority of patients knew about the advocacy service. Patients who had used an advocate were positive about them. A small number of patients didn't know what an advocate was or what they did.
- Where possible, staff ensured that patients had contact with families and carers. Some patients had escorted leave on a regular basis so they could visit family. Each building had a specific visiting room suitable for children. Some nursing staff had been specifically

trained to assist with children visiting. A family therapist worked in the Orchard. Part of their role was to assist families and carers. They helped families visit and got them involved with the patients care plan. They also ensured the staff team on the ward provided support. Relatives and carers were invited to ward rounds.

- The service had a member of staff whose role was to promote patient engagement. They also facilitated a carers' group. This was a safe space for carers to meet and discuss common issues. Senior management and carers spoke highly about this member of staff.
- Patients could provide feedback in two main ways. Each ward had a weekly community meeting. This meeting allowed discussion of a number of ward issues. It also meant patients could feedback to staff. Minutes of each meeting were typed and made available for patients. On Derby ward patients chaired and minuted the community meeting. The community meeting minutes for Barron ward did not include patients views or feedback.
- Patients could also feedback by using a touch screen tablet. This had specific questions about their experience on the ward. In the three months prior to the inspection, patients recorded their views 2103 times.
- Each ward had 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.

# Are services responsive to people's needs?

Good 

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

## Summary of findings

We rated responsive as **good** because:

- Most people were admitted through established processes and there were few transfers which were unplanned. At Broadmoor there were processes to prioritise urgent referrals. However at the West London forensic service, staff were not aware of the processes for urgent admissions.
- Wards had access to a range of rooms and spaces to meet the needs of patients and support treatment and care. Most wards had access to outdoor space. The trust was able to meet the needs of people from a range of backgrounds and religions and ensured that food choices included religious diets such as kosher and halal food. There was access to interpreters and patients were aware of complaints processes.

However some areas where the trust should improve were:

- There were some delays in the system when people at Broadmoor were waiting for a bed in a medium secure service, which meant that due to high occupancy people could not always be provided with care in the least restrictive environment which would safely meet their needs.
- In the West London forensic service, some patients were not provided with support in the ward which provided the least restrictive environment due to the availability of beds.
- Patients in the West London forensic service raised concerns about not being able or feeling comfortable making complaints about the service, although the trust reported a steady increase in complaints being made and those being upheld.
- Some patients in the West London forensic service raised concerns about the choice and quality of food, particularly vegetarian options.

- Patients were referred to Broadmoor Hospital from prisons, through the courts or from other secure hospitals. Most referrals were from the prison service. There was a process through which referrals were made via an admission panel which consisted of clinicians from different disciplines including consultant psychiatrists. Over the two months prior to our inspection, nine referrals were received. The time between referral and assessment was an average of one week and the time between assessment and a panel decision was an average of three weeks.
- Within the hospital there were two different 'pathways' depending on whether the patient's primary needs related to mental illness or personality disorder. Each pathway had admission wards, high dependency units and assertive rehabilitation wards. There was a medium dependency unit in the personality disorder pathway and the intensive care ward was shared between both pathways.
- Bed management meetings took place weekly for the mental illness pathway and fortnightly for the personality disorder pathway. We saw minutes from these meetings. At the time of our visit, we were told that there were around 20 patients waiting for beds in medium secure units.
- Regular internal transfer meetings took place within each 'pathway' to look at the priorities to move patients to different wards within the hospital. For example, when someone was able to move from a high dependency ward to an assertive rehabilitation ward. Each patient who was ready or needed to move was discussed within a multi-disciplinary team and decisions were made about clinical priorities. These meetings also tracked the length of time that patients had been waiting for internal moves within the hospital so the hospital management can understand where the potential blocks lie. Consultants told us that delays while waiting for discharges led to delayed in beds being available in assertive rehabilitation wards, which meant that sometimes people were not in the places where restrictions would be at the lowest level possible due to movement through the hospital being delayed.
- At the time of our inspection, the hospital had a 94% occupancy rate. Some beds were left vacant as a part of the contract arrangements with NHS England in order to accommodate emergency situations and

## Our findings

### Broadmoor Hospital Access and discharge



# Are services responsive to people's needs?

Good 

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

incompatibilities between patients. At the time of our inspection, the average length of stay was around 7 years. There were a few patients who had been in the hospital for very long periods of time which affected the average length of stay considerably. Length of stay generally is monitored by the clinical governance processes within the hospital.

## The facilities promote recovery, comfort, dignity and confidentiality

- Facilities and the ward environment varied significantly between wards within the hospital. A new hospital was being built while we were visiting and it is due to open in 2017.
- All wards had clinic rooms and rooms for activities and meetings to take place in. There was a separate visitors centre which included a childrens' visiting centre. However, some visits could take place on wards. The Paddock also had a separate visitors' area. In the general visit area, there was a vending machine where people could buy drinks and snacks. There was a space for non-contact visits and a pastoral room where patients could have more privacy during visits.
- Each ward had a separate small telephone room so that conversations could take place in private. There were policies related to random monitoring of telephone calls. Patients were made aware of these.
- All patients had access to outdoor space. However, for some wards this access was not direct. For example, on Leeds ward and Sheffield ward, outside space was accessed through Harrogate ward.
- We visited the enterprise workshops where patients produced items for sale in the shop including personalised mugs, leatherwork like bags, hats and belts. Other craftwork being undertaken included ceramic work, leather and textiles as well as a printing workshop. There were sports facilities on site including a gym and swimming pool. Some wards had gym equipment.
- Bedrooms were personalised to different degrees. Patients had space to put up pictures in their rooms and there were boards which patients could write on. All patients had access to secure space to lock their possessions on the wards.

- In the newer wards, all rooms had ensuite facilities. In some of the older buildings, such as York House and Kent House, there were shared shower facilities and communal showers. Efforts had been made to ensure that patients' dignity was preserved while they were taking showers so only one person was able to use the showers at a time. However, this meant that there was only one shower available to use for 20 men.

## Meeting the needs of all people who use the service

- The hospital had an equality and diversity forum which ran regularly to ensure that issues relating to equality and diversity were raised and discussed through 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 and LGBT social event, Eid celebrations, black history month celebrations and Christmas.
- There was a chaplain based at the hospital and patients had access to religion-specific support. For example, there was an imam who attended the hospital. Patients had access to religious diets such as halal and kosher food.
- A speech and language therapist (SLT) attended the hospital one day a week to provide help and support regarding patients' communication needs.
- Staff knew how to contact interpreters if they were required.

## Listening to and learning from concerns and complaints

- Patients we spoke with told us that they knew how to make complaints about the service. Six patients told us specifically that they had made complaints. One patient told us they had been helped to make a complaint by an advocate. Two patients told us that the complaints they had made had been resolved to their satisfaction. One patient told us that they did not feel complaints were taken seriously.
- Complaints were monitored on a monthly basis. Over a period of six months between December 2014 and May 2015 there had been 75 complaints and 14 compliments received by the trust relating to Broadmoor Hospital.

# Are services responsive to people's needs?

Good 

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

- Complaints and compliments were discussed in the monthly ward clinical improvement group meetings which fed into the hospital wide clinical improvement group meeting so information and learning could be shared through the hospital and through the trust.
- Around the hospital, in clinical and non-clinical settings there were 'you said – we did' signs which reflected actions taken in response to feedback in the relevant area.

## West London Forensic Services

### Access and discharge

- Referral routes into the medium secure facilities included prisons, the courts, and high secure hospitals, whilst the low secure part of the service also took patients from medium secure units, local mental health services and psychiatric intensive care units.
- Patients always had access to a bed on their return from leave. Patient beds were not used when they were on leave.
- Patients were occasionally moved between wards during an admission episode for the purposes of managing risk and incompatibilities. If a patient required seclusion and the seclusion room on their ward was full, they would be transferred to a seclusion room on a neighbouring ward.
- Admissions and discharges generally took place during working hours. Referrals were discussed in fortnightly referrals meeting. This meant that sometimes there may be a referral received but not discussed for 13 days. Staff were unable to tell us how they responded to urgent referrals.
- Discharge was occasionally delayed due to bed shortages in the identified move on ward, or suitable accommodation being available in the community. For example, there was a patient on Tennyson ward (rehabilitation) who had been assessed as ready to move on. The consultant had worked with the forensic outreach team to provide support and guidance to the place the patient was moving on to and to provide follow up support. This had helped reduce delayed discharges back into the community for male patients.
- Wards in the Orchard were clean and bright with good natural lighting and access to a pleasant courtyard area and garden. The Tony Hillis Wing, while clean was less well maintained, with visible damp patches and leaks. On Tennyson ward there were water leaks. The furniture was in need of replacement. Domestic staff rotated across the wards to provide cleaning services.
- There were no en-suite bedrooms for patients in Three Bridges or the Tony Hillis Wing. Toilet and shower facilities were communal. All of the patients bedrooms at the Orchard were en-suite
- All wards had a telephone and some were in private telephone rooms while some were on corridors. This meant that patients were not always able to make private phone calls on some wards. Some of the wards had taken steps to mitigate this by providing cordless phones which patients could take into their rooms.
- Some of the low secure/rehabilitation wards patients could access the kitchen to make drinks or snacks. On the medium secure unit patients were individually risk assessed for kitchen access. Kitchens were clean and well stocked.
- On some wards patients had keys to their bedrooms and were able to access their rooms at any time.
- Low secure wards were housed within the same building as the medium secure wards. This meant that low secure patients were subject to the same building security procedures upon entering and exiting the wards. These included handing in contraband items and passing through a metal detector and a number of locked doors.
- Female patients 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. Patients could access this area in line with their risk assessment.
- Patients from across the forensic services attended a recovery focussed rehabilitation group and would shop and cook for their weekly evening meal and were supported to organise a take away meal once a week.

### The facilities promote recovery, comfort, dignity and confidentiality

# Are services responsive to people's needs?

Good 

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

- Activities on the wards included healthy eating group, smoking cessation group, arts and crafts group (painting and jewellery making) bingo, relaxation group, yoga and gardening. Patients on some wards reported a lack of evening activities. Patients had the opportunity to work at the Café on the Hill, the café on the Tony Hillis Wing, the car velting service in the Atrium and to volunteer with the West London Dogs Trust.
- The visiting area for patient visitors was off the wards. If a patient was unwell staff could arrange for visitors to meet the patient on the ward.
- The wards had a number of rooms available for patient use including quiet rooms, clinic rooms and therapy rooms. There was equipment available to support patients to occupy their time including games, books and art materials. Patients on Melrose ward were painting a mural on the courtyard fence on the day of our visit.
- Each ward had access to outside space, though access to this was timed. Patients were not able to access outside areas when they wished.
- Patients gave mixed feedback about the food across the wards. Some patients complained of poor portion sizes and poor food quality. Two patients said that vegetarian options were limited and sometimes unavailable. One patient said she was given cereal and milk for her evening meal on a couple of occasions as there were no vegetarian options left. Halal and kosher food could be ordered.

## Meeting the needs of all people who use the service

- An Imam and Christian minister from the chaplaincy service were available to meet with patients when required. At the time of our visit staff were making plans for the Islamic festival of Ramadan due to take place the following week. Mealtimes and medication administration times had been adjusted to accommodate patients who intended to fast.
- There was a wide range of information displayed on noticeboards across the wards including leaflets and posters about diagnoses and treatments, psychoeducation, complaints procedures, patient forums, advocacy services and results of the patient survey.

- There was access to interpreters for patients who don't speak English through the patient affairs service. The staffing team across the service was ethnically diverse and reflected the diversity of the patient group. They were able to act as interpreters where appropriate.
- The wards at the Orchard were wheelchair accessible. Barron and Bevan wards had accessibility ramps in place. Staff told us they were concerned that there was no adequate evacuation plan in place for one patient with specific needs on one of the wards. This was raised with the ward manager on the day of the inspection and plans were put in place to ensure a safe evacuation could be carried out.

## Listening to and learning from concerns and complaints

- We received mixed feedback from patients regarding complaint handling across the wards. Ten patients told us they felt able to complain, that staff were approachable and helpful and would respond to their complaints. However, twelve patients told us there was no point in complaining as complaints would not be listened to. Five patients told us they didn't complain as they feared repercussions such as having leave cancelled or being moved to a different ward.
- The ward managers showed us where learning from complaints was discussed at team meetings and changes had taken place as a result. For example, a patient complained about an out of date review of his treatment and progress being read out by a nurse in the ward round. The ward manager responded to the complaint the next day, acknowledged and apologised for the mistake and told us about the change that had been implemented as a result of the complaint. Patients are now encouraged to write their own progress review to read out in the ward round.
- The staff told us they tried to address patients' concerns informally as they arose, though they were aware of the formal complaints process and knew how to signpost people to PALS when needed. Ward managers would escalate more serious complaints to the complaints manager covering the forensic services.

# Are services well-led?

Inadequate 

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 **inadequate** because:

- 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.

However, the trust had identified key issues which were reflected on the relevant risk registers. A quality improvement lead had been appointed at Broadmoor Hospital. The trust had leadership development programmes in place, including one which specifically focused on people from black and minority ethnic backgrounds.

## Our findings

### Broadmoor Hospital

#### Vision and values

- In our conversations with staff through the hospital, it was clear that they reflected the organisation's values in the way they approached their work and interacted with patients. It was particularly noticeable that the local management and staff through all parts of the hospital reflected the value of 'togetherness' by involving patients in their care and ensuring that there were a number of routes through which patient voice was heard and the value of 'hope' which was reflected in our conversations with staff about the desire to see patients progress through the hospital to be discharged.

- Most staff were aware of the local leadership within the hospital and within the trust. Some staff specifically mentioned the new director of nursing as having a positive impact since her arrival.
- However, many staff spoke of Broadmoor as being very different from the rest of the trust. This was both in location as it is geographically separate from the rest of the trust which is based in London and culturally, feeling that there they do not feel consistently engaged with the trust. Some examples we were given around this specifically related to central services, such as human resources, which were based in London and courses and meetings which took place in London without consideration being given to staff who may have to travel further to participate. This was the perception of staff at the hospital.
- The trust had worked on staff engagement at Broadmoor and there were a number of programmes in place to roll this out. However it was evident through our visit that there were some significant gaps in communication between what the trust and hospital management was doing to move forward and the perception of staff around what the trust and hospital management were doing. For example, we were told a number of rumours by staff about changes which they believed were going to happen. When we spoke with managers they confirmed that some of these were not based on fact, although the members of staff telling us believed them to be true. This meant that there was a significant gap in communication of the trust and hospital's objectives and future direction.

#### Good governance

- The hospital had moved to a new governance model in the months leading up to the inspection visit. This had streamlined some of the communication between the management and the ward with clinical leads for mental illness and personality disorder being appointed.
- Each ward had a clinical improvement group meeting monthly. These meetings had a standard agenda. This ensured that incidents, comments and complaints were collated and discussed at ward level. After these meetings, a summary was provided to the clinical director who took this information into the hospital wide clinical improvement group. The clinical director responded to the wards' summary information and

# Are services well-led?

Inadequate 

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information was distributed back through the hospital clinical improvement group to the ward clinical improvement groups so that this could be added to the agendas and discussed at the subsequent meetings.

- Information about staffing, vacancies, training, sickness and absence rates was available to clinical team leaders at a ward level.
- The hospital management had information which ensured they were aware of the key areas of concern within the hospital. The hospital risk register reflected the key areas of concern which we found. However, we did not see clear plans and target dates within the level 2 risk register developed to address the identified risks. Each ward had a risk register and this was discussed at the monthly clinical improvement group meetings. Issues from the ward risk register could be escalated to the hospital, directorate or trust risk registers as appropriate.
- The hospital management had plans in place to promote further recruitment having identified recruitment and retention as a key risk in the hospital. However, this had been a concern for an extended period of time and while recruitment had increased over the last six months, there was still a high level of staff turnover as staff were leaving. Managers had identified staff retention as a problem. However more action was needed to address the problem.
- Managers told us of plans to work in this area to improve quality of exit interviews and address the staff retention by analysing why staff were leaving but this had been a development which was not recent and needed to be accelerated.
- The senior management in the hospital and the trust carried out 'back to the floor' shifts to speak with and understand the experiences of staff working on the wards.

## Leadership, morale and staff engagement

- Twenty nine members of staff across the hospital raised with us concerns about the culture of the hospital including bullying, feeling uncomfortable to raise concerns or a lack of understanding and/or appreciation by 'senior management'.

- One member of staff talked about how many of the staff felt run down and burnt out. This reflected other conversations we had with staff members through the inspection week.
- Most staff felt that they were supported by their immediate line managers and told us that they would feel comfortable raising concerns with their managers. However two members of staff said that they did not feel their managers were approachable.
- Six members of staff told us that they felt that there had been an improvement in the leadership in the hospital over the 'past few months'.
- For the year ending 31 December 2014, the sickness absence levels had been 6.9% in the mental illness pathway and 5.8% in the personality disorder pathway.
- The trust had internal leadership development programmes including a programme specifically aimed at black and minority ethnic staff.
- The trust had a plan in place to promote staff engagement. There had been one staff forum which had been held at the time of our inspection and this was intended to be a work in progress which would continue to provide an arena for staff to engage with the trust and the hospital management. Some staff told us that they did not feel they had the opportunity to input into consultations or changes in the service or in the benefits which had been withdrawn such as changes in the pay structure.
- We received feedback through letters and comments cards left by members of staff and patients which referred to a 'bullying culture' in the service. These referred to staff members being bullied by other staff members rather than patients being bullied by staff members. Some staff told us that their managers discouraged them from reporting incidents related to staffing levels. We raised this with the service who told us that staff were encouraged to report incidents and while staff reporting incidents may be asked for further information, no incident was 'refused' by the hospital management.
- Some staff told us that the hospital had 'blame' culture and this made them reluctant to report incidents.
- There had been changes in the pay structures over the past 18 months. This meant that new staff did not

# Are services well-led?

Inadequate 

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receive a 'high secure lead' but members of staff who had been in employment continued to receive this. Staff on the ward we visited and in the focus groups we ran mentioned this as creating a 'two tier' pay structure which was not conducive to the retention of new staff and this had led to further strains in the morale among staff at the hospital.

## **Commitment to quality improvement and innovation**

- The trust had reflected on in great depth the findings of the Saville Enquiry and had implemented changes where needed.
- A quality improvement lead had recently been appointed, based at Broadmoor Hospital with the scope to push ahead with a specific agenda to look at quality and patient experience as well as focusing on restrictive practices through a strategy to reduce levels of seclusion and embed the new code of practice.
- There were some research projects which had been developed within the service, leading to changes in practice. For example, a paper was published in 2010 following research undertaken at Broadmoor to determine eight domains of need which best formulated the most effective work with patients in high secure services. This led to the development of a care planning approach which used these eight domains.
- The trust had committed to extending research and development within the service. However, some clinicians working at Broadmoor told us that they felt the senior management had a risk averse attitude and were not supportive of developing innovative practice. The service was involved in a number of regular forums with similar services in England to share information to improve practice in high secure hospitals.
- The hospital had implemented the 'safe wards' initiative on a Chepstow, Epsom, Woburn, Cranfield, Kempton and Ascot wards which looked at an evidence based way to reduce violent and aggressive behaviours on wards and work on reducing restrictive practices.
- Broadmoor hospital was 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.

## **West London Forensic Services**

### **Vision and values**

- Staff were aware of the visions and values of the trust and these were displayed on the trust intranet.
- Some staff told us they felt the executive board of the trust were supportive and they enjoyed reading the CEO's blog. Some staff told us that the senior management team were very visible and they conducted weekly walk arounds to all the wards. However, other staff said they did not know, or feel supported by senior management

### **Good governance**

- There were gaps in the governance processes as issues which had been identified were not raised and addressed soon enough. For example, while there were ongoing recruitment programmes to address staff shortages, there were high levels of staff turnover and more staff were leaving than being recruited.
- Operating systems were still embedding to monitor quality improvements, this included ward based audits. These were not yet always taking place consistently which meant information about ward level practice was not always available to the service management.
- There were a range of committees and steering groups to improve best practice. These included the suicide prevention group and the restrictive practice reduction group.
- Pharmacy audits were regularly carried out. However, we found some gaps which may have been picked up by more effective auditing. For example, the use of 'off license' medication and consent and discussions with patients in relation to this.
- We found that there were gaps evident in the Mental Health Act detention paperwork and that sometimes section 132 rights, where patients' were explained their rights under the Mental Health Act was not robustly audited as there were some gaps in these processes.

### **Leadership, morale and staff engagement**

- At the time of the inspection the forensic services had a recently appointed clinical directors and three clinical leads. It was evident that the director and his team were

# Are services well-led?

Inadequate 

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facing a very significant challenge in developing the services so they were safe, with a positive team of staff who felt appropriately engaged in the work of the service.

- Across the service, staff told us that they felt undervalued by management. The majority of staff told us that due to staffing levels, they were forced to take a firefighting, reactive approach as opposed to focussing on therapeutic, preventative work with the patients. This affected their morale.
- At the Orchard some staff reported feeling safe and well supported by colleagues and management. At Three Bridges and Tony Hillis Wing many staff said they felt unsupported by management, and that nothing happened when concerns were raised.
- We received mixed feedback from staff regarding how they felt about raising concerns. Many staff told us they would raise any concerns or complaints with their manager, and felt they would be supported and kept informed of the progress and outcome of the complaint. Some staff told us they felt wary of raising concerns due to repercussions such as being moved to another ward.
- 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. The culture was variously described as 'tribal', 'bullying' and as a 'gang culture.' The senior management team had commissioned a consultant to undertake an external analysis of the culture to assist them with changing this culture. Some staff told us there was a positive move away from a blame culture.

- Over the previous two years the trust had addressed concerns about bullying and harassment by investigating the allegations and making changes to the senior management team. They had also provided support for this management team from the Tavistock and Portman Hospital to help them deal with the additional pressure and stress. In addition approximately 20 teams in the forensic services have had input from occupational health in 2014 who held focus groups and specialists from the Health at Work team who held a series of facilitated meetings. Further action is needed to have sufficient impact to address these concerns.
- Sickness rates over the 12 months prior to the inspection had been 6% but varied between wards.
- There were routes to develop career pathways. Health care assistants had been supported to qualify as nurses and some nurses were supported to take senior roles through training. There was a leadership development programme within the trust.

## **Commitment to quality improvement and innovation**

- Six wards were using a model called 'safe wards' which was an evidence-based model to work to which looked at decreasing the use of physical interventions and restrictive practices on wards. Benjamin Zephaniah ward was also due to begin working to this model.
- The service participated the Royal College of Psychiatrists quality network for forensic mental health services.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

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 a breach of regulation 18(1)

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

#### Regulation

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 in the West London forensic service restraint and seclusion had not always been 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 a breach of regulation 13(1)(2)(4)(b)

#### Regulated activity

#### Regulation



This section is primarily information for the provider

## Requirement notices

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.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

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.

This was because in the West London forensic services there were some blanket rules and restrictions that were taking place.

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

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

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 a breach of regulation 12 (1)(2)(g)