

West London Mental Health NHS Trust

Other specialist services

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 Newmarket ward Sandown ward Woburn ward Canterbury ward Dover ward Folkestone ward Kempton ward Chepstow ward Epsom ward	RG45 7EG

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

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

Following this inspection the warning notice was removed and replaced by requirement notices. This was because the hospital had put the systems and processes in place to make the necessary improvements, but further work was needed to complete and embed these changes and ensure patients consistently received access to appropriate levels of meaningful therapeutic activities.

- The hospital had a recruitment strategy that was resulting in additional staff being recruited. The trust and hospital management had an understanding and oversight of the concerns which related to staffing in the hospital and had regular up to date information regarding the current status of recruitment and retention. The focus was not only on recruitment but also looking at ways to improve retention rates for staff at the hospital.
- There were improvements in patients' access to therapeutic activities. Most patients we spoke with were positive about the support provided in the hospital and some told us that there had been an improvement in access to activities since our previous inspection in November 2016.
- The leadership team at Broadmoor and in the trust were committed to making the improvements and were closely monitoring the progress being made. They recognised the areas where further work was needed.

However:

- While there had been considerable work undertaken to recruit additional nurses in the hospital, there were still significant vacancies, which continued to adversely impact on the consistency of patients' access to meaningful activities, association time (for those who were subject to the conditions of long term segregation) and therapeutic engagement with ward staff.
- The hospital had started to work on a more systematic way to record meaningful activities offered to patients. This was a way of providing assurances both internally and externally that every patient was offered a minimum of 25 hours meaningful activity weekly. This information was inconsistently recorded and not yet embedded. This meant staff could not guarantee data was always accurate.

Summary of findings

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

Are services safe?

We found the following areas where the service needs to improve:

- There were still significant gaps in the availability of nursing staff on the wards. The trust had taken action to increase recruitment of nursing staff and had additional plans to improve retention. While we saw that there was some positive impact, this did not yet ensure that sufficient staff were deployed to wards to provide optimum care for patients.

However, we also found the following areas of good practice:

- Reported incidents relating to staff shortages had decreased since our last inspection in November 2016.
- The proportion of shifts which had the appropriate number of nursing staff allocated had increased considerably since our last inspection in November 2016.

Are services responsive to people's needs?

We found the following areas where the service needed to improve:

- Data collected on the wards regarding activities was not yet consistent.
- Patients continued to experience cancellations of activities and planned association time due to low staffing levels.

However, we also found the following areas of good practice:

- The hospital had implemented a new system to record activities on the ward and this was in the process of being embedded. Ward managers and senior managers within the hospital reviewed this information regularly, had identified the lack of consistency and were looking at ways to improve this.

Are services well-led?

We found the following areas of good practice

- The senior management team had access to information about the levels of staffing and the impact that this had on patient experience. This was represented on the service and trust risk registers and regularly discussed in governance meetings so that there was oversight of the work that needed to be done.

Summary of findings

Information about the service

Broadmoor Hospital is one of three high secure hospitals in England. It is managed by West London Mental Health NHS Trust. The service provides approximately 200 beds for men who require care and treatment in the conditions of high security.

The services in the hospital are configured into two pathways, mental illness and personality disorder.

Mental Illness services:

Ascot ward – high dependency - 12 beds

Cranfield ward – intensive care (mental illness and personality disorder) – 11 beds

Harrogate ward – assertive rehabilitation – 20 beds with one bed for patients 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 - 15 beds

Personality disorder services:

Canterbury ward - assertive rehabilitation - 20 beds

Dover ward – assertive rehabilitation – 20 beds

Folkestone ward – assertive rehabilitation – 20 beds

Epsom ward – high dependency – 12 beds

Kempton ward – admission – 12 beds

Chepstow ward – medium dependency – 12 beds.

All patients admitted to the hospital are detained under the Mental Health Act (1983) (MHA).

Our inspection team

Lead Inspector: Victoria Hart (Inspector)

The team that inspected this service also included another three CQC inspectors, one CQC inspection manager, one specialist advisor who was a nurse with experience working in a high secure setting and two observers from Her Majesty's Inspectorate of Prisons.

Why we carried out this inspection

We carried out this focused inspection to check whether the provider had taken actions to improve following the warning notice served on 28 November 2016. The warning notice related mainly to ongoing concerns regarding the impact of staffing levels on the quality of care delivered to patients at Broadmoor Hospital.

CQC inspected Broadmoor Hospital in 2015 as a part of a comprehensive inspection of West London Mental Health NHS Trust and rated the forensic service, of which Broadmoor Hospital was a part, as requires improvement. CQC undertook a further comprehensive inspection in November 2016 of Broadmoor Hospital as a standalone service. Following that inspection, we rated

the Hospital overall as requires improvement. The safe domain was rated as requires improvement, effective was rated as requires improvement, caring was rated as good, responsive was rated as inadequate and well led was rated as requires improvement. We issued the provider with a warning notice and instructed that a significant improvement was required by 30 June 2017. They were required to take action to ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients. They were also required to ensure that patients had access to activities and therapeutic engagement according to their care plans. This was a continuing breach of regulation 18 (1) Staffing.

Summary of findings

There were additional requirement notices from the November 2016 inspection relating to regulation 11 of the Health and Social Care Act (Regulated Activities) - need for consent, regulation 12 of the Health and Social Care

Act (Regulated Activities) regulations 2014 – safe care and treatment and regulation 17 of the Health and Social Care Act (Regulated Activities) – governance. We did not follow these up at this focused inspection.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for feedback.

During the inspection visit, the inspection team:

- visited 12 wards and the recovery college, kitchen gardens, workshop and gym
- interviewed 51 patients on an individual basis
- spoke with 54 members of staff including nurses, doctors, healthcare facilitators and allied health professionals

- met with the clinical director, deputy executive director of high secure services, recruitment lead for the hospital and the lead occupational therapist
- requested additional information including policies and data from the trust before, during and after the inspection
- observed one handover meeting, three community meetings and one hospital wide daily communications meeting where significant incidents and staffing levels are discussed

What people who use the provider's services say

We spoke with 51 patients in the hospital throughout our inspection visit. Two patients called to give feedback after

the inspection visit. Most patients were happy with the care which they were receiving. However, a third of the patients we spoke with (32%) raised concerns about the staffing levels.

Areas for improvement

Action the provider MUST take to improve

- The provider must continue to work actively to ensure that there are sufficient qualified and experienced staff on the wards.
- The provider must continue to ensure that patients have access to activities and therapeutic engagement and that cancellations are minimised.

- The provider must continue to work towards ensuring that data collected relating to monitoring of meaningful activities is accurate and reflects the work carried out with patients in the hospital.

West London Mental Health NHS Trust

Other specialist services

Detailed findings

Name of service (e.g. ward/unit/team)**Name of CQC registered location**

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

Broadmoor Hospital

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

Our findings

Safe staffing

- During our previous inspection in November 2016, we identified that there were not sufficient suitably qualified staff on the wards to meet the needs of patients and that this had an impact on the patients' access to therapeutic activities and planned association time. This had also been identified as a concern in June 2015 and so we served the trust with a warning notice which required them to provide evidence of significant improvement by 30 June 2017.
- At this inspection, we requested information from the trust regarding the staffing situation in the hospital. We found that on 2 August 2017, there were 50 vacancies for qualified nurses on the wards at Broadmoor Hospital. In November 2016, we found that there were 68 vacancies. This meant that while there had been significant recruitment within the time frame, there was still a risk that some shifts were not staffed to the level that was determined by the hospital to be optimum.
- The trust had appointed a nurse to focus on recruitment specifically for Broadmoor Hospital and they had regularly attended careers and information days for student nurses around the UK and Republic of Ireland with specific contacts having been made with Scottish universities. This had increased recruitment of newly qualified nurses.
- As of 2 August 2017, an additional 56 nurses had been given starting dates in 2017. This meant that the trust had taken significant steps to improve nurse recruitment. However, this was dependent on nurses who had been recruited coming into their posts and existing nursing staff remaining in post.
- In addition to initial recruitment, the trust had focussed on longer term retention strategies. These included 'new starter' forums so that nurses at the beginning of their careers in the hospital had opportunities to meet with senior management. The trust had also worked with local housing associations to identify affordable local accommodation for staff as well as providing enhanced relocation packages.
- Thirty of 58 members of staff we spoke with, predominantly based on the wards and in activities programmes, told us that they had ongoing concerns about the staffing levels in the hospital and that they observed that staff shortages had an impact on the quality of patient care on the ward or in the area they worked in. Of these 30, five members of staff told us that they had noticed an improvement in the staffing, although it was not at an optimal level. Four members of staff told us that the staffing situation had got worse since November 2016 when we last inspected the service and three told us that they had not noticed any changes in the staffing since November 2016. Five members of staff told us that staffing levels had improved and they did not feel concerned with staffing levels on their ward or in their service. Other staff we spoke with told us about other concerns about the hospital including management support and communication.
- Three members of staff told us that, although there had been new staff employed, this could lead to increased pressure for experienced staff on the wards in order to provide guidance and assistance to new staff especially when new staff then left quickly and were replaced by another new starter.
- Seventeen patients out of the 53 patients we spoke with, specifically raised concerns about staffing levels and staff redirection on their wards. Three patients told us that things had improved since November 2016. Other patients spoke to us about the activities they participated on and off the ward but did not refer to cancelled activities specifically or activities that they were not able to access due to staffing levels.
- The trust provided us with information about their turnover rate for staff in the hospital between 1 July 2016 and 30 June 2017. For nurses based on the ward, the average turnover was 15%. At the previous inspection in November 2016, the average turnover rate for nurses in the year prior to the inspection had been 22%. This meant there was a slight improvement in staff retention.
- We checked the fill rate of staff across the hospital in the three months prior to our inspection visit. Fill rate is

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

determined by taking the actual hours worked by staff as a percentage of planned hours of staff coverage broken down by role to separate the fill rate for nurses and the fill rate for healthcare facilitators.

- Across the hospital, between 1 January 2017 and 30 June 2017, the average fill rate was 96% during the day and 92% at night for registered nurses and 90% during the day and 104% at night for healthcare facilitators. The hospital deployed more than the allocated numbers for healthcare facilitators in order to mitigate some of the risk of not having sufficient qualified nurses throughout the hospital. At our last inspection, the fill rates for the six months prior to the inspection, between 1 August 2016 and 31 October 2016, had been 87% for nurses during the day and 80% for nurses at night with 94% for healthcare facilitators during the day and 107% for healthcare facilitators at night. This meant that there had been an improvement in the fill rate for nurses since the last inspection in November 2016.

- At the time of the inspection in November 2016, there were significant gaps in the availability of registered nurses and that this had an impact on the care delivered in the hospital. At this inspection, we found that while there were still significant gaps, the service had made considerable effort to employ more staff and that this was beginning to lead to improvements in the outcomes for patients.

Track record on safety

- At our previous inspection in November 2016, there had been 106 incidents reported that specifically related to staff shortages in the six months prior to the inspection. Between 1 January 2017 and 30 June 2017, this had reduced to 58 incidents where staff shortages were specifically a factor.

Are services responsive to people's needs?

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

Our findings

Facilities promote recovery, comfort, dignity and confidentiality

- Patients within the hospital had access to a variety of activities including recreational and therapeutic activities. These included psychological therapies with individual and group work taking place both on wards and off ward. Activities on wards were led by staff from the recreational activities programme or by ward staff. When patients were offered activities, staff recorded these so that the trust could monitor patients' access to activities.
- At our previous inspection in November 2016, we found that staffing levels impacted significantly on patients' ability to access planned activities both on wards and off wards. Due to this, we served a warning notice to the trust in November 2016, requiring them to take urgent action to improve the access to therapeutic and recreational activities for patients.
- Between 1 January 2017 and 30 June 2017, 589 sessions run by staff for patients were cancelled due to low staffing levels. This was 3% of activities which were offered to patients. This meant that some patients continued to be affected negatively by the lack of available staff.
- Thirty patients we spoke with told us that they had regular access to activities either on or off the ward. Ten patients told us about cancellations of activities, which had a significant impact on them. For example, needing to wait or being limited in the amount they were able to use the telephone when they wished to. Five patients told us that the situation regarding the offer of activities had improved since November 2016.
- At our last inspection in November 2016, staff and patients told us that activity coordinators who were assigned to wards were redirected to other wards to work as healthcare facilitators. At this inspection, we spoke with four activities coordinators. The trust had changed the management structure for activities coordinators so that they were managed by clinical team managers on the wards rather than by the occupational therapy department. Staff told us that this meant that activity coordinators were moved to other wards much less frequently. However, activity coordinators and other nursing staff reported to us that it was not uncommon for them to be counted in the numbers of healthcare facilitators on the ward. This left them unable to devote their shifts to providing additional support for activities on the ward. However, when activities coordinators were working shifts as healthcare facilitators, they were able to provide some focus on activities through the course of the shift.
- Patients on Ascot, Cranfield, Epsom, Kempton, Newmarket, Sandown and Woburn wards were subject to night time confinement (NTC). This is when patients are locked in their bedrooms between 9.15pm and 7.30am. The rationale for NTC, which is in place across the high secure hospitals in England, is that staff will be released to provide additional activities during the day with a minimum of 25 hours a week of meaningful activities being offered to every patient but with a focus on those who are subject to NTC. We requested information from the trust about the numbers of hours of activities offered to patients throughout the hospital. There were 98 beds on the wards where NTC was in place, not all of which were constantly in use. In January 2017, 54 patients who were subject to NTC were offered a minimum of 25 hours in meaningful activities, this dipped to 38 patients in February 2017. However, by May 2017, this figure was 78 patients and 72 patients in June 2017. We saw that there was a notable increase in the numbers of patients who were subject to NTC being offered a minimum of 25 hours meaningful activity. This meant that there was an improvement since the inspection in November 2016.
- The hospital recorded meaningful activities in a number of ways. All activities which were offered by staff who were not based on the wards were recorded directly by staff in those services. For example, activities by the occupational therapy department, the psychology department and the sports, leisure and recreational services teams were recorded by those teams. Since our last inspection in November 2016, the hospital had initiated the use of activity recording logs on every ward. This included all activities which were offered on the ward, including those offered by activity coordinators, so that more accurate information could be collected across the hospital. The service had, in conjunction with other high secure hospitals in England, established a working definition of what constituted a 'meaningful

Are services responsive to people's needs?

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

activity' for patients on the ward. This had included the use of surveys of the patients by the occupational therapy team to determine the activities which patients valued.

- We checked activities books on the wards that we visited and requested information after the inspection regarding the activities logs. We found that there was significant variation in the quality of the data collected on the wards. Staff on some wards told us that it was the responsibility of the activities coordinator to collate this information and record it electronically. On other wards it was the role of the ward administrator to transfer the information from paper to electronic formats. This also meant that there was a lack of consistency in what was recorded as meaningful activity for individual patients. For example, on one ward, we saw that nursing reviews of seclusion had been included as meaningful activities. Another ward recorded access to the garden area as a meaningful activity and this was noted as being an activity for all patients, not only those who were subject to the conditions of long term segregation.
- We requested information from each ward about the activities recorded, and found some examples of inconsistencies. We spoke with staff on the wards about the inconsistencies in recording. Three members of staff told us that they carried out more activities than they logged, but that the time they took to record the activities impacted on their availability to carry out activities. Some staff also told us that the impact of the staff shortages on the wards meant that activities which happened were not always recorded. This meant that we could not be assured that the information provided by the trust regarding activities was accurate.
- Some patients in the hospital were subject to long term segregation (LTS) which is defined in the Mental Health Act Code of Practice as when "a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis." Patients subject to the restrictions of LTS had access to 'association time'. This is when the patients may be able to leave their rooms and mix with other patients or members of staff. We asked for information about how often planned association time had been cancelled due to shortages of staff. Between 1 January 2017 and 30 June 2017, this had happened on 83 occasions. At our previous inspection, this had happened on 102 occasions in the six months prior to our inspection. From the information provided by the trust, we saw that over the six months between 1 January and 30 June, there had been a continuing trend in the reduction of these cancellations. While there were 32 incidents of cancellation in January 2017, there were eight in June. The wards where this was most frequently occurring were Epsom ward, on 26 occasions and Cranfield ward, on 27 occasions. These were the wards with the highest incidence of LTS.

Are services well-led?

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

Our findings

Good governance

- Since our last inspection in November 2016, the trust had worked to improve ways of recording activities offered, accepted and refused by patients. This had been raised in meetings between wards, discussing reducing restrictive practices and data collection across the hospital. In March 2017, staff had started to use 'activity log books' to record activities for patients on the wards. The consistency of recording within these books was not yet sufficient to provide a robust assurance across the hospital, and this had been identified in meetings within the management team in the hospital as an area that needed increased work. Although there were still concerns about the accuracy and consistency of the collection of information about meaningful activities offered, the governance systems within the

hospital had identified this as a concern and were working on improvements. The trust was addressing this by asking wards where the system was working more effectively to liaise with wards that were struggling, in order to drive improvement.

- The hospital and trust risk registers reflected concerns identified relating to the risks of low staffing levels in relation to nurses. This was a high priority for the trust and recruitment and retention of staff was discussed within the senior management team at the hospital. The hospital senior management team received and collated weekly updates regarding staffing levels, vacancies and leavers in order to understand where the key concerns were. As well as a focus on recruitment, additional work was being carried out to improve retention strategies including ongoing staff forums with senior managers and a specific forum for new starters.

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 was not ensuring that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people using the service.

There were 50 vacancies for registered nurses in the hospital.

Activities both on the wards and off the wards were cancelled due to staffing issues on a consistent basis.

This is 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 17 HSCA (RA) Regulations 2014 Good governance

The registered person had not ensured that the service was maintaining an accurate, complete and contemporaneous record in respect to each service user.

This was because the ward activity logs were not consistently recording activities across all the wards.

This is a breach of regulation 18 (2) (c)