West London NHS Trust

High secure hospitals

Inspection report

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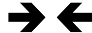
Ratings

Overall rating for this service	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Our findings

High secure hospitals

Good 

We carried out this announced focused inspection to check on the safety and quality of the service at Broadmoor Hospital and whether improvements had been made as a result of the requirement notices issued at our previous inspection in June 2018. In December 2019 the hospital moved into purpose-built accommodation on a new hospital site. In addition, four existing wards were retained and incorporated into the new hospital. Unfortunately the patients had not yet fully benefitted from all the facilities and communal areas due to restrictions on patients mixing as a result of COVID-19 but the new ward areas had played a vital role in preventing the spread of infection as all patients now had ensuite bathrooms and easy access to fresh air.

Our rating of the service stayed the same. We rated them as good because:

The trust had successfully opened the new hospital and the patients had transferred across without incident.

Staff and leaders had worked hard to minimise the impact of the COVID-19 pandemic on the quality of care and treatment and patient safety. They had carefully explained the need for infection prevention and control measures to patients and received good cooperation when additional restrictions had to be imposed. As a result COVID-19 outbreaks had been well-contained.

Staff and leaders did their best to minimise the impact of national staff shortages on care, treatment, safety and security. Numerous recruitment initiatives were ongoing and the impact on patients and existing staff was kept under constant review.

Staff treated patients with compassion and kindness. Patients received exemplary care and treatment that was tailored to meet their individual needs and preferences. Staff spoke about patients with hope and had an excellent knowledge of each patient and the best way to respond to and interact with them.

Patients felt respected and valued as individuals and were empowered as partners in their care, both practically and emotionally. There was a strong person-centred culture and staff put the patients' needs at the heart of care and treatment.

Staff provided care that was personalised, holistic and recovery-oriented. They respected patients' privacy and dignity. Staff were proactive in involving families and carers in patient care, when appropriate. Staff understood how to protect patients from abuse and the hospital worked well with other agencies to do so.

Co-production with patients was central to the service. Staff were committed to ensuring the patient voice was embedded in decisions about the hospital, when appropriate. Their input was valued and patients had a significant influence on service improvement through patient forums, research and feedback.

The new hospital had been designed with full regard to the physical and emotional well-being of patients and safety for all. All patients, staff and carers described the new facilities as outstanding. Wards were clean and well maintained.

Our findings

Staff proactively assessed and managed risks to patients well and achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. One ligature risk in some garden areas had been identified but required further action and the hospital attended to this immediately. Staff followed best practice in anticipating, de-escalating and managing distressed behaviour. The hospital was piloting the use of a long-term segregation pathway which had resulted in segregated patients spending more time out of their bedrooms.

Staff had training in key safety skills and managed safety incidents well. The hospital had clearly defined and embedded systems, processes and policies to keep people safe.

Managers investigated incidents and complaints and shared the lessons learned with staff to minimise the risk of them happening again.

Staff from different disciplines worked together professionally and with mutual respect to achieve the best possible outcomes for patients using the service. They provided a range of care and treatment interventions consistent with national guidance on best practice.

There was a multi-disciplinary approach towards every aspect of the patient journey from admission to discharge. Staff were committed to partnership and collaborative working in order to deliver holistic care. Teams collaborated with each other and with external agencies.

Staff reported the hospital strongly promoted equality and diversity in its work with patients. The hospital had set up a Black, Asian and minority ethnic (BAME) carers forum to specifically address concerns raised as a result of the Black Lives Matter movement. Work was progressing with cultural formulation and cultural care plans.

The hospital had a positive, open and inclusive culture which centred on improving the quality of care patients received through empowerment and involvement. Throughout our inspection we saw that staff promoted the values of the trust in all aspects of their work and spoke about the patients being at the heart of the service.

Managers demonstrated that they were very experienced, knowledgeable and highly skilled in their roles. They have been consistently open and honest with the Care Quality Commission about their successes and the challenges within the service during inspections and routine engagement.

The hospital collected, analysed, managed and used information well to support all its activities. Managers had access to the information they needed to provide safe and effective care and used that information to good effect.

However:

Whilst the hospital had made many improvements since our last inspection in June 2018, there were still high vacancy levels for registered nurses. This impacted on the care and treatment that patients received, affected staff morale and staff ability to participate in supervision sessions and team meetings. Staff recruitment campaigns and efforts to retain staff were comprehensive and ongoing.

Some ligature risks required further mitigations on Embankment, Victoria and Chepstow wards.

Our findings

For some patients, multiple medicines were prescribed to manage the same health condition. Where patients had 'when required' oral and intramuscular medicines prescribed the care plans did not detail which medicine was preferred in which circumstances.

On Kempton Ward some staff had not completed the knowledge and understanding framework required to work with people on the personality disorder pathway, so may not have been fully equipped for their roles.

Patients on Kempton Ward had reduced access to psychology and occupational therapy.

Not all staff were familiar with the role of the Freedom to Speak Up Guardian or the process for raising concerns.

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

All wards were clean, well-furnished, well equipped and well maintained. However, some wards were not always as safe as they could be as some ligature risks had not been identified.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Regular checks of the environment were carried out by the designated nurses. All wards had good visibility and clear lines of sight and staff had clear views of day areas and bedroom corridors when they were in the ward nursing offices. Wards were spacious and uncluttered. All communal areas, corridors, seclusion rooms and laundry rooms were covered by closed circuit television (CCTV). CCTV was monitored live by security staff. Staff carried body-worn cameras, which were switched on when required, for example, when attending an incident.

Staff were always present in the communal areas of the ward. This helped in supporting and managing patient interactions as staff were immediately on hand to intervene and de-escalate potentially negative interactions quickly and safely.

Each ward had completed a comprehensive ligature risk assessment. Staff knew about potential ligature anchor points but the mitigation for some ligature anchor points was not sufficient to address the nature of the risk.

In the garden areas for Victoria and Embankment wards there were handrails which could be used to secure a ligature. This was identified as low risk on the ligature risk assessment. However, these handrails were situated above a drop of approximately 90cms in an area of the garden that was difficult to see from the nurses' office.

Patient bedrooms and seclusion rooms on Chepstow Ward had a particular fitting in the bathrooms that could be used to secure a ligature. This posed a risk to patient safety. Staff said that patients with a high risk of self-harm were closely monitored to ensure their safety. While this did mitigate risk, it did not account for unpredictable self-harm behaviour.

Our findings

All staff had personal alarms and patients had easy access to nurse call systems in their rooms. Patients said staff responded when they pressed the call button. At our last inspection we recommended that personal alarms were replaced in a timely manner. At this inspection we found improvements. The hospital had upgraded the personal alarm system. Staff confirmed that personal alarms were fully tested at the start of each shift. Staff did not report any concerns in respect of the alarm system or response during our inspection.

Patients could access outdoor space and gardens directly from all wards. This was something that had not been possible in the old hospital.

The hospital had a central security team, which consisted of clinical and non-clinical staff, who had oversight of physical security within the hospital. A security liaison team of nurses provided a link between the ward teams and the security teams. Security staff could access out-of-hours support from the on-call security manager.

There was a specialist team within the hospital to provide specific support when an incident occurred. Its members had additional training in the prevention and management of violence and aggression and they used personal protective equipment in their interventions when required.

The hospital is required to undertake an annual security audit to ensure its compliance with The High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2019 issued by the Department of Health and Social Care. Physical, procedural and relational security is covered.

The last audit was carried out in September 2021 by members of staff from the security teams at the other high secure hospitals in England. Broadmoor Hospital received a 'green', substantial compliance rating.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean and tidy. Patients said, and we observed, that there was a high standard of cleanliness. Staff and patients said that any faults or repairs were swiftly identified and addressed. The new hospital had been thoughtfully designed with plenty of space.

Staff followed infection control policy, including handwashing. Staff were aware of the hospital's guidance, policies and procedures for hygiene, cleanliness and infection control. Staff followed infection control principles, including the use of personal protective equipment. Wards conducted monthly infection control audits and at the height of the COVID-19 pandemic the hospital had received a visit from Infection Prevention and Control leads for the North West London Integrated Care System to check best practice was being followed. They were satisfied it was. Staff said audit findings were discussed in handover meetings and the ward managers emailed staff with follow up actions if any issues were identified. The infection, prevention and control lead within the hospital offered advice and support to the wards. Where wards had COVID outbreaks these were well managed and closely monitored to prevent the spread of infection.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. All seclusion rooms had facilities that were consistent with the requirements of the Mental Health Act Code of Practice. Staff were easily able to observe the patient during seclusion to ensure they were safe. Specialist equipment enabled the staff to monitor patients' vital signs without entering the room.

Our findings

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. At our last inspection we required the provider to ensure that equipment available for emergency use was within date. At this inspection we found most equipment to be within the expiry date, however we found two adult resuscitator masks on Embankment Ward were out of date. This was despite the staff having recorded that all emergency use equipment was in date. This was highlighted to staff during the inspection who addressed this immediately by replacing the masks. At the last inspection, we required the provider to review the accessibility of adrenaline for anaphylaxis use. At this inspection we found improvements, adrenaline injections for emergency use were stored in the emergency medicines bag.

Safe staffing

The service did not have enough nursing and support staff to keep patients safe. Nurse vacancy rates were high, a high number of shifts were not filled, staff were redirected to support other wards and this impacted on the delivery of care. Managers regularly reviewed staffing levels and skill mix and all efforts were made to increase staffing levels for each shift. However, this did not always provide established levels of staffing.

The service had enough medical staff, who knew the patients. All staff received basic training to keep people safe from avoidable harm.

Nursing staff

The hospital did not have enough staff in the nursing team to keep patients safe at all times. At our last inspection we required the provider to ensure that there were sufficient staff. At this inspection, vacancy rates remained high across the hospital due to national shortages of nursing staff. There were 78 registered nurse vacancies, which represented a vacancy rate of 36%. Non-registered nurse (healthcare assistant posts) were over-recruited to at the time of the inspection to try to provide some mitigation. Staff and patients told us staff shortages impacted on patient care. All staff said that staffing levels across the hospital needed to improve and that more work was required to retain staff.

The hospital was finding it challenging to recruit registered nurses despite using both tried and tested and creative recruitment methods. There were continuous advertisements for nursing staff vacancies. Recruitment events with universities were recommencing and the hospital had started to recruit international nurses, this had also been paused during the pandemic. To attract staff the hospital paid a relocation allowance, offered an additional two days annual leave and paid a retention and recruitment premium. The hospital had plans to develop a post-graduate certificate in high secure nursing and to recruit registered general nurses to support the development of integrated physical health skills in ward teams. Managers reviewed staffing at each handover to ensure that they could provide safe care.

Staff absence due to COVID-19 exacerbated staff shortages. In addition, staff reported that they were often redirected to support higher risk wards when those wards were short of staff and patient acuity was high.

We reviewed staffing rosters for four wards and found the number of nurses and health care assistants did not always match the planned numbers. For example, on Chepstow Ward between December 2021 and March 2022 the ward had 24 shifts where they were operating with six staff instead of seven due to staff being redeployed and staff sickness. For the month of March 2022 Victoria Ward had 18 shifts where the nursing team did not have its full complement of qualified staff.

Our findings

On Embankment Ward we reviewed the number of nursing staff on 16 shifts between 17 and 22 March 2022. On seven of these shifts (44%) there was only one registered nurse on the ward. The ward had been one member of staff short on eight of the 16 shifts (50%). The shortfall in registered nurses was usually caused by the need for nurses to be redeployed internally to support patients in the high dependency units.

The hospital had a high use of bank staff. A total of 3,173 shifts were filled by bank staff between 1 December 2021 and 28 February 2022. The hospital tried to use bank staff to cover all leave, absences and sickness. However, when bank staff were unavailable permanent staff undertook overtime on the wards. No agency nursing staff or healthcare assistant staff were used in the hospital. The only agency staff utilised by the hospital were doctors and social workers. Managers requested staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Staff said that when unfamiliar staff were on the wards, patients felt less contained and they were less likely to trust new faces which could increase the level of risk and put more strain on permanent staff.

A total of 746 shifts were not filled between 1 December 2021 and 28 February 2022.

The turnover rate for the 12 months to February 2022 was 11%. Over the same period, the trust sickness rate was 6%.

Staff said that more could be done nationally and locally to improve nurse and other staff retention. For example, staff said that salaries did not reflect the demands of working in a high secure environment. They also said that changes to shift patterns had made it more difficult for staff to manage their commitments outside work.

Despite the efforts of all concerned, nurse shortages impacted on patients and other team members. Patients did not always receive regular one to one sessions with their named nurse. Staff in vocational services were sometimes redirected to work on the wards, this meant that patients did not always know whether a planned session, such as woodwork, would take place. Sports and leisure staff were regularly redirected to work on the wards.

Patients had their escorted leave or activities cancelled due to the hospital being short staffed. Patients and staff gave us numerous examples of the impact of staff shortages on access to the gym, recovery college and creative arts centre. Where possible patients had their escorted leave rearranged to times when there was enough staff to facilitate this. There was a waiting list for the recovery college, and on some occasions, patients were unable to attend because there were no staff to escort them. Patients on Embankment Ward said that a lack of staff meant that it took time for staff to respond to their requests. For example, it could take a long time for staff to facilitate a telephone call.

However, the hospital made sure there were enough staff on each shift to carry out any physical interventions safely.

The ward managers were permitted to adjust staffing levels according to the needs of the patients. Managers could increase the number of staff on the ward if there was a high level of acuity or there were patients assigned to enhanced observations.

Managers supported staff who needed time off for ill health. Staff confirmed their managers were understanding and supportive when this happened.

Medical staff

Our findings

The hospital had enough daytime and night time medical cover and a doctor available to go to the wards quickly in an emergency. There were three junior doctor vacancies that were being recruited to. These vacancies were covered by locum staff.

Managers made sure all locum doctors had a full induction and understood the service before starting their shift.

Mandatory training

Staff had received and were up to date with appropriate mandatory training to ensure they had the appropriate knowledge and skills to carry out their roles safely. Except for training on information governance which was at 83%, completion rates for all other topics were above 85%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training sessions were provided either in person or virtually. During the height of the COVID-19 pandemic virtual sessions replaced face-to-face sessions. The hospital had now re-introduced face-to-face sessions. Staff said they felt confident carrying out their roles and were able to apply their training to their practice.

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff said they were supported to carry out any additional required training, for example, on dual diagnosis, nasogastric tube insertion and wound care.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed comprehensive risk assessments of every patient on admission. Risk assessments were reviewed and updated regularly, including after any incident.

Staff used a recognised risk assessment tool, the HCR-20 (Historical Clinical Risk Management) risk assessment tool, to ensure that all aspects of patient risk were covered, for example on Embankment Ward, we observed a meeting at which staff assessed the risks associated with a patient who was being admitted to the ward the following day.

Management of patient risk

Person-centred risk management processes were in place to anticipate, manage and reduce the risks of patients experiencing harm. Staff knew about any risks to or from each patient and acted to prevent or reduce risks. Staff shared key information to keep patients safe when handing over their care to others. Staff in multi-disciplinary team meetings comprehensively discussed individual patients' needs and demonstrated an in-depth understanding of each patient.

Our findings

Staff had a strong understanding of relational security. Relational security is the knowledge and understanding staff have of a patient and of the environment. Staff were able to use this knowledge and understanding to build safe and effective relationships with patients. This helped staff develop appropriate responses, care and support for each individual.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff used their knowledge of patients to understand and predict patient risk behaviour and triggers and intervened with suitable support such as reassurance, increased observations, medicine review and the use of seclusion. Patients confirmed they were involved in their risk management plans. Staff regularly discussed patient dynamics and compatibility within the teams and across the wards to ensure patients who had a negative relationship with patients on other wards would not encounter them.

Staff observed patients in line with the trust's policies and procedures. Wards were designed to allow observation of all areas. The hospital had installed CCTV in communal areas. Staff checked all patients regularly. When patients presented a heightened level of risk, patient observations were increased.

The trust had installed a remote monitoring system which could be used, when appropriate, to monitor patients' vital signs. For example, after rapid tranquilisation had been administered. Due to the risks associated with the hospital patients, from their presentation or on account of the complexity of their medicines regimes, there was no opt out option for patients. However, the trust was keeping this under review. Patients we spoke with said it helped to keep them safe and limited night-time disturbance.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. All patients were subject to searches which took place in accordance with the High Security Psychiatric Services (Safety and Security) Directions 2019. An external audit of all aspects of security covered by these directions had confirmed that the hospital was fully compliant.

Use of restrictive interventions

Levels of restrictive interventions were proportionate to the level of risk presented by the patients. Staff participated in the hospital's restrictive interventions reduction programme, which met best practice standards. The programme was well established and being carried out alongside the other high secure hospitals in England. Minimisation of the use of restrictive interventions was embedded within the hospital as business as usual. When staff described their work, it was apparent this was the norm. When patients were subject to any restrictive interventions these were person-centred.

The hospital also used elements of the 'Safewards' model. The model addresses how to assess and change ward culture, de-escalation and alternatives to restrictive interventions. This included the use of positive and 'soft' words when speaking to patients.

Staff dealt with situations skillfully and they said they were confident that other team members would back them up. Staff kept records that showed they used advanced de-escalation techniques to avoid the use of restraint. Incident reports included information on how patients were supported when restrained with details about the length and type of restraint and debriefing for both patients and staff.

When restraint did take place, each episode was discussed, reviewed and analysed within the multi-disciplinary team to understand how the patient could be better supported to avoid a repetition.

Our findings

Individual care plans covered all elements of risk and safety. Separate care plans were in place for long term segregation, night-time confinement, risk to self and risk to others. Care plans were personalised, co-produced with the patient and the patient's views about the restrictive interventions were clearly recorded. Staff were aware of the potential triggers for each patient.

The hospital had policies and procedures which reduced the need for restraint. There were robust governance arrangements in place to ensure that there was good oversight, challenge and review when a patient was assessed to require more restrictive interventions. For example, if a patient required the use of a waist restraint belt this could only be agreed by the trust's executive team and the use of nasogastric Clozapine had to be authorised by the clinical director for the service line.

The hospital was piloting the use of a reducing restrictive practice (RRP) team to support all the wards in managing restrictive practices. We received very positive feedback from staff and patients about this initiative and how this had improved the quality of life for patients subject to restrictive practices. The reducing restrictive practice team had been offering support, resources and mentoring to ward staff to help them find ways of supporting patients in long term segregation (LTS) to come out of their rooms safely and reintegrate with their peers, where appropriate. The team also worked with ward staff to prevent patients going into LTS. LTS is used when a patient, for their own safety or for the safety of others, is required to be provided with nursing care and treatment in isolation from other patients for more time than is the case with seclusion. At the time of our inspection 37 patients were subject to LTS. The team were piloting a five stage transition pathway to support patients to leave LTS. The team used a zoning system and a five steps approach to help patients understand how their LTS could be reduced or exited completely. No patients on the intensive care or high dependency wards were on step one where they do not come out of their rooms at all.

Staff had been successful in reducing the use of mechanical restraints (waist restraint belt) and holds were no longer needed for several patients. Staff on Stratford Ward (the intensive care unit) said "it was a joy to see [progress]" as some patients had been so entrenched in their aggressive behaviours they had been in LTS for a long time.

The RRP team was made up of experienced staff, some of whom were from the Prevention of Violence and Aggression (PMVA) and management team. The wards were all working towards supporting patients out of their rooms for activities, therapies, physical health care, mealtimes and fresh air as much as possible, although staffing levels meant that patients' needs had to be put in priority order on some days. Patients fed back that the team had made a huge difference to their day to day lives and referred to the project as the "safe wards team."

Staff followed NICE guidance when using rapid tranquilisation. For example, records showed that staff checked the patient's blood pressure, pulse, temperature, hydration, respirations and oxygen saturation level after administering rapid tranquilisation.

Senior staff within the hospital monitored and reported regularly on the use of restrictive practices. The hospital held a weekly restrictive practice group which focused on learning, dissemination of information and sharing good practice. All wards were invited to attend, but the focus was on wards where patients were subject to the restrictions of LTS. The restrictive practice group was also available for consultation and advice at other times.

Long term segregation, use of seclusion and the use of mechanical restraint was reviewed monthly in seclusion monitoring and review group (SMARG) meetings across the hospital chaired by the clinical director. The NHS commissioner for the hospital and the CQC had open invitations to these meetings to ensure independent oversight and advocates were also represented. The meeting considered each patient who was subject to LTS, as well as how well reviews were recorded.

Our findings

At our inspection in 2018 we required the provider to ensure that episodes of seclusion were reviewed and recorded in line with the Mental Health Act Code of Practice and that the reasons for LTS were clear in care records. At this inspection we found improvements. When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. All seclusion records reviewed contained hourly written records on the patient. Where patients were subject to LTS, patient records detailed the rationale for using LTS.

Patients on the acute, intensive care and admission wards were subject to night time confinement (NTC). Patients on these wards were confined to their bedrooms between 9.15pm in the evening and 7.30am in the morning. Patients were provided with snacks and drinks in their rooms. Staff ensured that patients received their evening medicines at the correct time. Patients on the assertive rehabilitation wards were not subject to NTC. However, on some occasions NTC had been introduced on these wards because of the effect of staff shortages on staffing levels at night. When this happened, it was reported to the trust board and the clinical director wrote to each patient explaining the reasons why. The trust also notified CQC and the NHS commissioner.

Arrangements were in place for postal monitoring. The hospital had two postal monitors who worked closely with other members of the security and logistics teams within the hospital. Postal monitors demonstrated an in-depth knowledge of the policy and the process of monitoring, inspecting and withholding mail and applied it proportionately and consistently. Patients were informed when mail had been opened or items withheld. Responsible clinicians were referred items for consideration by the postal monitors when appropriate. When patients' mail was withheld, this was regularly reviewed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff were kept up to date with their safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff were confident in identifying and making safeguarding referrals and knew who to inform if they had concerns. We observed a clinical multi-disciplinary team safeguarding discussion which took a holistic approach and included reflection on the patient's views and understanding.

Each ward had an allocated social worker who led on safeguarding referrals and the hospital had a two monthly safeguarding adults' panel which was attended by a representative from the local Bracknell Forest safeguarding team and a representative from NHS England.

Patients said they felt safe on the wards. Staff understood their responsibilities to ensure that patients were protected from bullying and harassment. Patients reported they could raise any concerns at community meetings or confidentially in one-to-one meetings. The hospital took appropriate steps to keep incompatible patients away from each other when needed. Staff gave an example where they safeguarded a patient from another patient who was making threats. Staff facilitated a process of patient separation and then patient mediation which resulted in a positive outcome for both patients.

Our findings

There were strict protocols around visits to patients by children. They had to be assessed as being in the child's best interests. When permission was granted a well-equipped child visitor suite with toys, games and an outside courtyard was available and the route to it prevented the child from accidentally coming into contact with any other patient.

At our last inspection, we recommended that staff across the hospital had a better understanding and awareness of the Freedom to Speak up Guardian. At this inspection we found some improvements. Most staff were aware of the Freedom to Speak Up Guardian. The hospital displayed information about the Freedom to Speak Up services, including the contact details, in nurses' offices. Staff knew how to raise concerns if they felt they could not raise them with their manager or if they had received a response from their manager that did not satisfy them. The hospital Speak Up Champion attended staff forums and listening events. However, on Kempton Ward and within the health care centre we found that not all staff were familiar with the role of the Freedom to Speak Up Guardian or the process for raising concerns.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. Records relating to patients' care and treatment were stored on an electronic patient record. Staff were able to access both paper and electronic records quickly. However, the electronic tablets for recording patients' activities often did not work so staff had to record this information in a paper logbook.

At our last inspection we recommended that key risk information was shared in a consistent way during nurse handovers. At this inspection we found improvements. Staff shared key information to keep patients safe when handing over their care to others. Staff attended a comprehensive handover at the start of each shift. Information discussed in these meetings was recorded. However, staff on Chepstow and Victoria wards reported that on some occasions, due to staff shortages, they were unable to attend the handover. When this happened they received an individual handover later during the shift. This meant that some staff were not able to fully discuss and understand service and team developments and share multi-disciplinary knowledge about patients.

Staff in the physical health centre reported that the main hospital used a different electronic patient records system to that used in the physical health centre. These systems were not connected, and staff described this as frustrating and time consuming.

When patients transferred to a new ward, there were no delays in staff accessing their records, as the electronic records could be accessed by anyone working with the patient.

Records were stored securely. Staff needed to enter a personal identification, a password and use an identity card to access the electronic patient record.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines most of the time. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Our findings

Staff reviewed each patient's medicines regularly and provided advice to patients about their medicines. For example, staff on Kempton Ward noted that a patient had gained weight after they began taking antipsychotic medicine. Staff completed regular physical health checks, referred the patient for imaging scans and created a specific care plan with the patient to address this issue.

Staff completed medicines records accurately and kept them up to date. All records included details of assessments of the patient's capacity to consent to the medicines that were prescribed.

Staff stored and managed all medicines and prescribing documents safely. At our last inspection we required the provider to maintain and monitor medicines and ensure that medicines were stored at the correct temperatures. At this inspection we found improvements, fridge and clinic room temperatures were checked, recorded daily and were always within the required range.

Staff learned from safety alerts and incidents to improve practice. The hospital had employed a medicine management compliance nurse to provide practical expertise when medicine incidents occurred. This, together with a locally based medicine management group, allowed ward staff to reflect on medicine incidents and provide shared learning. Staff spoke positively about the reflective individualised and practical approach to medicine errors.

The hospital ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. From the prescription charts examined there was limited administration of medicines by intramuscular injection (IM) for managing violence and aggression. This is also known as rapid tranquilisation. Between 1 March 2021 and 28 February 2022 there had been 46 episodes of IM rapid tranquilisation involving nine patients. There were 42 episodes involving two patients where Clozapine had been administered naso-gastrically.

However, individual behavioural support plans did not include reference to the medicines prescribed. There were also some instances where multiple medicines were prescribed 'as required' to manage the same health condition. This included both mental health medicines to manage violence and aggression and medicines to manage physical health side effects, such as constipation. There was no indication in the charts or care records as to which medicine or administration route was preferred in which circumstances. National guidance states there should be a strategy in place to guide staff in respect of the use of required medicines when managing violence and aggression.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance, for example, for patients on Clozapine, physical health monitoring included regular pulse, blood pressure, constipation and temperature monitoring. Clozapine care plans included a constipation booklet for patients which had been trialled on Waterloo Ward before being implemented across the hospital.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Our findings

Staff knew what incidents to report and how to report them. They understood their responsibilities to raise concerns and report incidents and near misses and said they felt confident and supported in reporting incidents. Staff recorded incidents on an electronic incident record. They said there were opportunities to discuss incidents and safety concerns raised by staff and patients.

Staff reported serious incidents clearly and in line with trust policy. There had been 45 serious incidents in the hospital in the 12 months before the inspection. Incidents included physical assaults on patients and staff, security incidents and self-harm. When a serious incident had taken place there was evidence of learning. For example, following the death of a patient from airway obstruction caused by clothing on Stratford Ward, the hospital had improved its dynamic risk assessment process and reviewed and enhanced its approach to observations.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong, for example, when there were medicine errors.

Managers debriefed and supported staff after any serious incident. All staff confirmed that they were well supported. Patients were also supported to debrief following an incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff said they were well informed about incidents. Staff received feedback from investigation of incidents, both internal and external to the hospital. Staff and patients met to discuss the feedback and staff looked at improvements to patient care in the clinical multi-disciplinary meetings and reflective practice meetings. Staff received daily communication from the trust by email and quarterly bulletins. This included information about patient safety incidents and any associated learning.

There was evidence that changes had been made as a result of feedback, for example, staff were now required to undertake dysphagia training following a choking incident and additional vital signs monitoring tablets had been made available so that they could be used for patients being nursed in their bedrooms who required eyesight observations. The physical health team had developed a bespoke dysphagia awareness module for all mental health inpatient services.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multi-disciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements and a positive behavioural support plan.

Our findings

There was a holistic approach to assessing, planning and delivering care and treatment to patients. There was a strong focus on recovery.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. This included a mental state examination and an assessment of any risk the patient presented. It was regularly reviewed during their time on the wards. Staff supported patients with their physical health needs and worked collaboratively with specialists when needed. Comprehensive physical assessments were completed and plans for on-going monitoring of health conditions and healthcare investigations were developed. This included regular monitoring of blood samples, heart rate, pulse, urine tests, temperature, weight monitoring and electrocardiograms (ECG).

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were mostly personalised, holistic, recovery-orientated and tailored to meet the needs of each patient. Care plans for people's mental and physical health needs were clear, simple to understand and explained exactly what staff needed to do to help maintain patients' health. For example, one care plan explained a patient's tachycardia condition with information about ongoing monitoring, care and treatment.

Staff worked with patients to regularly review and update care plans when patients' needs changed. The clinical multi-disciplinary team reviewed every patient and regularly updated each patient's care plan with the patient's involvement actively encouraged and supported. Care planning documentation clearly reflected the patient's voice and involvement. All patients had been given the option to be fully involved in discussions and they had contributed as much as they wanted. If patients were unable or unwilling to participate, staff recorded this but continued to encourage participation. Patients told us that they were aware of their care plans and were actively involved in their development and review so that they had the support they needed in the way they wanted.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance from relevant bodies such as the National Institute for Health and Care Excellence (NICE). Staff teams provided a range of individual and group interventions which included medicines, psychological therapy and education, anger management, understanding trauma, positive behaviour support, understanding personality disorder, living safer lives, and relationships and intimacy. For example, the forensic psychologist on Victoria Ward provided cognitive behavioural therapy that focused on reducing violent offending. There was an emphasis on trauma-informed care, with a wide training programme for staff.

Staff on Embankment Ward provided treatment and rehabilitation for patients with mental illness. Patients attended therapeutic groups, facilitated by a psychologist, to help them in understanding their mental illness. The ward followed a model of assertive rehabilitation. This involved providing individual, person-centred care and treatment with the aim of enabling patients to move on to less secure services.

Patients were supported with their care and treatment at a pace that was comfortable to them and met their individual needs. Psychological treatment also included developing positive narratives about the person. This involved identifying

positive aspects of a patient's personality and reinforcing this. For some patients the hospital used the positive behaviour support model to understand patient behaviours which challenged. The foundation of positive behavioural support is to understand why an individual exhibits challenging behaviour and to address the issues that trigger that behaviour.

The trust was due to launch a trust-wide autism strategy in the month following the inspection. In Broadmoor they were establishing a virtual team for autistic (and other neurodivergent patients) and were aiming to have autism-informed staff on every ward. Neurodivergent patients in Broadmoor all have mental illness or personality disorder in addition to their particular neurodiversity.

Patients were now routinely screened for autism on admission with a full neuropsychological assessment if the need for this was indicated. Basic staff training in autism had been available for many years but was due to be ramped up with the implementation of the trust strategy with Oliver McGowan training becoming mandatory for all trust staff within their first year of employment.

Autistic patients reported feeling safe and understood by staff, but we saw that the diagnosis of autism was rarely prominent in relevant patients' records (although staff knew who they were) and risk assessments and care plans seldom took full account of sensory and communication needs. Both managers and clinicians told us there was work to be done in this area and we note that some people with atypical autism may have a different range of needs.

On Embankment Ward, three patients had been diagnosed with autism. These patients had received a specialist assessment from a psychiatrist, a psychologist and a speech and language therapist. For one autistic patient, the ward was using a recognised framework to understand the patient's needs and provide appropriate support.

Staff worked with patients to regularly review and update care plans when patients' needs changed. The multi-disciplinary team reviewed every patient each week and regularly updated each patient's care plan with the patient's involvement actively encouraged and supported.

Staff identified patients' physical health needs and recorded them in their care plans in a simple format that helped to understand and share information. Staff made sure patients had access to physical health care, including specialists as required, for example, staff had been supported by the palliative care team at a local acute hospital to provide end of life care for a patient. The hospital had service level agreements with the local acute hospitals in the area. Due to safety and security concerns all routine appointments were pre-planned with the individual hospitals.

Patients received a high standard of physical health care. The hospital had a modern physical health centre that patients could access. The practice manager, registered general nurses (RGNs) and healthcare facilitators within the team supported staff and patients on the wards. They were supported by other health care professionals including a GP, dentist, dietician, and physiotherapist. Any other services required were provided via service level agreements with local general hospitals, such as general surgery, urology, sonography, cardiology and endocrinology. Work was taking place to develop a formal physical healthcare strategy and to allocate a link RGN to each ward.

The physical health centre had adapted how they had responded to patients during the pandemic. Where possible specialist consultations were undertaken by telephone or video consultation to minimise the risk of infection associated with physical health professionals moving from ward to ward or patients from different wards mixing in the physical health centre. The physical health professionals had therefore worked closely with ward doctors only visiting the wards when it was essential for them to do so.

Our findings

At the time of the inspection, patients, following a risk assessment, were again able to make an appointment to visit the GP at the health centre. All wards reported that the GP service and physical healthcare team were responsive to any referrals that were made.

All patients received an annual health check and various clinics such as DEXA bone scanning, MRI scanning, spirometry and retinopathy were held on site with external specialists and equipment brought in as required. The hospital had adopted a very person-centred approach towards all aspects of patients' physical healthcare. For example, they had explored patients' vaccination fears on a one-to-one basis when necessary.

Staff regularly reviewed patients' physical health using the National Early Warning Score (NEWS2). This system monitors patients' health through regular assessment of a range of physical health indicators. Patients receive a score based on the results of the assessment, with certain scores triggering clinical intervention by staff. The NEWS charts we viewed were completed comprehensively and staff understood how to use them.

Physical health monitoring was in accordance with NICE guidance for patients on antipsychotics and mood stabilisers. When patients required physical investigations, these were carried out with the patient's consent. Where patients had specific conditions, such as sleep apnoea or diabetes, effective plans were in place to manage the complexities of their condition.

Patients had access to gyms within the hospital and were encouraged and supported to attend. Staff worked hard to support unmotivated patients maintain good physical healthcare.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. For example, one patient was restricting their food intake when they were admitted. Staff monitored the patient's daily intake using a food and fluid chart and supported the patient to regain weight.

Wards' multi-disciplinary teams included speech and language therapists and ward teams were able to access the hospital dietician. These specialists worked with staff and patients to fully understand patients' swallowing, nutrition and hydration needs. Care plans showed staff clarified with patients whether they had any dietary requirements related to their health or religion.

Staff helped patients live healthier lives by supporting them to take part in programmes or by giving advice. Approximately 75% of patients were obese and 21% had diabetes, both can be side effects of certain medicines. Staff limited the amount of 'second helpings' of food that patients received at each meal. The dietician supported individual patients with healthy eating and weight reduction plans. Patients could access gym facilities on the ward and the hospital shop offered patients healthier options than it used to.

The physical health leads in the hospital supported staff to improve their skills and knowledge of all the conditions experienced by patients on the wards, for example, staff had been provided with wound care training and plans were in place for staff to undertake further training in diabetes.

A remote system to monitor people's vital signs had been installed in every bedroom and seclusion rooms throughout the hospital. This provided a contact-free, vision-based monitoring and management system. Each ward had an electronic tablet used by staff to monitor vital signs without entering the patient's bedroom or seclusion room. This helped to keep both staff and patients safe when patients were distressed and it meant staff could check on them whilst they slept without disturbing them. Patients were well informed about the system in place and involved in evaluating its use.

Our findings

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, occupational therapists used the activity participation outcome measure (APOM) within their assessments of patients.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers ensured staff carried out a range of audits to check that best practice guidance was being followed. For example, there were audits of care plans, risk assessments, medicines and room searches. Managers discussed the outcome of local audits in team handovers and individually with staff. Managers reviewed the performance of the wards at monthly Clinical Improvement Group meetings. Audit results were used to identify where improvements were needed.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, staff shortages had impacted the frequency of supervision sessions.

The hospital had a full range of specialists to meet the needs of the patients on the ward. This included doctors, registered nurses, clinical and forensic psychologists, psychological wellbeing practitioners, occupational therapists, speech and language therapists, social workers, pharmacists, physical health leads and sports therapists. However, on Kempton Ward, the provision of both psychology and occupational therapy had been inconsistent. The psychologist had been unable to have direct contact with patients for a number of months. At the time of the inspection, the psychologist was on maternity leave. There were plans for the hospital's head of psychology to provide cover. There was no dedicated occupational therapist or activities co-ordinator. The provision of occupational therapy by sessional staff had been disrupted by staff sickness.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Managers gave each new member of staff a full induction to the service before they started work. As well as a generic induction, new staff were also provided with a thorough induction to the ward they were assigned to, which focused on the specific patient group supported. This included training on personal safety, relational security, managing violence and aggression, security procedures, and safe restraint techniques. There was an induction checklist that staff completed which included areas such as incident reporting and environmental safety.

However, on Kempton Ward, the level of experience staff had in working with patients on the personality disorder pathway was mixed. Some staff had worked on the ward for many years and had a lot of experience. New staff could find it difficult to understand and adjust to the communication style of each patient. Two long-standing staff on Kempton Ward said that new staff needed further training and support to understand security, setting boundaries and the importance of ensuring a consistent approach to patients. Not all staff had completed the knowledge and understanding framework for people with personality disorders. This was exacerbated by the frequent use of temporary staff on the ward to cover absence and vacancies.

Managers supported staff through regular, constructive appraisals of their work. Non-medical staff usually received regular, constructive clinical supervision of their work. However, on Victoria and Embankment wards regular supervision did not take place due to staff vacancies, staff sickness and staff being redeployed to other wards. For example, on

Our findings

Victoria Ward during November 2021 only 23% of staff received supervision that month, whilst on Embankment Ward the figure stood at 40%. Staff on Victoria Ward said they often had supervision cancelled as there was not adequate cover for them to step away from the ward. Bank staff did not receive regular, structured supervision but they told us they could always approach colleagues for assistance if they needed to.

Data on supervision was reviewed at monthly clinical improvement meetings. Managers recognised there were gaps in this area and were looking at ways to improve this.

Staff said that when supervision did take place they were able to use the sessions to discuss their wellbeing, case management, personal and professional development and to reflect on and learn from practice. Each of the ward teams had regular reflective practice sessions.

Most wards had regular team meetings. However, staff shortages on Chepstow and Victoria wards had impacted on their ability to facilitate team business meetings. Between July 2021 and March 2022 both wards only had four team business meetings. Staff on both wards said that instead they used handover meetings to communicate information such as service developments, staffing matters, medicines management, security updates, feedback from audits and community meetings.

Staff vacancies and staff being redeployed had a direct impact on staff morale. This was particularly evident on Chepstow Ward. Staff said they often felt burnout and under immense pressure with very little time to focus on service and team development and administration tasks which, in turn, was affecting teamwork. Staff prioritised patient support to minimise any direct impact of staff shortages on patients but this was difficult to sustain. The ward manager was aware staff morale was extremely low. Senior managers were providing enhanced support to the ward and work was taking place to embed the new nurse associate role in a way that complemented the existing registered mental health nurse role to ensure cohesion between the two.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge, including access to specialist training. Staff said there was an extensive range of mandatory and specialist training on offer to develop their professional competence. Training sessions for staff had been significantly impacted by the COVID-19 pandemic, with training becoming online rather than face-to-face. As the pandemic eased training was starting to return to face-to-face sessions with social distancing in place.

Staff were fully supported by the practice development team. The team designed training to meet the specific needs of the patient groups and kept the content under review, for example, suicide and self-harm training had been revised following a review to ensure it better reflected the high secure experience in these areas. The team also provided additional supervision for individual nursing staff, either for personal development or where managers had identified practice issues.

The continuing development of staff skills, competence and knowledge was recognised as an essential component for providing high quality care and treatment. In order to achieve this, the hospital worked closely with the other high secure hospitals, for example, they had worked together to develop a bespoke personal boundaries training course.

The trust had a comprehensive preceptorship programme for newly qualified registered nurses, tailored to develop the skills and knowledge required to work in a high secure forensic environment.

Multi-disciplinary and interagency team work

Our findings

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular clinical multi-disciplinary meetings to discuss patients and improve their care. There was well developed multi-disciplinary within the hospital. Staff worked together to understand and meet the range and complexity of patients' needs. The multi-disciplinary teams completed a formulation meeting with all patients when they arrived on the wards. Each patient's progress and care was subsequently reviewed on a regular basis.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handovers were comprehensive and included effective communication of all important information such as risk and updates related to individual patients to staff coming onto the shift.

Ward teams had effective working relationships with other teams in the hospital. We saw that staff teams worked with other wards to manage patient compatibility and patient safety. Staff reported that referrals to the physical health team were responded to quickly, for example concerns regarding swallowing were referred to the speech and language therapist for assessment.

Ward teams had positive working relationships with external teams and organisations. There were effective working relationships with other health and social care professionals. Staff worked closely with the local safeguarding team and patients' care coordinators in their local areas to facilitate effective discharge planning and follow-up care. We saw examples of good physical healthcare practice where the hospital had worked collaboratively with medical consultants in the local acute hospital. Cooperation between the two hospitals had been exemplary during the COVID-19 pandemic.

The hospital worked with universities to provide student placements. The hospital shared their expertise, knowledge and skills with the other two high secure hospitals in England.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received training on the Mental Health Act and the Mental Health Act Code of Practice. They knew how to access support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Patients had access to information about independent mental health advocacy. Advocacy contact details were clearly displayed on the wards. Patients said staff helped them access independent mental health advocates (IMHAs) and they felt they were able to voice their views and were listened to. Six IMHAs worked across the hospital. The IMHAs were actively involved in meetings, such as seclusion reviews, in order to safeguard the rights of patients. The manager of the advocacy service said that the hospital was supportive of their work.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated it as necessary and recorded it clearly in the patient's notes each time. Records confirmed this took place in line with the Mental Health Act (MHA) Code of Practice.

Our findings

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and/or with the Ministry of Justice. Staff reviewed arrangements for leave at the handover meetings each day.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Copies of patients' detention papers and associated records were stored correctly and staff could access them when needed.

Managers and staff checked the hospital applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

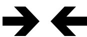
Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of the five principles. The Mental Capacity Act was included in mandatory training.

There was a clear policy on the Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access via the trust intranet and they understood how to obtain further advice.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. When staff assessed patients as not having capacity, the members of the multi-disciplinary team followed trust procedures to make decisions in the best interests of patients and considered the patient's wishes, feelings, culture and history.

At our last inspection we recommended that the provider should ensure that staff record capacity to consent to treatment clearly in patient records. At this inspection we found improvements. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision, including treatment decisions. Pharmacy staff carried out monthly consent to treatment audits across all the wards. Any shortfalls were discussed with individual clinicians.

Is the service caring?

Outstanding 

Our rating of caring stayed the same. We rated it as outstanding.

Kindness, privacy, dignity, respect, compassion and support

Our findings

Staff treated patients with compassion and kindness and valued them as partners. Whilst patients acknowledged that the service was short staffed, they told us that they were very well looked after. There was a strong person-centred culture. Staff were highly motivated and inspired to provide care that promoted and respected patients' privacy and dignity. They understood and valued the individual needs of patients and supported patients to understand, lead and manage their care, treatment or condition.

Patients received high quality care and support from a staff team that worked within a strong person-centred culture. Despite the challenges of the pandemic and the provocations staff had to deal with at times, there was an extraordinary caring ethos throughout the hospital. Staff talked about valuing people, respecting their rights to make decisions, being inclusive and respecting people's diverse needs. All staff spoke about patients with compassion and empathy. Staff explained the importance of providing care and compassion to patients whilst being very clear about professional boundaries. They highlighted the importance of boundaries, consistency and containment within their therapeutic approach.

Patients were very positive about the way staff interacted and supported them. They confirmed staff were respectful, attentive, non-judgmental, caring and tailored care to their individual needs. Patient also reported staff provided practical help, emotional support and advice when they needed it. Patients said staff treated them well, behaved kindly and were responsive to their needs. Their only complaint was that, at times, there were not enough of them.

The staff interactions with patients we observed were professional, sensitive and appropriate at all times. Staff spoke to people in a respectful tone and with warmth, giving them enough time to understand and respond. They asked questions that showed they were taking an interest in what patients were doing. We observed that staff used enabling, positive language in all their interactions and spoke about people in a way which promoted a person-centred culture.

Throughout the COVID-19 pandemic senior managers kept patients updated about the changes taking place in the hospital to keep patients and staff safe. They wrote to each patient regularly and gave them an update about infection control measures, social visits, visiting by professionals, MHA tribunal hearings and access to activities. They explained why the extra COVID-19 restrictions were needed and most patients should be highly commended for the positive way they responded.

Staff understood and respected the individual needs of each patient. Staff said that getting to know patients was a fundamental part of their work. Staff demonstrated an in-depth knowledge and understanding of patients' needs and were able to demonstrate that they had positive relationships with each patient. Staff told us that effective communication was key to ensuring safety and managing risk.

Patients described staff being exemplary in ensuring their safety and providing emotional support. We heard how staff went the extra mile to behave in a way that met the unique individual needs of each patient. For example, a patient described the excellent emotional and physical support Broadmoor staff had provided to them during and following an admission to a local acute hospital. They said, "All the staff are brilliant, supportive and very kind. They have gone beyond what they need to do to help me"

Staff followed policy to keep patient information confidential. Patients felt staff were suitably discreet when communicating.

Involvement in care

Our findings

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the wider hospital facilities as part of the admission process. Patients said they were orientated to the ward when they were admitted.

Staff supported patients to understand and manage their own care, treatment or condition. They adapted their approach to meet each person's needs and worked with patients' individual preferences within the limitations of their conditions of detention.

The hospital was exceptional at helping patients to express their views. Staff involved patients in care planning, risk assessments and risk management. Care plans and risk assessments demonstrated patient input. Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication needs, including through easy read documents. For patients who had difficulty understanding English staff ensured interpreters were booked for care programme approach (CPA) and clinical multi-disciplinary team meetings. Staff made sure patients could access advocacy services. Advocates supported patients at clinical multi-disciplinary team meetings and CPA meetings if the patient requested this.

Patients said they met with their doctors each week and discussed their symptoms and medicines at these meetings. Staff explained that they involved patients as much as possible in decision making. Patients in long term seclusion had the opportunity to be involved in discussions about safe ways to reduce the restrictive interventions they were subject to. The steps involved were explained to them and they could contribute their own ideas.

Care planning documentation clearly reflected the patient's voice and involvement. Patients told us that they were aware of their care plans and were actively involved in their development and review so that they had the support they needed in the way they wanted.

Patients said they found the groups on understanding mental illness to be helpful. One patient explained that they had learned about the phases of schizophrenia, covering the build up to an episode, the main phase of positive symptoms and delusional thoughts, and the final phase of preventing relapse.

Staff involved and supported patients in decisions about the hospital, when appropriate. Patients were respected and valued as individuals and were supported to be partners in their care. Staff supported patients to take an active role in feeding back their views about the service they received. After appropriate training, patient representatives participated in staff recruitment panels for all senior posts, such as the recent consultant psychiatrist, trust medical director, chaplaincy and advocate interviews. Some of the interview questions the patients had developed were shared with us and it was clear a lot of thought and personal experience had gone into them.

There was a strong focus on co-production. The psychological services information booklet for patients, carers and staff had been co-produced. The hospital worked closely with an expert by experience to develop policies and procedures and staff training sessions, as well as co-delivered sessions for patients preparing to move on to medium secure facilities. All three high secure hospitals were participating in a patient survey about night time confinement. A focus group led by Broadmoor had been set up so that patients could co-produce this survey.

Our findings

Patients had been heavily involved in the design of the new hospital and provided feedback on the ongoing development and design of the multi-use games area. The hospital produced a regular newsletter for patients that included information on the development of facilities.

Patient consultations had taken place around the introduction of remote monitoring of vital physical health signs. Whilst this was a clinical matter, the security team were involved in initial patient consultations because they did not want patients to confuse the vital signs monitoring with CCTV and think that the hospital was reneging on its promise not to have CCTV in bedrooms and bathrooms. Patient identifiable data did not leave the hospital site, it remained on internal servers unless specifically required for inquests. Only anonymised patient data was shared with the system provider. We found patients were well-informed about the remote monitoring.

Each ward displayed information about how the ward had responded to patients' suggestions about how to improve the service.

All wards had a patient representative who attended the monthly patient forum. Patients representatives were provided with updates on service development at the forum which they then shared with the patients on each ward. All ward community meetings fed into this forum so issues raised on individual wards received a wider hearing. Senior leaders, such as the trust's chief executive, and advocates attended and were able to respond to patient queries and suggestions promptly, for example, patients had requested shopping tablets for ordering goods. The hospital had run a successful pilot to check safety and security and senior leaders had now agreed that these could be made available to the wards. When patient suggestions were not able to be facilitated leaders and staff were open and transparent about the reasons.

Staff from the advocacy service said that staff listened and responded appropriately to patients in community meetings and the patients' forum. Patients had raised concerns about the lack of soundproofing for telephone rooms and the need for a toilet in the communal area of the hospital that could be used when the canteen was closed. Advocates said that hospital managers were attempting to address these concerns.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families and carers. Family members and carers were involved as much as the individual patient wished them to be. Overall feedback from carers was positive about the care and treatment their family members received, however we did receive some negative feedback from two carers regarding communication. They told us that communication from their allocated social workers was poor and they did not receive regular contact. Other carers told us they had regular contact with their social workers and were kept updated about CPA meetings and Mental Health Tribunals.

The senior leaders held quarterly carers strategy meetings to gain feedback from carers and to check they were being provided with the right support. The hospital had introduced the Triangle of Care national initiative. This is a therapeutic alliance between patients, staff and carers that promotes safety, supports recovery and sustains wellbeing. Each ward had a carer champion identified so that the initiative could be implemented across the hospital. Staff had opportunities to undertake carer awareness training.

Carers could attend the three-monthly carers forum. During the COVID-19 pandemic these meetings were held virtually but face-to-face meetings were starting again. At these meetings carers were provided with updates on the service and it was an opportunity to raise any concerns they had.

Our findings

The hospital had set up an additional Black, Asian and minority ethnic (BAME) carers forum in response to concerns raised by BAME carers as a result of the Black Lives Matter movement. BAME carers wanted to look at their family members' detention through the lens of trauma and discrimination and to be reassured that it was not continuing in the hospital. The trust shared relevant anonymised data with them to provide some assurance and gave a presentation on restrictive interventions. A virtual drop-in had been set up for any carers who want a one-to-one discussion with social workers. The forum had input and support from the BAME transitional lead and the BAME medical lead.

Carers could be provided with a range of financial and practical support to visit their relatives in the hospital when COVID-19 restrictions were not in place. This was arranged through the hospital social workers. The hospital recognised that carers often travelled a long way to visits which could be upsetting so measures were in place to make sure all financial and practical aspects were as easy as possible, such as help with fares, access to food and drink and minibus pick ups from the station one day each month.

The only type of visit that remained restricted was 'food visits'. Prior to the pandemic each patient was entitled to an annual family visit which involved the family bringing in a take-away meal or home cooked food to share with their relative. The hospital intended to resume these soon.

The COVID-19 pandemic had led the hospital to develop appropriate protocols and provide suitable equipment to support patients to make video calls to families and carers who could not visit. This had worked well for some families and its use was continuing alongside the reintroduction of face-to-face visits. All carers we spoke with confirmed that this had allowed them to maintain regular contact and attend care programme approach meetings. It was especially useful for patients who did not have family living within easy reach of the hospital.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned and managed patient discharge well. There was a proactive approach to understanding the needs and preferences of different groups. They liaised well with other services and were appropriately assertive in managing care pathways for patients who were making the transition to or from another inpatient service or to prison.

Bed management

Managers made sure bed occupancy did not go above 93%. At the time of the inspection the occupancy was at 85%. Beds were always available for emergency admissions. Two wards were kept empty in the event they were required for emergency use by the hospital or the other two high secure hospitals. One had been used to nurse COVID-positive patients for a short period. Patients were only granted leave in very limited circumstances, for example, for trial visits to new placements, and there was always a bed available on their allocated ward when they returned.

Our findings

The hospital held a weekly hospital-wide transfers meeting where ward managers and consultants met with the clinical director to discuss each patient who was ready for transfer to another ward or be discharged from the hospital. The hospital had good oversight of any delays in the progress of patients and the potential for any delayed discharges.

The pathway into the service was managed by the Ministry of Justice. The hospital had a weekly admissions panel which considered all new referrals from external referrers. The panel reviewed all assessments undertaken before deciding whether the patient met the criteria for admission. At the time of inspection the patients awaiting admission were due to be accommodated very shortly and the hospital has subsequently confirmed they are now in residence.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. For example, on Kempton Ward, one of the admission wards, most patients had been on the ward between three and eighteen months. Once staff had completed their assessments of a patient, they planned their transfer to a more appropriate facility. Occasionally, assessments took much longer than the planned six months due to relapses in patients' health. Patients were not moved between admission wards unless it was justified on clear clinical or safety reasons or it was in the best interests of the patient.

Discharge and transfers of care

Managers and staff worked to make sure they did not discharge patients before they were ready.

Discharges were well planned and patients were active participants in planning when they wished to be. For example, on Embankment Ward, staff and patients discussed moves to less secure settings collaboratively.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Staff worked with the Ministry of Justice, care managers, care co-ordinators and commissioners to make sure discharges went well. Each ward's multi-disciplinary team reviewed upcoming discharges and transfers of care at regular meetings. Actions and recommendations were discussed and followed through to support discharges. The COVID-19 pandemic caused some delays to patients being discharged but staff were confident this had now been resolved.

Staff supported patients when they were referred or transferred between services. Staff made prompt referrals to other services when these were needed, for example, if a patient required to attend the local acute hospital for inpatient care for a physical condition.

Careful risk assessment and planning took place to ensure appropriate transport and escorts were available to move patients and, when required, support them whilst they were in the care of another service, for example, when attending a court hearing.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. The new hospital had been designed to a high standard. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks unless this presented significant risks to them or others.

Our findings

Each patient had their own ensuite bedroom and had their own secure place for their personal possessions which they could request to be unlocked. All patients and carers we talked with spoke very highly of the facilities available to patients.

The hospital had a full range of rooms and equipment to support treatment and care. Wards had seclusion and de-escalation rooms. Each ward had a gym that patients could use and garden access.

The hospital had an extensive, purpose-built central therapy hub, although risk factors limited some patients to the facilities on their ward. The hub contained the health centre, shop, café, hairdresser, integrated therapy rooms, multi-faith sanctuary, library, IT suite, the recovery college, woodwork and pottery workshops. At the time of inspection access was limited due to COVID-19 risks but precautions were easing and patients were no longer completely restricted to mixing only with patients from their own ward so opportunities for group activities and group therapy were gradually starting to open up. This was evident in respect of the recovery college which operated using a 'bubble' approach during the transition to re-opening, for example, patients on the rehabilitation wards accessed the recovery college together. Soon after the inspection we were informed that all group therapeutic, educational and vocational activities had resumed within the hospital and patients could now attend sessions with patients from all other wards.

Each ward had quiet areas and a room where patients could meet with visitors in private. Face-to-face visits were being gradually introduced in line with COVID-19 restrictions easing. All relatives we spoke with confirmed that they had been able to undertake virtual visits during the height of the pandemic.

Patients could make phone calls to people on their approved list in private where they had been risk assessed to do so. Managers were addressing concerns about soundproofing.

The hospital had an outside space that patients could access as well as garden areas. All access was individually risk assessed. The multi-use games area and horticultural area were still under development.

The hospital offered a variety of good quality food. Patient representatives from each ward attended a monthly retail forum where they were able to feedback on the quality of food provided and make suggestions. They also fed back on food items available in the shop.

Patients' engagement with the wider community

Staff encouraged patients to develop and maintain appropriate relationships with other patients, their families and friends.

Staff made sure patients had access to opportunities for education and work experience and supported patients to achieve their potential. Each ward was required to ensure patients carried out 25 hours of meaningful activity each week. Patient therapeutic activity data for the period 1 September 2021 – 31 March 2022 confirmed patients were offered this. Take up of this offer varied between 39% to 65% for this period. Activities took place either on the ward or in the recovery hub. However, on Victoria Ward staff and patients reported that staff shortages had resulted in a reduction of ward activities. On Kempton Ward, patients said they mainly did activities on the ward, such as playing board games, bingo and completing crosswords. Patients could do cooking once a week. These sessions were supervised by staff.

Our findings

Staff helped patients to stay in contact with families and carers; patients confirmed this. Each ward had a carers' champion and the ward social workers had links with family members. Four of the carers we spoke with told us the ward social workers had provided a useful point of contact but two had a negative view of this. All carers we spoke with confirmed the hospital had written to them throughout the pandemic, giving updates on the daily routine, virtual visiting, safeguards and the restrictions in place.

Meeting the needs of all people who use the service

People's individual needs and preferences were central to the delivery of tailored services. The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The hospital could support and make adjustments for disabled people and those with communication needs or other specific needs. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met patients' individual needs, which was accessible and promoted equality.

Consideration had been given to establishing a ward specifically for autistic patients, but there were incompatibilities between some of the current patients so this had been discounted and an autism pathway was now the preferred model. The new trust-wide autism strategy should support improvements to autistic patients' experience.

The hospital had an equality and diversity strategy group that met quarterly and an equality, diversity and inclusion (EDI) lead who focused on reducing disparities in care experienced by minority ethnic patients. This role also focused on addressing the biases, discrimination and racism minority ethnic patients experienced. For example, we saw evidence that the hospital had taken steps to protect staff and patients from patients' extreme views, including prior to admission. They adopted a firm consistent response when those views were expressed and also worked with the patients therapeutically.

All wards were accessible for patients with mobility issues. One patient bedroom on each ward was able to accommodate a height adjustable nursing bed and mobility aids when required. This meant patients did not have to move wards when their health deteriorated unless there were other good reasons for doing so.

Staff made sure patients could access information on treatment, their rights and how to complain. The hospital had information leaflets available in languages spoken by the patients and local community. For example, staff translated a complaints outcome letter into the language spoken by the patient who submitted the complaint.

Managers made sure staff and patients could get help from interpreters or signers when needed. Interpreters were booked as necessary, for example a patient on Embankment Ward was not fluent in English. Staff arranged for an interpreter to visit the ward each week to support this patient when they met their doctor at clinical team meetings. Staff also arranged for patients from a similar part of the world to meet up and support each other.

The hospital provided a variety of healthy food to meet the dietary and cultural needs of all patients. One ward held different themed food nights where staff and patients could learn more about food from different cultures. Some patients felt the quality of the hospital food could be improved. Patients provided feedback on menus and food items in the shop at the retail forum.

Patients had access to spiritual, religious and cultural support. The hospital had changed the times at which a patient could have their meals and medication during Ramadan. Celebrations were held on site for significant religious events,

such as Christmas or Eid. There was a chaplaincy service based at the hospital. The multi-faith sanctuary had been thoughtfully designed to support all patients. Plans were in place for study groups to take place in the foyer with the easing of COVID-19 restrictions. An ablutions room for Muslim staff and patients was available, as well as a range of religious texts for all faiths.

If patient risks could be managed, those who wished could access a number of regular religious services. These included Roman Catholic mass, an ecumenical Christian service and Muslim prayers. Most services were held virtually at the peak of COVID-19 but face-to-face services were made available as soon as the restrictions eased. Religious, spiritual and cultural group activities were the first to resume. In addition, the chaplaincy provided generic support for patients from minority religions and patients who had a broader interest in spirituality. The chaplaincy service also attended patient and carer forums to provide additional support.

We heard of numerous examples where patients had been supported by the multi-disciplinary team and the chaplains with end of life care, bereavement and attending funerals. The support provided was person-centred and adapted for each patient's particular circumstances and needs. The hospital and the Ministry of Justice worked together to find an appropriate way to support a patient to receive dignified and compassionate end of life care with help from community services.

Stratford Ward was using cultural formulation and had gathered patient, carer and staff narratives to develop cultural care plans in order to respond more effectively to all patients' experiences. A formulation is a joint effort between patients, carers and clinicians to summarise the patient's difficulties, to explain why they may be happening and to make sense of them.

There was a plan to roll cultural care plans out further. This initiative was being led by the hospital's lead for Black, Asian and minority ethnic patients.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients knew how to complain or raise concerns. Patients said they were aware of how to make complaints and understood the process. As well as the formal complaints process and raising concerns directly with staff and managers, patients had the opportunity to raise issues in community meetings and with the patient representatives if they wished.

The hospital clearly displayed information about how to raise a concern in patient areas. Staff also explained how to raise concerns and complaints to patients when required.

Staff understood the policy on complaints and knew how to handle them. The trust had a comprehensive complaints policy that all staff could access through the intranet. Some patients made numerous complaints, often as a result of their mental health condition, but they were still taken seriously. In such cases the trust did not always respond to each one individually, instead the clinical team held fortnightly meetings with the patient to go through them all. This was covered in the complaints policy but when it was applied to a patient it was reviewed every three months to ensure it was still the most appropriate response to their situation.

Our findings

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers identified any themes. The hospital produced an annual complaints report which was presented to the senior management team. The report included feedback on the number of complaints, investigation outcomes, learning from complaints and any actions taken. The complaints team also produced a monthly patient safety report which included complaints information which was shared with the trust-wide governance team.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff felt confident that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without retribution. The good lines of sight and CCTV coverage of communal areas within the new hospital meant that opportunities for abuse or harassment to go unwitnessed had significantly reduced.

Managers shared feedback from complaints with staff and learning was used to improve the service. This was discussed in handover meetings, clinical improvement groups and in clinical multi-disciplinary meetings. Learning from complaints formed part of the quarterly patient safety and governance newsletter which was emailed to all staff and available on the trust intranet.

The hospital used compliments to learn, celebrate success and improve the quality of care. The hospital had recorded 50 compliments in the last 12 months.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The leadership team within the hospital promoted and prioritised safe, high quality, compassionate care. They actively modelled the high standards expected within the hospital. Staff spoke highly of the senior leaders and managers in the service. Leaders in the service could describe how staff were working to provide safe, high quality care and were striving for excellence. They were aware of the key risks, priorities and challenges the hospital faced and were open in sharing them. Ward managers were visible to staff and patients. Managers spent time on the wards and knew their staff and patients very well. Staff said they felt supported by their managers and confirmed the clinical director and other senior leaders regularly visited the wards.

Leadership development opportunities were available, including opportunities for staff who were not yet in management or leadership roles. Nursing staff said they felt very supported in their professional development and were able to develop their skills so they could take on more senior roles.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Our findings

Staff understood and demonstrated the provider's vision and values. Throughout our inspection we saw how both staff and leaders applied the trust values of 'togetherness', 'caring', 'excellence' and 'responsibility' in their day to day work. These values were demonstrated in staff members' respectful and inclusive interactions and behaviours with patients, especially when patients were extremely distressed and challenging as a result.

The full implementation of the new clinical strategy had been significantly delayed because of the COVID-19 pandemic. Staff and patients had contributed to discussions about the strategy through patient and staff forums.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

The hospital had a caring, positive, open and inclusive culture which centred on improving the quality of care patients received through hope, compassion, empowerment, partnership and involvement. All members of the staff team were committed to ensuring that patients and their carers were at the heart of the service. Staff were proud of the hospital as a place to work and spoke highly of the of the person-centred culture.

The benefits of this positive culture were strikingly demonstrated by the successful transfer of patients from the old hospital to the new hospital. All bar one of the patients were escorted on foot to the new hospital and there were no incidents.

Staff felt positive about their work and what they were managing to achieve within the staffing constraints. All staff showed passion and commitment to providing high quality patient care. Staff described staff teams that worked well together and supported each other. Staff told us there was an open culture where everyone was encouraged to share their views. However, staff morale had been affected in some teams by staffing shortages, redirection to other wards and the effects of the pandemic. Senior managers were aware of this and were supporting staff teams to improve team cohesion, well-being and resilience. Affected staff took care not to burden patients with their low morale.

Staff told us that they received appropriate support from their line managers and colleagues and they valued the expertise and dedication of staff across the hospital. Staff felt able to raise concerns without fear of retribution. Staff said they would feel comfortable to raise any concerns with their colleagues and managers. They felt their views and opinions would be listened to. The hospital displayed information about the Freedom to Speak Up Guardian, including the contact details. However, not all staff were familiar with the role of the Freedom to Speak Up Guardian or the process for raising concerns.

Teams worked well together and where there were difficulties managers dealt with them appropriately. Staff gave examples of how they had pulled together during COVID-19 and became more effective as a team. Staff told us they valued each other.

Staff felt respected, supported and valued. The trust was determined to do all it could to address inequalities and this was reflected throughout the hospital. Biases and microagressions were challenged and this was appreciated by staff and patients but work in this area was ongoing. The trust was fully alert to the impact of inequalities and discrimination on many patients' life experience which may have contributed to their detention under the Mental Health Act and contact with the criminal justice system. Part of the hospital's response to this was the development of cultural, spiritual and religious care plans. These had received positive feedback from staff and patients.

Our findings

Staff confirmed the hospital promoted equality and diversity in its work with patients and in terms of the workforce. The hospital embraced cultural differences and truly valued the knowledge and understanding a diverse workforce brought to the service. Staff said there was a clearly embedded system for promoting equality and diversity in their daily work and they were provided with opportunities for development and career progression.

The hospital had an equality, diversity and inclusion (EDI) transition lead who was focused on reducing disparities in the experience of care and treatment by minority ethnic patients. Their role also included creating opportunities for Black, Asian and minority ethnic (BAME) staff to develop their managerial and leadership abilities. The individual in this role was a senior clinical manager who reported that the trust had provided the autonomy and resources to develop an inclusive and diverse work environment that supported minority ethnic staff and patients.

In order to support equality, inclusion and diversity the trust ensured a diversity champion sat on all interview panels. A range of equality, inclusion and diversity mandatory training had been developed. It included training on cultural awareness, leading with compassion and being an active bystander. The EID transition lead felt that the range of training helped staff establish positive behaviours they then role modelled to their teams. The trust had also developed white allies training and had identified the first cohort of senior managers to attend. They were also in the process of developing cultural competence training for staff. The hospital had several EDI and LGBT+ allies in place to support both staff and patients.

In addition, staff were offered training and support to understand the biases, assumptions and discrimination that occur in health and justice settings. The hospital encouraged clinical and support teams to engage in conversations about race and culture issues and to consider their impact on the delivery of the service in areas such as restrictive practices, medicines and seclusion. The hospital had evaluated the application of restrictive practices and seclusion in respect of BAME patients, as well as the use of medicines, during 2021 and their findings indicated these patient groups were not disproportionately represented in these areas.

During the COVID-19 pandemic the hospital recognised the disproportionate impact this had on Black, Asian and minority ethnic staff and patients and put support structures in place. Senior leaders supported teams within the service and maintained a physical presence and frequent communication throughout the pandemic. Staff risk assessments were carried out and vulnerable staff were supported to work from home. Managers kept in touch with staff who were shielding or working from home. Staff reported that they had been offered accommodation if they did not want to travel to and from home, free hospital meals when working additional hours and taxis so that they did not have to use public transport.

Managers considered the wellbeing of staff. Staff had access to support for their own physical and emotional health needs. The trust had an effective staff wellbeing strategy. Over 30 staff had been trained as wellbeing champions and 14 staff trained as mental health first aiders within the hospital. Senior managers did not underestimate the toll that the pandemic had taken on staff and the effects of 'compassion fatigue'. Updates on wellbeing were provided through a quarterly newsletter and comprehensive information on the trust intranet. Supervision and appraisal meetings included wellbeing conversations. A new staff support and liaison practitioner role had been created for the hospital. The role will be an integral part of the high secure service clinical incident strategy and will provide support to staff who have experienced violence, aggression or abuse at work.

The trust provided staff with access to counselling, desktop yoga, massage, occupational health services, financial advice, rewards and staff benefits. Where staff had carer responsibilities, they completed a carer passport which detailed the support they required to achieve a work-life balance. All the staff we spoke with demonstrated a high level of resilience despite the challenges of the previous two years.

Our findings

Managers dealt with poor staff performance appropriately when needed. Performance issues were initially addressed during to one-to-one supervision sessions and goals and objectives were introduced for staff whose performance needed to be improved. The practice development team could also offer support for this.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. The provider had addressed most concerns raised at our last inspection. However, having decreased considerably when the new hospital initially opened, the number of staff vacancies had increased overall since our last inspection. Senior managers were aware that staff shortages and the coronavirus pandemic were having an impact on morale, supervision, attendance at team meetings and the availability of therapeutic activities for patients. The management team knew where the 'hot spots' were and provided enhanced support and monitoring of those teams and much effort was being put into improving recruitment and retention in the face of national staff shortages.

The hospital systematically monitored standards of care to continually improve outcomes for patients. All wards carried out a programme of clinical audits to monitor areas such as care and treatment records, medicines, consent, therapeutic engagement and supportive observations (TESO), patient activities, staffing levels, medicines management, staff supervision and appraisals. The audits ensured that quality was reviewed frequently and systems were in place to identify and address any gaps in the delivery of safe high quality care.

The hospital was developing a physical health strategy to support clinicians in improving physical health outcomes for patients and was about to implement the trust-wide autism strategy.

The hospital held a range of meetings at which staff shared issues and concerns, identified actions and monitored progress. All wards had a framework of community meetings with patients, handover meetings, ward rounds, multi-disciplinary meetings and clinical improvement group meetings. Agendas for meetings were standardised across the hospital and covered learning from incidents, complaints and safeguarding cases.

Managers had access to information on how their team performed and knew their team's strengths, as well as the areas where improvements were needed. Teams were actively working to make those improvements and mitigate risks. There were effective forums in place to discuss and improve care, topics covered included complex cases, risk, referrals, discharges and clinical audits findings.

Staff were clear about their roles and responsibilities and they understood the management structure within the hospital.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. Ward managers and clinical leads were aware of the key risk areas on their wards. Wards had a risk register. However, the risk register on Kempton Ward did not reflect all the concerns raised by staff. The risk register included risks around the poor design of windows, overspend, violence from patients and legionella. Whilst these were legitimate risks, the shortage of staff and high vacancy rate was a greater concern. Registered nurse vacancies were on the overall hospital risk register.

Our findings

Each day ward teams reviewed the risks for their wards and patients. The ward teams knew the patients very well and were able to defuse most situations effectively before they escalated. They were well informed about incidents and used the clinical multi-disciplinary team meetings and handover meetings to discuss any changes to patients' care or new insights into their presentation. There were systems in place to monitor risks associated with patients' physical health and any issues were quickly picked up and addressed.

The hospital produced a monthly clinical performance summary. This enabled wards to review their clinical performance data and compare it to other wards within the hospital. The performance indicators included the percentage of patients who had an initial assessment within 72 hours of admission, the percentage of patients who had had a comprehensive risk assessment within three months, supervision rates for staff and the levels of patient activity.

The hospital had contingency plans for emergencies which wards reviewed. Throughout the pandemic senior leaders attended the trust-wide Gold and Silver command meetings.

Wards carried out regular health and safety monitoring and each patient had a personal emergency evacuation plan. Plans detailed individual patient risk that staff needed to be aware of in the event of an emergency.

Sickness and absence rates were monitored and managers offered support to staff who returned to work after a period of absence. Staff had not raised any concerns about bullying or harassment in the hospital.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had access to equipment and information technology to do their work. Staff reported that whist there had been an improvement in this area there were regular delays as any new IT equipment and software had to be made secure for the hospital.

Managers had access to the information on their team's performance collected through clinical audits. This included information on completion of patient care plans, risk assessments, medicines and room searches. Ward managers could access dashboards which had accurate up-to-date information on staffing, safeguarding, care planning and incidents.

Engagement

Staff received regular information about the trust and the hospital through the trust intranet, newsletters, bulletins and emails.

Co-production involving patients was deeply embedded in the culture of the hospital and patients were involved in decisions and consulted about proposed changes to the service. When changes had to be imposed, as a result of COVID-19 or due to staff shortages, this was fully explained to patients in ways they could understand. For example, when night time confinement had to be re-introduced on the rehabilitation wards in February 2022 for a short period, the reason was made clear so most patients were quite accepting of the situation. Monthly patient and quarterly carer forums took place and had continued throughout the pandemic, although not always in a face-to-face format.

Our findings

The hospital worked closely with the other two high secure hospitals to develop clinical practice and share expertise, for example, all three hospitals, as part of their reducing restrictive practice strategies, had carried out a blanket restrictions survey seeking patient views and reviewing current practice in December 2021.

The trust engaged with the National Oversight Group (NOG) and the Clinical Secure Practice Forum for high secure services. The groups brought together key partners to provide oversight of high secure services on behalf of the Secretary of State. At the Clinical Secure Practice Forum, the hospital worked collaboratively on key areas of clinical practice to enhance safety, security and the reduction of restrictive practices.

Learning, continuous improvement and innovation

Managers had adapted the treatment model to ensure that there was continuity of treatment during the pandemic by cohorting groups of patients and transferring therapeutic and other activities to individual wards.

There was a culture of continuous improvement within the hospital. The hospital aimed to deliver high quality evidence-based patient care underpinned by the latest research. Managers at all levels worked closely with staff to enhance learning and drive continual improvement. For example, following a self-inflicted death on Stratford Ward, the hospital had improved its dynamic risk assessment process and reviewed and enhanced its approach to observations.

The hospital had a research hub, research strategy and a dedicated research lead. The team was engaged in a range of research and had close links with a number of high profile universities working in related fields. There were several active research projects in which the hospital was involved. One was evaluating the impact of the new hospital on patient care, including clinical outcomes, physical health, security and staff engagement in conjunction with a qualitative study on patient experiences of the new hospital. Other research projects covered psychopharmacology, the applications of virtual reality for forensic services, evaluation of remote vital signs monitoring, outcome measures in high secure services, violence and self-harm, trauma and adverse childhood experiences, autism, culture and diversity. Staff had contributed to a number of published articles in various forensic mental health journals.

The hospital had recently established the High Secure Hospitals Research Network (HSHRN) which was managed by the research hub and in which Rampton, Ashworth and Carstairs hospitals also participate. Regular multi-disciplinary research meetings took place and whilst they were high secure hospitals focused they were made available to other stakeholders, such as prison services to build an inclusive research culture.

Since our last inspection, staff had become increasingly aware of the impact of autism on patients' recovery journeys and some of these impacts had been confirmed by research that had been conducted by clinicians within the hospital. Autism research was well-established and senior clinicians who would be developing the autism pathway were involved in that research and collaborating with external experts in order to improve practice.

The hospital was also working with academics to develop cultural formulation to aid consultants, doctors and other clinicians in supporting and treating patients. The plan was to present this work, once complete, for peer review. If it is commended it will then feed into medical diagnoses.

The trust had established patient and public involvement (PPI) groups where patients were able to contribute directly to the development of research projects in the hospital, for example, patients were involved in the evaluation of the remote vital signs monitoring system, research into the effects of long-term hospitalisation and research into chronic pain.

Our findings

The hospital was about to adopt new digital technology to support patient physical health observations. A NEWS2 scoring calculator had been designed to instantly update the patient electronic record with vital signs scores and to send an alert directly to the ward doctor if readings are out of range or there are other signs that a patient's condition is deteriorating. The National Early Warning Score (NEWS2) is a system for scoring patients' physiological measurements. Plans were in place to roll out this technology throughout the hospital in April 2022.

Clinical staff had access to a comprehensive academic teaching programme. Various seminars were held monthly, topics included assessments in forensic psychiatry, complex case discussions and legal matters in high secure services.

Our findings

Outstanding practice

We found the following outstanding practice:

The new hospital, co-designed with patients, had vastly improved the quality of the environment, promoted patient's recovery and ensured patients had direct access to fresh air. Wards were spacious, well-lit, well-furnished and patients could, within certain parameters, control the temperature and lights in their individual bedrooms. All patients, carers and staff were overwhelmingly positive about the hospital environment. This will be further enhanced by the multi-use games area and horticultural centre when they are finished.

Staff had enhanced skills in managing relational security, evidenced by the successful transfer of all the patients to the new hospital which occurred without incident. All logistical challenges arising from the transfer of staff, patients, equipment and personal possessions to the new hospital had been very well planned and executed safely.

The reducing restrictive practice team had enhanced the quality of life for patients who were subject to long term segregation (LTS) and short term seclusion. We saw that the team worked collaboratively with patients and ward staff to deliver a person-centred service which considered people's individual needs and preferences and had achieved considerable success with patients who had previously been unable to leave LTS due to the risks they posed to themselves or others. We saw positive change for, and increased engagement with, people who had been in LTS at the time of our last inspection. The team delivered safe and therapeutic interventions which allowed patients to leave their bedroom to access activities, therapies, meals and fresh air safely. As a result, mechanical restraint (waist restraint belt) and physical holds were no longer needed for several patients. The use of rapid tranquilisation was low, and the 'Safewards' model had led to a safer, calmer, working and therapeutic environment for both staff and patients. Patients spoke very highly of the impact of the team and long-standing staff told us that the number of patients in LTS was at the lowest level they could remember.

There was a strong, visible, person-centred culture. Staff treated patients with compassion and kindness. Patients felt cared for and that they really mattered. Feedback from patients was consistently positive about the way staff treated them. Staff from across the hospital worked sensitively and creatively to support patients at times of bereavement or loss.

The hospital was taking practical steps to reduce inequalities and eliminate discrimination. A dedicated equality, diversity and inclusion transition lead had been appointed. The hospital had supported the setting up of a Black, Asian and minority ethnic (BAME) carers forum in response to questions raised as a result of the Black Lives Matter movement. A BAME leadership programme was well-established. The hospital encouraged clinical and support teams to engage in conversations about race and cultural issues and to monitor and review their work in the light of the knowledge gained from this, as well as from an extensive range of training on the topic. Work was taking place on using cultural formulation to support care and treatment. Patients with physical disabilities or ill-health could usually remain on their familiar ward as each had a bedroom that could be adapted for their specific needs.

Areas for improvement

Action the trust MUST take to improve:

Our findings

The trust must ensure that sufficient mitigations are in place to address the risks presented by all potential ligature anchor points. Regulation 12(1)(2)(a)

The trust must continue to ensure that there are sufficient staff deployed to the wards. Staffing levels and skills must be continually reviewed to ensure that patients receive safe care Regulation 18(1)

Action the trust SHOULD take to improve:

The trust should provide staff with explicit guidance for the use of 'when required' medicines, especially when more than one is prescribed for a condition.

The trust should ensure that all staff have had training in meeting the specific needs of the patient group they are assigned to.

The trust should ensure that all staff have regular supervision at the frequency described in its policy.

The trust should ensure that regular team meetings take place on all wards.

The trust should ensure that all staff are aware of the role of the Freedom to Speak Up Guardian.

The trust should ensure that ward risk registers reflect all the current risks on the ward.

Our inspection team

The team that inspected the hospital comprised a CQC lead inspector, five inspectors, one pharmacist inspector, two inspection managers, three Mental Health Act reviewers and three specialist professional advisors who had experience of working in forensic 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	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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