

Requires improvement 

West London Mental Health NHS Trust

Other specialist services

Quality Report

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Date of inspection visit: 8 - 11 November and 17 and 18 November 2016
Date of publication: 09/02/2017

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RKL51	Broadmoor Hospital	Ascot ward Cranfield ward Harrogate ward Leeds ward Sheffield ward Newmarket ward Sandhurst ward Sandown ward Woburn ward Canterbury ward Dover ward Folkestone ward Kempton ward Chepstow ward Epsom ward	RG45 7EG

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

Summary of findings

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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

Summary of findings

Ratings

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

Overall rating for the service

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Inadequate



Are services well-led?

Requires improvement



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

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

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

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
The five questions we ask about the service and what we found	6
Information about the service	10
Our inspection team	10
Why we carried out this inspection	10
How we carried out this inspection	11
What people who use the provider's services say	11
Good practice	12
Areas for improvement	12

Detailed findings from this inspection

Locations inspected	13
Mental Health Act responsibilities	13
Mental Capacity Act and Deprivation of Liberty Safeguards	13
Findings by our five questions	15
Action we have told the provider to take	32

Summary of findings

Overall summary

We rated other specialist services (high secure wards) as **requires improvement** because:

- In our inspection in June 2015, we found that staffing levels were not adequate as they had not ensured that patients had access to therapeutic and recreational activities that they were scheduled to have access to. This continued to be the case. In November 2016 we served the trust with a warning notice.
- There were some records relating to seclusion and long term segregation which did not evidence that the required monitoring had taken place.
- The trust had not consistently arranged external three month reviews of patients who were in long term segregation for more than three months.
- There were some assessments of capacity which had not been completed in a way to determine that a comprehensive discussion had taken place with patients about the impact of their treatment. This meant that there was a risk that capacity assessments were not sufficiently robust to either prove capacity or the lack of it.
- Staff throughout the hospital reported to us that their morale had not improved significantly over the year since the last inspection in June 2015.

However:

- Staff had a good understanding of their patients and patients reported that staff treated them with kindness and respect.
- There were good systems in place to embed the patient voice including the patient forum, the development of the peer support role on Leeds ward and a commitment to coproduction.
- The service had put significant effort into reducing long term segregation and there had been a reduction in the use of long term segregation across the hospital. This was particularly notable on Epsom ward but other projects had been undertaken on Cranfield, Ascot and Woburn wards.
- Staff were aware of the incident reporting system and were able to give us examples of learning from incidents.
- There was a strong medicines management process in place and pharmacists were available to provide both staff and patients with advice and guidance where necessary.

Summary of findings

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

Are services safe?

We rated safe as **requires improvement** because:

- At our inspection in June 2015, there were not sufficient staff to meet the needs of patients as the lack of staff had impacted on their ability to access therapeutic and recreational activities. In this inspection, despite significant recruitment attempts, we found that vacancies in the hospital had not improved. There were still significant challenges with the recruitment and retention of registered nursing staff.
- We found that some records relating to seclusion and long term segregation were not complete which meant that we could not be assured that all the required monitoring was being carried out.

However:

- The trust had put significant work into specific quality improvement projects to minimise restrictive practices, specifically the use of long term segregation on Epsom and Cranfield wards and there were also projects on Ascot and Woburn wards which had reduced the use of long term segregation.
- Risk assessments were robust and thorough and were regularly updated to reflect current risk. Staff had a good understanding of risk on their ward and with patients that they were familiar with.
- Staff across the hospital had a good understanding of safeguarding and liaised with the local authority and other partner agencies to ensure that issues which arose were investigated as necessary.
- There was a robust medicines management system in place. Pharmacists were present on the wards and ward staff as well as patients told us that they had access to support from pharmacists.
- Staff were aware of how to report incidents and were able to give us examples of where there had been learning from incidents across the hospital.

Requires improvement



Are services effective?

We rated effective as **requires improvement** because:

Requires improvement



Summary of findings

- Staff did not ensure that a doctor from another hospital reviewed all patients who had been subject to long term segregation for over three months as required by the Mental Health Act code of practice.
- Staff in the hospital were not thoroughly recording assessments of capacity relating to capacity to consent to treatment in a way that demonstrated that comprehensive conversations had taken place with each patient, with the exception of Kempton ward where there were very clear assessments of capacity recorded.

However:

- Patients had comprehensive and holistic care plans which reflected their needs and which were reviewed and updated regularly.
- There were strong multi-disciplinary teams on each ward and patients had access to a wide range of support including social work, psychology and occupational therapy.
- Staff told us that they had good opportunities for professional development and gave us examples of additional training which they had undertaken.
- Staff had a good understanding of the Mental Capacity Act.
- While there continued to be vacancies for administrative staff, the vacant posts had been recruited to and those appointed were due to start in early 2016 which would relieve some of the administrative burden on nursing staff on the wards.

Are services caring?

We rated caring as **good** because

- Patients told us that staff treated them with respect and kindness. We observed that staff were thoughtful in their approach towards patients and had a good understanding of individual patient needs.
- Strong patient involvement was embedded in the running of the hospital with a well-established patient forum, patient ward representatives, community meetings on each ward and involvement from patients in other forums such as clinical improvement groups, catering forum, patient and carer experience group and the equality and diversity network.
- On Leeds ward, there was a patient who had been appointed as peer representative and accessed additional support to undertake this role which provided support to patients who were new to the ward.

Good



Summary of findings

However:

- Work had been started to audit carers' needs regarding their caring role but work in this area, including offering carers' assessments where necessary and involving carers widely in feedback was not yet fully embedded.

Are services responsive to people's needs?

We rated responsive as **inadequate** because:

- On occasions some patients were still not having access to therapeutic activities in line with their care plans. Also patients who were subject to conditions of night time confinement were not consistently offered a minimum of 25 hours of meaningful activities and patients who were in long term segregation had association time limited due to the lack of availability of staff.
- The trust PALS service was based in Ealing and some of the information was not specific to patients at Broadmoor who wished to make complaints.

However:

- The hospital always retained capacity to ensure that patients were able to be admitted in an emergency.
- While ward environments varied significantly between the wards, all patients had access to lockable space and rooms for meetings, therapy and visits. There was also a dedicated visitor's area including a children's visiting area.
- The service provided a range of functions and celebrations to reflect the religious and cultural mix of patients in the hospital, including events to mark Christmas, Eid, Black History Month, St George's Day and St Patrick's Day.
- Patients were aware of how to make complaints.

Inadequate



Are services well-led?

We rated well-led as **requires improvement** because

- During the inspection in June 2015, staff reported to us that they did not feel engaged with the trust and improvements in communication to the staff team were needed. During this inspection we saw that some work had been done in this area with the staff forum which had been running for over a year and feedback from senior managers through ward 'back to the floor' exercises. Having spoken to staff, we found that there were still improvements to be made in this area.

Requires improvement



Summary of findings

- Staff reported that morale was low but we had more positive feedback about the input from the trust, including positive feedback about the new clinical director and their impact and the new trust chief executive.

However:

- Staff on the wards had access to information about their team performance including complaints, sickness levels, vacancies, supervision and compliance with mandatory training.
- Clinical staff had opportunities to undertake audits which were planned on an annual basis and the outcomes of audits fed into the quality improvement across the hospital and a better understanding of key concerns.
- The trust had started to work on quality improvement and had run some projects which had had some successful outcomes like the Epsom ward reduction in long term segregation.
- The trust had developed a manual for training in the prevention and management of violence and aggression which had been endorsed by NICE.
- We had mixed feedback regarding sharing learning between Broadmoor Hospital and the West London Forensic Service. There were meetings at clinical director level so that higher level feedback could be shared and some conferences focussed on issues such as learning lessons were held across the trust.

Summary of findings

Information about the service

Broadmoor Hospital is a high secure hospital for men. On the day of our inspection there were 198 inpatients. The services are configured into two directorates, mental illness and personality disorder.

Mental Illness services

Ascot ward – high dependency – 12 beds

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

Harrogate ward – assertive rehabilitation - 20 beds with one bed for physical healthcare needs

Leeds ward – assertive rehabilitation – 20 beds

Newmarket ward – admission – 12 beds

Sandhurst ward – assertive rehabilitation – 12 beds

Sandown ward – admission – 12 beds

Sheffield ward – assertive rehabilitation – 20 beds

Woburn ward – high dependency – 15 beds

Personality Disorder services

Canterbury ward – assertive rehabilitation – 14 beds

Dover ward - assertive rehabilitation – 14 beds

Folkestone ward – assertive rehabilitation 14 beds

Epsom ward – high dependency – 12 beds

Kempton ward – admission – 12 beds

Chepstow ward – medium dependency – 12 beds

Our inspection team

Our inspection team which visited Broadmoor Hospital consisted of two CQC inspectors, one CQC assistant inspector, one CQC pharmacy specialist, two Mental Health Act reviewers, the principal second opinion

appointed doctor, the CQC Mental Health Act complaints manager, two consultant forensic psychiatrists, one mental health nurse with experience working in forensic services and one expert by experience.

Why we carried out this inspection

When we last inspected this service in June 2015, we rated forensic inpatient wards as **inadequate** overall. This rating included the West London forensic services as well as the high secure services. At this inspection we have separated the reports.

At the last inspection we rated this core service as inadequate for safe, good for effective, good for caring, good for responsive and inadequate for well-led.

Following the June 2015 inspection, we told the trust it must make the following actions to improve high secure services:

- The trust must ensure that staffing levels are sufficient to not only ensure safety of staff and

patients but also to promote the quality of life of patients in terms of ensuring they can access therapeutic and leisure activities as agreed in their care plan.

- The trust must ensure that staff are engaged in the running of the hospital and that communication with staff at all levels and in all areas of the hospital improves. This is to ensure that better care can be provided to patients and that staff feel that the environment and culture of the hospital and trust is one that values their input and engagement.

These related to the following regulations under the Health and Social Care Act (Regulated

Activities) Regulations 2014:

Regulation 17 Good governance

Summary of findings

Regulation 18 Staffing

At this inspection we followed up the actions we asked the trust to make at the last inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from carers of patients in advance of the inspection.

During the inspection visit, the inspection team:

- visited all fifteen of the wards and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 71 patients who were using the service
- spoke with the managers or acting managers for 13 of the wards with the exception of two ward where we spoke with the nurse in charge on the wards(Sandown and Dover)

- spoke with 115 other staff members; including doctors, nurses, social workers, health care facilitators, activity coordinators, security staff, occupational therapists, advocates, psychologists and administrative staff.
- held ten focus groups across a range of different professional groups and including one focus group specifically for black and minority ethnic staff.85 members of staff across the hospital attended these focus groups.
- interviewed the Deputy Director of High Secure Services, the Clinical Director of Broadmoor Hospital, and the Deputy Director of Nursing for Broadmoor Hospital and met with the senior management team at the hospital.
- attended and observed three hand-over meetings and three multi-disciplinary meetings.
- attended the hospital-wide monthly patient's forum and three ward based community meetings.
- checked medication charts of all 198 patients in the hospital including documentation related to consent to treatment.
- checked 31 patient records including risk assessments, care plans and daily records.
- checked a sample of specific incident reports, seclusion, restraint and long term segregation records on the wards we visited.

What people who use the provider's services say

Most of the patients we spoke with during our inspection visit were positive about the quality of support they received from staff but were critical of staffing levels within the hospital. Twenty nine patients individually raised concerns about staffing levels within the hospital with us which was the biggest single theme of feedback.

We collected 28 comments cards before the inspection. Five of these were positive, fifteen were negative and the rest were mixed. Most of the comments cards mentioned shortages of staff. The positive comments related to caring staff.

Summary of findings

Good practice

- The provider had developed a robust system of embedded user involvement in a number of committees and forums through the hospital. Each ward had a patient representative who attended the hospital wide patient forum on a monthly basis. These meetings were ensured that patient voice was evident up to the senior management level in the hospital and the minutes had action plans with timescales which could be tracked. Patients were also involved in community meetings on every ward which were well-established.
- There had been considerable work done to reduce the frequency and length of long term segregation. There was a specific quality improvement project on Epsom and Cranfield wards but also specific work had been done on Woburn and Ascot wards to reduce long term segregation within the hospital. This was evident in the data provided which monitored the progress of these projects.
- Leeds ward had a peer representative which was a new role and meant that one patient took the lead on welcoming new patients to the ward and was involved in co-producing an introductory information booklet for patients who were new to the ward. They received supervision from a member of staff regularly to enable them to make the most of the role.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that there are sufficient qualified and experienced staff on the wards.
- The trust must ensure that patients have access to activities and therapeutic engagement according to their care plans.
- The trust must ensure that assessments of capacity to consent to care and treatment reflect the individual needs of patients and that capacity is considered robustly to reflect the treatment that is provided and that these assessments of capacity are recorded comprehensively.
- The trust must continue to ensure that staff engagement is prioritised and that staff voices are heard in the running of the hospital.
- The trust must ensure that reviews of seclusion and long term segregation, including three monthly external reviews of long term segregation are carried

out and recorded comprehensively as recommended in the Mental Health Act Code of Practice and that any cogent reasons for diverging from the Code of Practice are comprehensively recorded to ensure the safety of patients who are subject to these restrictive practices.

Action the provider **SHOULD** take to improve

- The trust should ensure that involvement and communication with carers is prioritised and that carers are provided with necessary support and information to facilitate involvement.
- The trust should ensure that environmental risk assessments include blind spots and areas in the ward where there may be risks as well as risks which are specifically related to ligatures.
- The trust should ensure that temperature control is managed in seclusion rooms in Epsom ward.

West London Mental Health NHS Trust

Other specialist services

Detailed findings

Locations inspected

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

Name of CQC registered location

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

Broadmoor Hospital

Mental Health Act responsibilities

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

We found that staff across the hospital had a good understanding of the Mental Health Act and their duties in respect to ensuring that both the Act and the Code of Practice were taken into account when care and treatment was provided.

We found that consent to treatment documentation was not sufficiently robust to evidence that individual assessments of capacity had taken place where patients agreed to their treatment plan apart from on Kempton ward where we found the assessments of capacity to consent to treatment to be of a high quality.

Patients were told their rights under the Mental Health Act and this was recorded. We saw that this was also repeated on a regular basis.

Detailed findings

Paperwork relating to patients' detention under the Mental Health Act was uploaded onto electronic records to ensure that staff on the ward had access to the relevant paperwork.

There was a Mental Health Act administration office on site within the hospital to provide advice, guidance and support and staff were aware of how to access additional advice when necessary.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff throughout the hospital had a good understanding of the Mental Capacity Act and how it related to the work that they carried out. They were able to give us examples of how they had ensured that they worked to the principles of the Mental Capacity Act with patients through the hospital.

Mental Capacity Act training was mandatory in the trust but had recently been added to the schedule of mandatory training so compliance rates across the hospital were at 54%.

Are services safe?

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

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

Our findings

Safe and clean environment

- Broadmoor Hospital consists of a number of buildings which range from old Victorian buildings which are over 150 years old to newer facilities such as the Paddock Centre which was built in 2005. This means that the condition of facilities varies significantly depending on the building in which the wards are housed. A new hospital was being built at the time of the inspection which is due to open in spring 2017.
- Ward layouts varied significantly between the buildings which were used for wards. For example, in the Paddock Centre each patient had an ensuite toilet and shower, however in the older buildings such as York House; patients accessed shared toilet and shower facilities.
- Wards were clean and well-kept. Each ward had a designated infection control lead and information about current infection control status, for example, handwashing audits were on display in the wards.
- Each ward had a designated clinic room. Staff on the wards had access to equipment such as blood pressure monitors and weighing scales. When equipment had been cleaned it was marked with a sticker which meant that staff were aware when equipment had been cleaned and was due to be cleaned. We saw that clinic rooms had sharps boxes which were dated and signed.
- Staff on the wards we visited were aware of the location of ligature cutters and emergency equipment such as oxygen, defibrillators and emergency medication such as adrenalin.
- Where there were ligature risks present, they were identified in ligature risk assessments which were carried out annually with quarterly updates. Where there were areas on the ward with risks of attaching ligatures, these were identified in the individual ward assessments and in the ward operating policies. We spoke with staff on the wards we visited and most staff had a good understanding of the specific environmental risks on the wards in which they worked. Some staff told us that when they were redirected, they were not consistently informed about environmental risks.
- Some outdoor areas, such as the garden in York House, were not included specifically on ligature risk assessments. However, access to this area was managed through individual risk assessment.
- We checked seclusion rooms on the wards we visited. All wards had access to seclusion rooms, however, the state of these varied significantly. Wards in some of the older buildings such as York House and Kent House had seclusion rooms which were located on the main ward corridor. This meant that there was a risk that patients' dignity and privacy may be compromised. The hospital is due to relocate in spring 2017 where this will no longer be an issue of concern.
- One of the seclusion rooms on Epsom ward was identified as having a draught. This was not the most commonly used seclusion room and was used only when the other room was in use. Staff told us that to mitigate against patients' discomfort in this room, they provided patients with additional blankets when this room was used.
- Staff across the hospital had a very good understanding of security on the wards and within the hospital. Call bells were located at fixed points in the wards and staff were aware of how to contact assistance. Staff across all the wards we visited told us that when they call for assistance, there was a speedy response and were able to give us examples of when they had needed additional assistance. As well as ward staff, there was a central specialist team who provided support with incidents and who had received additional training regarding prevention and management of violence and aggression and were referred to as the PPE (patient protective equipment) team.
- Each ward had a quarterly health and safety audit covering environmental issues on the wards. We saw that these were completed on the wards we visited and where there were action points, they were tracked through the audit process.

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- We saw on Cranfield ward, additional work had been carried out to ensure that environment was more appropriate for patients. For example, one patient who had been in long term segregation was allocated a second room and had access to their own outside area. This patient told us that this was a significant improvement.
- Each year, the National Offender Management Service reviews security within the hospital. The most recent audit at Broadmoor Hospital resulted in achieving a 99.75% compliance.

Safe staffing

- During our last inspection in June 2015, we identified that there were not sufficient suitably qualified staff on the wards to meet the needs of patients and this had impacted on patients' ability to access therapeutic activities.
- At this inspection fifty two members of staff raised concerns with us about staffing levels in the hospital and seven focus groups specifically identified concerns with a lack of nurses. Twenty nine patients specifically raised concerns with us about the staffing levels, particularly regarding nurses on the wards in the hospital.
- At the time of our inspection there were 68 vacancies for staff nurses. This meant that some shifts were not staffed at the levels which had been determined by the trust.
- In the year between 1 November 2015 and 31 October 2016 the turnover rate for staff nurses was 22% and was 14% for healthcare facilitators.
- We checked the fill rate of staff across the hospital and on specific wards to gauge the impact of staffing across the hospital. Fill rate is determined by taking the actual hours worked by staff as a percentage of planned hours of staff coverage broken down by role, for example, the fill rate for registered nurses is separate from the fill rate for healthcare facilitators. Across the hospital, the average fill rate for registered nurses between 1 August 2016 and 31 October 2016 was 87% during the day and 80% at night. The average fill rate for healthcare facilitators was 94% during the day and 107% at night. This meant that there were gaps in the rota for registered nurses and that, across the hospital, staffing was not consistently reflected in skill mix determined by the trust for the hospital. This fill rate varied between wards, for example, on Woburn ward, which is a high dependency ward with fifteen patients, the average fill rate between 1 August 2016 and 31 October 2016 was 70% during the day and 66% at night and over the same period, the fill rate for healthcare facilitators was 103% during the day and 113% at night. This meant that healthcare facilitators did provide some cover for nursing vacancies but the skill mix on the ward did not meet the level determined by the trust to ensure safe staffing levels. The hospital did not use any agency staff to cover nursing shifts on the wards.

- As of 31 October 2016, most staff had completed relevant mandatory training. Across Broadmoor Hospital, the compliance rate for mandatory training was 89% against a trust target of 90%. Eight courses were below the trust target of 90% including information governance (72%) and WRAP (Prevent) Training at 68%. Promoting safer and therapeutic services (PSTS) training, which equips staff to manage potentially aggressive or violent situations had a compliance rate across the hospital of 99% and safeguarding adults training had a compliance rate of 97%. Three members of staff told us that they had found it difficult to attend mandatory training due to the staffing levels on the wards on which they worked.

Assessing and managing risk to patients and staff

- We checked patient risk assessments on the wards we visited. We found that risk assessments were thoroughly completed and were updated regularly reflecting current risks. The service used a standard HCR-20 (historical, clinical risk) which is commonly used in forensic mental health services. Risk assessments were completed by staff prior to patients' admission to the hospital and this was considered as a part of the admission process. We observed three nursing handovers and saw that key risk information relating to specific patients was shared and recorded so that staff were aware before coming onto the ward about information that was necessary. We asked staff about how information was shared when they were redirected to wards they were unfamiliar with and asked to provide care for patients who they did not know. We had a mixed response from staff. Most staff told us that they received comprehensive handovers from staff on the

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wards where they were moving to. Three members of nursing staff out of the many nurses we spoke to told us that they had been redirected to wards or that staff had been redirected to the wards they were working on and they had not been able to give or receive a full handover. This meant that there was a risk that a member of staff may be working with an unfamiliar patient and could be exposed to risk that they are unaware of on that basis.

- Between 1 May 2016 and 31 October 2016, there were 103 incidents of restraint across the hospital involving 85 different patients. Of these restraints, 63 were in the prone position and two resulted in the use of rapid tranquillisation (RT). The incidents of restraint were highest on Cranfield ward, which is the intensive care ward with 29 and Woburn ward which is a high dependency ward which had 22 incidents. The highest levels of prone restraint were on Cranfield, Woburn and Epsom ward which is also a high dependency ward which had 12 incidents each. This was a reduction from the incidents of restraint which we saw in the previous inspection.
- We saw that one patient had been administered rapid tranquilisation on one occasion on Cranfield ward. The nurse showed us evidence of post RT reporting on the electronic database and appropriate physical observations that were carried out regularly. This meant that staff were monitoring the safety for this patient.
- There were 234 incidents of seclusion between 1 May 2016 and 31 October 2016. The highest levels were on Ascot ward with 46 incidents, Woburn ward with 42 incidents and Epsom ward with 41 incidents. These were all high dependency wards and the higher level of seclusion reflects lower rates of long term segregation.
- The numbers of incidents of long term segregation in the six months between 1 May 2016 and 31 October 2016 were 87 with the highest levels on Epsom ward with 23 and Cranfield ward with 15. At the time of our inspection, there were 30 patients in long term segregation (LTS) of whom 11 had been in segregation for over 12 months. This was a reduction from the inspection visit last year in June 2015 where there had been 37 patients in long term segregation of whom 20 had been in LTS for 12 months or more.
- The service had put considerable effort into work to reduce restrictive practices at Broadmoor Hospital, particularly focussing on the patient experience on Epsom ward which previously had a high level of long term segregation and Cranfield ward, which is the intensive care ward to focus on the patient access to activities as more patients on Cranfield ward were subject to long term segregation. We saw that staff on the wards and management in the hospital and developed a quality improvement programme which had had effective outcomes in reducing the levels of long term segregation on Epsom ward. Staff and patients we spoke with were enthusiastic about the progress which had been made in this area and the service had been awarded with an internal award to recognise the work by staff and patients in this area. This showed that there was commitment and an eagerness to promote and develop ways to reduce restrictive practices in the hospital and improve the quality of life for staff and patients.
- We checked seclusion and long term segregation records across the hospital. We saw that most records were completed comprehensively. Patients who were subject to long term segregation were reviewed by a monthly panel headed by the clinical director. This enabled peer challenge around the use of long term segregation. We saw minutes from the most recent meetings between April 2016 and September 2016, which took place to review the use of long term segregation as well as the use of short term seclusion and saw that each patient was discussed. We also saw that gaps in recording related to reviews were picked up at these meetings providing an internal mechanism to check the quality of reporting related to reviews of seclusion and long term segregation. However, on Cranfield ward, we checked ten records of patients on LTS. We could not see evidence recorded that LTS reviews took place every 24 hours. On the day of our visit, although we were told that patients had received a review in line with policy, there was an unacceptable delay of this being recorded in the electronic record. Some patients did not have a recorded review for up to three days prior to our visit. The provider's LTS policy states that patients should be reviewed every 24 hours so we did not see evidence that this was happening. We saw one record on Harrogate ward and one record on Woburn ward where it was not clear that a discussion

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had taken place when the seclusion of a patient had ended. On Sheffield ward we saw that there was one record of a patient who had been secluded and there were some gaps in the seclusion records which did not evidence when the first multi-disciplinary meeting had taken place and there were some delays in four hourly medical reviews.

- Staff had a good understanding of adult safeguarding processes. We saw that the safeguarding guidance was available and visible on each ward and had been updated in to reflect the Care Act 2014. We saw that there was a comprehensive process in place to raise and manage safeguarding concerns as they arose. Social workers were allocated to each ward and could provide specific advice and support when necessary. Staff knew who to contact if they had any queries related to safeguarding issues. The trust worked well with external agencies including Bracknell Forest local authority. The hospital had regular meetings to update and share current safeguarding referrals and concerns and these meetings included the local management, ward based staff and included rolling invites to external partners such as the local authority and CQC.
- The trust made suitable arrangements to ensure service users were protected against the risks associated with the inappropriate treatment of medicines. We found that care and treatment were provided in a safe way for service users.
- Medicines at the hospital were stored securely and appropriately. This meant that there were processes and practices in place to ensure people and staff were safeguarded from abuse. Keys to medicines cupboards, controlled drugs (CD) cabinets and treatment rooms were held by appropriate staff and there was effective monitoring in place when they were handed over.
- All medicines cupboards and fridges inspected were clean and tidy, and fridge temperatures were within the recommended range of 2-8°C, with daily audits carried out. Throughout the location all the medicines inspected were in date and no delays in the top up of these medicines were reported by staff. Room temperature monitoring was done and we found evidence that this was carried out on a daily basis, which meant that medicines requiring storage below 25°C had been taken into account. The allergy statuses of patients were routinely recorded on the medicines chart and that in general there was effective overview of these charts by pharmacists. However, we did find a few discrepancies where the spelling of some medicines (such as pirenzepine) was wrong and had not been corrected by pharmacy staff. This was pointed out to staff who immediately sought to have it corrected.
- Medicines used for resuscitation and other medical emergencies (for example anaphylaxis and intravenous flumazenil) were readily available, accessible for immediate use and tamperproof. Daily checks took place to ensure the appropriate medicines were stocked and had not expired.
- Controlled drugs (CDs) were securely stored in accordance with legal requirements. A separate key was held by authorised staff and entries double-signed in the register to provide evidence of an authorised witness. CDs were audited on a quarterly basis by pharmacy staff, and no major concerns had been identified recently.
- The location used paper medicines charts. Staff were proactive in carrying out medicines reconciliation. The latest data showed that more than 90% of patients had a medicines reconciliation done within 24 hours across several wards in the hospital.
- Arrangements for the supply of medicines were good. We found no evidence of 'out of stock' medicines during the inspection and there were effective arrangements in place to reconcile medicines that had been ordered and advice out of hours by the on-call pharmacist. Staff we spoke to said they had no issues obtaining medicines from the pharmacy when needed.
- Although the pharmacy team was small, there was a right skill mix of pharmacy staff to ensure that the risks associated with the management of medicines are managed and reduced. Two pharmacists were involved in multi-disciplinary teams in high risk areas such as the intensive care unit and high dependency units. However, the chief pharmacist did highlight that due to a small team there was not much flexibility should a member of pharmacy staff be off, and this could impact on the clinical services provided to the hospital. However, we did not see any evidence of this having an impact during the inspection.

Are services safe?

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

- Staff had access to relevant local medicines policies such as medicines management, rapid tranquilisation and controlled drugs. Additionally, staff had access to the trust's intranet pages on medicines management.
- Pharmacy opening times for the main dispensary were between 9:30am and 4:30pm from Monday to Friday. All areas of the hospital had access to an on-call pharmacist out of hours who could be contacted for advice and assistance with medicines supply issues. Staff had access to the emergency medicines cupboard in one of the wards. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.

Track record on safety

- Between 1 November 2015 and 31 October 2016, there were 27 incidents reported which were identified serious incidents requiring investigation. This category is determined by the national framework for learning and reporting on serious incidents requiring investigation. Nine of these incidents related to actual, apparent or suspected self-inflicted harm which was the highest category. The ward with the highest number of incidents was Kempton ward, with four.
- Since the last inspection in June 2015, the trust submitted one Prevention of Future Death report as directed by the coroner's office. This report related to a death in April 2013 and identified issues related to eyesight observations. During this inspection, we checked a sample of observation records. We saw that these were completed comprehensively and staff had a good understanding of the trust observation policy. We saw that in April 2016, nurse consultants had carried out an audit of the use of observation records across the hospital. This audit had displayed a 100% compliance rate. This demonstrated that the report had led to changes in practice and additional focus on observation and observation records.

Reporting incidents and learning from when things go wrong

- Staff we spoke with had a good understanding of how to report incidents. The incident reporting system had

recently changed within the hospital shortly before the inspection. Staff told us that information was easier to find on the newer incident reporting system. Incidents were reported through an online database and information was then collated centrally by a governance team onsite who shared data and details with ward teams as well as discussing data at service-wide management meetings.

- Staff understood how to recognise and report medicines safety incidents via the trust reporting framework. There was evidence of learning from incidents within the trust. For example, due to recent incidents involving the wrong dose of insulin being given to patients (4 in the last 18 months), the nurse practitioner from the physical health centre gave training to nursing staff on the correct administration procedure for insulin. Staff were aware of the dissemination of learning from these incidents, including by email and through a 'Medicines Monthly' bulletin. In conjunction with this, a pharmacist hosted a medicines safety session monthly with staff to discuss incidents and ways of improving the safety of medicines. This had resulted in a new flag/sticker for patients on high dose antipsychotics, so that their monitoring could be more easily identified. We saw that these stickers were in place on the wards we visited.
- Staff across the hospital had a good understanding and awareness of incidents which had taken place both on their own wards but also within Broadmoor Hospital. We were given a number of examples of learning which had taken place following specific incidents. For example, there had been an incident on Kempton ward which had led to changes in the way that patient searches were carried out.
- We saw an example of where the principles of the duty of candour had been followed. We spoke with one patient who had received an apology from the clinical director after an incident had occurred where an error had been made which had led to avoidable harm.
- Across the hospital, staff told us that they had access to debriefs following incidents as well as reflective practice sessions.

Are services effective?

Requires improvement 

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

Our findings

Assessment of needs and planning of care

- Staff completed full assessments and care plans with patients when they were admitted to the hospital. Initial assessments and care plans on the wards we visited were generally comprehensive, holistic and up to date.
- Medical and nursing staff undertook regular physical health checks for patients. The hospital used the national early warning system (NEWS) to update and monitor physical health and to escalate concerns when they arose. Patients' physical healthcare monitoring and information was recorded in a specific physical healthcare portal. Physical health monitoring across the wards we visited was completed regularly and comprehensively.

Best practice in treatment and care

- Medical staff in the hospital had a good understanding of established NICE guidelines regarding prescribing medication. Where medication was prescribed above the recommended levels, this was flagged in medication charts.
- Each ward had access to a clinical psychologist as a part of the multi-disciplinary team and psychologists attended clinical team meetings to provide input into discussions about patients' care. The hospital had a group work programme which included patients' access to cognitive behavioural therapy but also a range of other therapeutic interventions including eye movement desensitisation and reprocessing therapy (EMDR) which was a particular way of working with patients who have experienced trauma. Groups were run by psychologists and nurse therapists who had specific training in the therapies delivered. These groups included specific sessions like 'understanding personality disorder' and 'understanding mental illness' as well as dialectic behavioural therapy being available both for individuals and in groups. There were also groups which addressed specific issues such as 'understanding fire setting' and substance misuse groups. These groups involved external professionals when this was useful. For example, the local fire service had attended a group relating to fire setting. Patients were very positive about the impact and scope of therapies which were available to them at the hospital.

We saw that clinical psychologists, nurse therapists, consultant psychotherapists within the team at Broadmoor had published a number of articles in national and international journals reflecting the research base and progress of patients as a part of the group work programmes in place.

- The hospital had a GP who was based on site for two days a week and had a medical centre with GP surgery, dentist surgery, ECT suite and additional rooms for practice nurses. There was a dedicated physical health modern matron who provided support to ward staff for patients who had additional physical health needs. Patients accessed specialist physical health support as necessary. For example, a diabetes specialist nurse visited the hospital regularly, as well as an endocrinologist who visited the patients who had a diagnoses of diabetes every 12 weeks.
- Practitioners and clinicians across the service ensured that outcomes for patients were measured on a number of scales depending on the professional backgrounds. For example, secure health of the nation outcome scales was used on the wards to benchmark needs on admission and throughout the time at the hospital.
- The occupational therapy team in the mental illness directorate introduced an evidence based model called the Vona du Toit Model of Creative Ability into their work with patients in this area. This focussed on an assessment of ability through observation undertaking unfamiliar tasks and focussing on therapeutic goals within occupational therapy sessions. Across the directorates, occupational therapists used activity participation outcome measures to determine patients' progress and these measures were shared with patients so that they could evaluate their own progress.
- In the year between 1 April 2015 and 31 March 2016 staff at Broadmoor Hospital undertook 18 clinical audit projects. Eight of these were led by doctors, three by nursing staff, four by psychologists, two by mental health act administrators and one by the prevention and management of violence and aggression staff. There were also a number of trust wide audits which took place including high secure services. Specific audits carried out at Broadmoor included a piece of work by a doctor about the impact of leave of absence, for example, when patients were admitted to a general hospital, so there could be a better understanding of

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how this impacted on the rest of the hospital. Another example of a clinical audit undertaken by a doctor related to the frequency of mental state examinations on Woburn ward. This comprehensive audit programme led to a greater understanding of aspects of clinical care within the hospital.

- Broadmoor Hospital had undertaken an extensive piece of work relating to the reduction of long term segregation since our visit to the hospital in June 2015. This project specifically focussed on Epsom and Cranfield wards and had involved prevention and management of violence and aggression (PMVA) trainers being attached to wards to help to facilitate a reduction in the time that patients spent in the room and preparing them to move on from long term segregation in a safe way which provided assurance to staff and encouraged positive risk taking. Staff on the wards were very positive about the approach that had been taken. The piece of work had specifically been undertaken as a quality improvement project and the progress had been measured extensively for impact. This was a successful project and the ward teams had been awarded internally.
- Patient outcomes from medicines were monitored and assessed via several audits conducted at the location. These included

Skilled staff to deliver care

- Staff we spoke with told us that they received regular supervision. Supervision was monitored by clinical nurse managers on the wards and we saw that staff had access to regular supervision. Two nurses told us that they received managerial supervision but did not receive separate clinical supervision and felt that this was an area which was lacking; however, most staff we spoke with were positive about the supervision they received.
- Each ward had allocated reflective practice groups which ran weekly where staff could attend and discuss and reflect on issues which were pertinent to their practice.
- Staff across the hospital but particularly nursing staff, were positive about the development opportunities within the trust and within the hospital. Staff gave us examples of situations where they had been able to access additional training beyond statutory training.

One member of staff who worked on a ward in the personality disorder directorate told us that they had received specific training related to working with people who had diagnosed personality disorders which they said had been helpful. We also spoke with one healthcare facilitator who was undertaking training modules as a part of the associate practitioner pathway and told us that this was very useful. Another member of staff told us that even though they did not want to access additional training, it would be available if they wished to.

- Staff across the hospital in clinical and non-clinical roles told us that they had access to short training sessions called '2 hour training' which reflected areas such as human resources and policies which were useful to those who were in management roles. This was accessed on site and we received positive feedback about this.
- Each ward had specific clinical improvement group (CIG) meetings which took place monthly. These meetings reflected key areas of the ward performance, including incidents, complaints and audits. Information was also shared at these meetings about incidents from other wards on site.
- Staff across the hospital and from different disciplines told us that the induction they received when they started working at the hospital was extensive and prepared them for their work on wards or in the areas they were assigned. For nursing staff, they had a four week induction including PMVA training before starting work on the wards. A number of staff told us that this was the most comprehensive induction which they had received compared to previous jobs.
- 80% of nursing staff had had annual appraisals up to the 30 September 2016. Two wards had appraisal rates which were below 50%, they were Woburn ward where it was 44% and Newmarket ward where the appraisal rate was 30%. 100% of doctors had been revalidated by 30 June 2016.
- There were three vacancies for ward administrators at the time of our inspection. In our inspection in June 2015, we identified that a lack of ward administrators had placed increased administrative pressures on nursing staff. We saw that this continued to be the case,

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although the three vacant positions had been filled and those appointed were due to start early in 2016. This meant that there would be an improvement in the availability of administrative staff.

Multi-disciplinary and inter-agency team work

- Each ward had a weekly clinical team meeting. This included ward based staff from different clinical disciplines, for example, doctors, nurses, occupational therapists, social workers, clinical psychologists and pharmacists.
- We observed four handovers; three were handovers between morning and afternoon staff and one handover between afternoon staff and night staff. Handovers were recorded and information was shared about key risk issues during the day. Staff told us that they received vital information at handovers. However, three members of staff told us that sometimes the lack of availability of staff meant that handovers were not consistently comprehensive when they were redirected to other wards or when other staff were redirected to wards where they were working.
- There were clear pharmacy governance structures within the hospital with adequate representation from pharmacists at various groups including medicines safety workshops, Clinical Information Governance groups and MDT meetings. Staff we spoke to demonstrated adequate training had been provided on the safe use and handling of medicines and there was a process in place for implementing drug safety updates from the MHRA (Medicines and Healthcare Regulatory Agency). Staff we spoke to recognised how to report adverse reactions to medicines correctly using the 'yellow card scheme'.

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

- Training rates for Mental Health Act were at 91% across the site. This was 100% on Ascot, Chepstow and Harrogate wards. The lowest was Kempton ward on 80%.
- Most staff on the wards we visited had a good understanding of the Mental Health Act and were aware of their responsibilities regarding it. There was a Mental Health Act administrator based on site and staff were able to access support and guidance as necessary.

- As a part of our inspection, we carried out four specific Mental Health Act visits where Mental Health Act reviewers visited wards to determine the ward performance specifically in relation to provisions of the Mental Health Act. We visited Cranfield, Ascot, Sandhurst and Sheffield wards in this capacity.
- Patients had access to advocates who visited wards twice weekly. Information was available on the ward about contacting advocates outside this time.
- Paperwork relating to the Mental Health Act was generally completed accurately and was uploaded electronically to patients' records.
- We checked all the records related to patients' capacity to consent to treatment and checked their medication records reflected treatment that they had either consented to or had been approved to be prescribed by a second opinion appointed doctor (after three months of their initial detention). We found that in the majority of records where doctors had indicated that patients had the capacity to consent to their medication which was 46% of patients in the hospital, the capacity assessments were not extensive enough to indicate that a full discussion around capacity and impact of medication had taken place. The exception to this was on Kempton ward where we found excellent examples of detained capacity assessments which had involved the individual patients and reflected their understanding clearly.
- Where patients had not consented to their treatment and required additional authorisation of a second opinion appointed doctor, we found five had been prescribed medication outside the authorisation of the second opinion appointed doctor. We also found that where doctors had approved urgent treatment on a one off basis, there were three records where the treatment was for more than one dose and therefore not necessarily 'one off'.
- Patients who were subject to LTS for a period of over three months should be reviewed every three months by an external hospital. We found that for patients at Broadmoor this was not consistently happening although there had been attempts made to link with an

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external hospital; the reviews were not being carried out for all patients who met these criteria. This meant that patients were not being afforded protections prescribed in the Mental Health Act Code of Practice.

Good practice in applying the Mental Capacity Act

- Most staff we spoke with had a good working understanding of the Mental Capacity Act and were aware of its relevance within the hospital and the day to day work which they did.
- The trust had added training relating to the Mental Capacity Act into its core mandatory training. At the time of our inspection, across the hospital, 54% of staff had undertaken this training. The highest compliance rates were on Folkestone ward at 88% and were lowest on Kempton ward with 17%. However, we saw that staff on Kempton ward, had a good understanding of the Mental Capacity Act.
- We saw that staff had an understanding of the relevance of the Mental Capacity Act in their day to day work on the ward, for example where a patient may make specific decisions about their physical health or healthy eating. There had been some changes in restrictive practices and blanket restrictions which reflected a greater emphasis on patient choice.
- Each ward had a social worker attached and they were able to provide additional support and information relating to the Mental Capacity Act. We saw that information was available on the wards about the Mental Capacity Act that staff were able to refer to and staff we spoke with knew who to ask for additional advice if necessary.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Most patients we spoke with were positive about the care which they received from nursing staff within the hospital. Some examples of comments which were shared with us included that staff try their best and one patient told us that they had great admiration for the staff because they were caring and wanted to do things with patients. Another patient told us that he knew he was being cared for. This reflected the comments which were given to us throughout the inspection visit.
- We received feedback from 28 comments cards which were left around the hospital. Five of these were positive, fifteen were negative and eight were mixed with both positive and negative comments. Some of the positive comments included that staff were caring and professional. Almost all the negative comments referred to a lack of staff including comments such as staff being too busy to care for patients and small food portions.
- We observed staff providing care to patients and invariably we saw that staff showed sensitivity, kindness and understanding in their interactions with patients in the hospital.
- PLACE assessments are assessments which were undertaken by NHS and independent providers and include at least 50% members of the public. In 2016, Broadmoor Hospital scored 69% for privacy, dignity and wellbeing. This is below the national average.
- Staff on the wards we visited displayed understanding and knowledge of the individual patients in the hospital.
- All wards also had weekly community meetings. We attended two community meetings during our inspection visit. We saw that community meetings were recorded so that patients who were not able to attend were able to pick up relevant information and feedback.
- There were a number of mechanisms by which the patient voice was reflected in the organisation of the hospital. Patients attended clinical improvement groups on the ward and were able part of a number of other meetings and committees which met and made decisions regarding the running of the hospital. For example, there was a patient representative on the catering committee.
- On Leeds ward, there was a peer representative. Their role was to liaise with patients who were admitted to the ward and to provide advice and support to new patients. We met with the peer support representative on Leeds ward who told us that the role had been valuable. They had been involved in producing a welcome pack which was specific to the ward. As a part of their role, they also received regular supervision six weekly from a member of staff.
- Leeds ward had produced an introduction leaflet to the ward which was designed in conjunction with patients on the ward. This explained to patients who were new to the ward what to expect including a glossary of useful terms which were explained clearly. This meant that patients who came onto Leeds ward were given extensive information and were supported by a peer.
- There was a bimonthly carer's forum. We spoke with three family carers prior to the inspection and received mixed feedback regarding their involvement in the running of the hospital and communication with staff and management within the hospital. The hospital had undertaken a project to highlight specific needs of carers; however, some of the work was still to be embedded. We checked the minutes of the Patient and Carer Experience Group held in the hospital on a bimonthly basis. We saw that some of the actions relating to carers were not clearly followed up within specified timescales. For example, we saw in minutes from the January 2016 meeting that the Carers Information Pack was being developed. This pack was with the communications team in July and in the minutes in September, was still to be circulated to members of the committee with an action by November

The involvement of people in the care that they receive

- Each ward in the hospital has patient representatives who attended the monthly patient forum. We observed this forum during our visit and saw that it was an opportunity for patients to feedback information, concerns and any other issues to the senior management within the hospital. The forums were well-established and recorded each month with minutes sent to each ward. There was an action tracker so patients received regular updates regarding actions which were established during the meetings.

Are services caring?

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

2016. In the documentation provided we saw that the plan was for this information pack to be delivered when patients move to the new hospital in spring 2017. Carers who we spoke to told us that they had received different information from the hospital so the timescale to provide this information pack to carers was lengthy and had been in development for a significant period of time. Carers did not attend the Patient and Carer Experience Group, however, patients did attend. There were a number of initiatives which were happening to involve carers but the lack of carer feedback was evident in the minutes of these meetings. The social work manager in the hospital told us that the hospital social workers can carry out carer's assessments as required under the Care Act but they rarely did so, as it was dependent on the circumstances of individual carers and the local area where the carer was living. They were due to undertake an audit of carer's assessments, having established that carers of patients at Broadmoor were entitled to assessments under the Care Act which came into force in April 2015. This meant that there was a risk that carers' were not receiving the statutory

support that they were entitled to. There were a lot of plans to look at aspects of the triangle of care and involving carers in the hospital, however, some of the key processes were not yet completed, despite an extensive audit of carer views having taken place in 2015.

- The trust provided support to carers to visit family members in the hospital. For example, providing transport at the weekend once a month from local train stations and reimbursing travel costs to carers. The trust also has links with a local independent hotel which they can use when carers have long distances to travel.
- All patients had access to advocates who were based in the hospital. We met with advocates as a part of the inspection. Each ward was allocated an advocate who visited twice a week as well as attending clinical team meetings, CPA reviews and ward community meetings.
- Patients at the hospital produced a newsletter which was distributed to each of the wards. This enabled patients to contribute with articles, poetry and pictures.

Are services responsive to people's needs?

Inadequate 

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

Our findings

Access and discharge

- While all admissions to Broadmoor Hospital were planned admissions, the hospital was able to respond in an emergency and accept patients where necessary. There were 198 patients admitted at the time of our inspection. This meant that there were always beds available in the hospital both for emergency admissions and with some scope for transfers between wards within the hospital when necessary, for example, following incidents where patients may need to be transferred to a ward which had higher level of dependency. We saw this happen during the inspection visit where patients needed to be transferred between an assertive rehabilitation ward and a high dependency ward following an incident.
- At the time of our inspection, there were sixteen patients who were awaiting transfers to medium secure units. 8 patients were waiting for admission to the hospital either from other high secure hospitals or from medium secure hospitals.
- There was one patient on the admission, high dependency or medium dependency wards that was waiting to be transferred into assertive rehabilitation wards. A further 10 had been referred within the previous three weeks. One patient was waiting for transfer into an intensive care bed. This meant that there were some people who were placed in wards or in the hospital at a higher level of security that was necessary at that point in time.
- When patients went on leave to medium secure units, their beds were not retained for them, although if it were necessary for them to be transferred back to Broadmoor, they were admitted back onto admission wards. This meant that assertive rehabilitation beds were made available for those patients moving through pathways within the hospital. The trust reported one readmission of a patient within 90 days between 1 January 2016 and 30 June 2016 which was on Sandown ward.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital provided a wide range of therapeutic activities. At the last inspection we found that staffing levels impacted on patients being able to access these activities. At this inspection, we found that this continued to be the case and we served a warning notice to the trust on 29 November requiring them to take urgent steps to improve the access to therapeutic activities and association time for patients at Broadmoor Hospital.
- Between May 2016 and October 2016, there had been 396 activity sessions cancelled due to staffing issues. One session may be a morning or afternoon session and was counted by numbers of patients affected. We spoke with three activities coordinators and one activity coordinator left us written feedback. They told us that it was not unusual for activities coordinators to be redirected from wards to cover healthcare facilitator positions where there was a shortage. Some patients we spoke with told us that this had an impact on the availability of ward-based activities, particularly for patients who did not have access to off ward activities.
- Patients on Ascot, Cranfield, Epsom, Kempton, Newmarket, Sandown and Woburn wards are subject to night time confinement (NTC). This is when patients are locked into their bedrooms between 9.15pm and 7.15am. This was implemented in line with the security directions for high secure hospitals (2013) issued by the Department of Health. We saw that all patients who were subject to night time confinement were not routinely offered a minimum of 25 hours of meaningful activity per week. This varied significantly across the wards, for example, on Ascot, Chepstow, Kempton and Sandown wards, most patients were offered a minimum of 25 hours of meaningful activity but on Cranfield, Woburn, Newmarket and Epsom wards, fewer patients had. For example, in October 2016, one patient each on Cranfield, Epsom and Woburn wards had been offered 25 hours a week meaningful activity. While patients on these wards were offered some meaningful activities, this was not at the minimum expected level of 25 hours per week.
- Some patients and staff told us about incidents where patients' doors had been unlocked later than 7.15am due to shortages in staffing. We asked the trust to provide us with information about how many times this had happened between 1 May 2016 and 31 October

Are services responsive to people's needs?

Inadequate 

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

2016. The trust provided us with data which indicated that this happened on three occasions on Woburn ward (twice in May 2016 and once in September 2016), twice on Epsom ward (once in June 2016 and once in July 2016) and once on Kempton ward in May 2016 and that there had been no incidents where this had happened in October 2016. However, when we looked at specific daily reports from October, we found two incidents on 2 October on Epsom ward and 29 October on Kempton ward. This meant that the data provided was not consistent. One patient on Epsom ward and one patient on Kempton ward told us that they were 'unlocked late' and that this had impacted on access to activities.

- Some patients across the hospital were subject to long term segregation (LTS). This was used when patients, for their own safety or for the safety of others, were required to be provided with nursing care in isolation for longer periods of time than the shorter periods of seclusion. Patients who were subject to the protections of LTS had access to 'association time'. This is time when patients are able to leave their rooms and mix with other patients or members of staff. We asked for information from the trust about how many sessions of association time had been cancelled due to shortages of staff. Between 1 May 2016 and 31 October 2016, 26 sessions had been cancelled. We saw that between 1 August and 31 October 2016, this association time had been reduced on the basis of staff shortages on 102 days. This had been most prevalent on Woburn ward with 72 incidents. There were 22 incidents on Newmarket ward and eight times on Epsom ward. No other wards indicated that this had happened.
- The environment on the wards we visited varied significantly due to the different buildings which accommodated wards. For example, the wards in the Paddock Centre and in Bedford House (Cranfield and Woburn), had ensuite facilities whereas the wards in the older part of the hospital, including York House (Sheffield, Leeds and Harrogate wards) and Kent House (Canterbury, Folkestone and Dover wards) did not all have access to ensuite facilities and patients accessed shared bathrooms, showers and toilet facilities.
- Each ward had a dedicated clinic room. Some wards had couches in the clinic rooms but where these were not available; staff were able to conduct medical examinations, where necessary in patient bedrooms.

- Each ward had a lounge area which was accessible for all patients. Wards also had quiet rooms including rooms for meetings and therapies. Where patients were first admitted to wards, family members were able to visit them on the ward. There were rooms available on the wards for private visits. Rooms had alarms on them and there were static alarms throughout the hospital people to call for assistance if required.
- There was a dedicated visitors' facility in the hospital. This included a separate children's' visit area which was equipped to be child-friendly.
- On each ward, patients had access to lockable space to store belongings as well as food items.
- Feedback about the food at the hospital was mixed. Six patients specifically told us that they did not like the food that they were served and four people raised concerns about the portion sizes. However, four patients were positive about the food. We saw that patients attended a regular catering forum. This was where information was shared and discussed with the chef and central kitchen. Patients had a number of choices of meals and instead of hot meals, could choose snack boxes which included sandwiches or wraps. We had lunch with patients on one of the wards and saw that patients told us that they generally were satisfied with meals. They particularly enjoyed cooking their own meals which was an option on some of the rehabilitation wards.
- The PLACE assessment score for food was the lowest across the trust sites with a score of 67%. The average score across England is 92% so this was significantly lower.

Meeting the needs of all people who use the service

- Patients across the hospital told us that staff had an understanding of specific cultural, religious and spiritual needs. Patients had access to a hospital chaplaincy service and Christian and Muslim religious leaders attended the hospital regularly. Other religious leaders also attended on request. Patients told us that they had access to meals which reflected their religious diets and we met patients who accessed kosher and halal meals.

Are services responsive to people's needs?

Inadequate 

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

- The hospital had a regular equality and diversity forum which was attended by two patient representatives as well as members of staff from across the hospital. This forum fed into the trust wide equality and diversity group as well as the senior management team meeting.
- The hospital marked a number of important cultural and religious events, such as Black History Month, Eid, Christmas, St George's Day, Burns Night and St Patrick's Day. There was also an annual LGBT celebration and event. There were also celebrations or events to mark World Mental Health Day and a national Recovery Walk whereby patients participated in a walk in the grounds of the hospital.
- Staff gave us examples of providing support to patients who identified as transgender and accessing additional specialist support when they have needed to support patients in the past regarding this.

Listening to and learning from concerns and complaints

- Most patients we spoke with told us that they knew and understood how to make complaints and how to access the advocacy service within the hospital. However, five patients told us that they either were not sure how to make complaints or did not feel confident in the complaints system. This included two patients who had made formal complaints to the hospital.
- There was accessible information on every ward about how to make complaints both within the trust but also with contact details for the Care Quality Commission. The trust had a patient advice and liaison service (PALS) which was based in Ealing. However, staff based at Broadmoor had a sticker with local information which they added to leaflets which directed patients to locally based staff. Patients at Broadmoor had access to a free telephone number through which they could access complaints staff.
- The hospital reports monthly on complaints including themes and learning from complaints. This information was shared with senior managers within the hospital but also across the trust.
- We reviewed some complaints files during the inspection. We found that most complaints reflected the trust complaints policy. However, we saw that with one complaint a decision had been made by clinicians that it was more appropriate to be dealt with through PALS but we did not see that this had been discussed and agreed with the patient concerned. It was not consistently clear in the complaints we looked at that complainants were always included in the decision about how their complaints would be managed.
- Broadmoor Hospital received 166 complaints in the year between 1 July 2015 and 30 June 2016. This was 32% of the trust total complaints. Broadmoor also received 32 compliments in this period which was also 32% of the trust total compliments. 17% of these complaints (10%) were fully upheld with 54 (32%) partially upheld. No complaints were referred to the ombudsman. The ward with the highest volume of complaints was Harrogate with 26 of which 8 were upheld and the ward with the highest proportion of complaints which were upheld was Chepstow ward which had 19 complaints, of which 14 were upheld.

Are services well-led?

Requires improvement 

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

Our findings

Vision and values

- Staff across the hospital both clinical and non-clinical roles reflected a strong value base and promotion of patients' wellbeing as the key focus of their work.
- Most staff had a good understanding of the leadership within the trust and at the senior leadership within the hospital. Staff gave us mixed responses regarding the visibility of the local and trust wide leadership team.
- Staff were generally positive about the impact of the new chief executive. They told us that they felt the board had a stronger interest in Broadmoor because they had seen the Chief Executive and the Chair attending regularly.

Good governance

- As well as a central governance team at the trust headquarters, there was a team based specifically at Broadmoor Hospital who were able to provide support, guidance and information at a ward and hospital level. Each ward participated in monthly clinical improvement groups. These meetings shared performance information at a ward level.
- We found that most clinical team managers had access to and were able to interpret ward-based performance information. However, on Epsom ward we saw that information about a specific incident was not immediately available to the ward manager. The incident reporting system had changed shortly before our inspection and we were told that the new incident reporting system allowed staff members to search all incidents on the basis of ward as well as their own involvement in that incident.
- The service had a strong ethos of allowing nursing, medical and psychology staff to participate actively in clinical audit which drove improvement but also enabled staff across the hospital to have a greater understanding of the performance of their wards and the hospital as a whole.

- Since our last inspection, ward operating policies had been aligned and streamlined so that they were consistent. This meant that staff coming onto the wards had a clear understanding of the role of specific wards within the treatment pathway.
- Clinical team managers had a good understanding of the key risks and strengths on the wards they worked on. Most staff told us that they had a good relationship with their immediate line managers.
- There had been some changes in the governance structures around monitoring of seclusion and long term segregation so where there had been two meetings for the two directorates, these meetings had come together to be held on the same day. This had allowed some greater consistency in reporting.
- There were a number of different meetings and committees which took place at the hospital around a numerous different aspects of care and treatment at the hospital, for example, the carers' strategy group and the carers' and patients' experience group. It was not clear how these committees fed into each other and whether information was replicated. Carers reported to us that they found this confusing at time.

Leadership, morale and staff engagement

- At our last inspection in June 2015, we found that morale was mixed and staff told us that they felt detached from the trust in London. During this inspection, we also received mixed feedback from staff about the morale in the hospital. However, more staff reflected positively about the visibility of the trust, particularly the chief executive, director of nursing and chair of the trust.
- Between 1 September 2015 and 31 October 2016, total staff sickness across the wards in the hospital was 7.4%. The highest sickness levels were on Sheffield ward (12%) with Canterbury, Dover and Kempton on 10% and the lowest levels of staff sickness were on Chepstow ward (3%) and 5% for Folkestone and Harrogate wards. Between 1 July 2015 and 30 June 2016, there had been two members of staff who had been suspended.
- Staff told us that they were aware of how to raise concerns and most staff told us that they would do so and feel comfortable doing so. However, some staff across the hospital told us that they did not feel

Are services well-led?

Requires improvement 

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confident that raising concerns about practice within the hospital could be done without negative implications. This meant that in some parts of the hospital, the links between staff and their managers was more strained. In some focus groups, we heard staff telling us that they felt under pressure to say positive things about their work.

- Forty one staff members of the 200 we spoke to told us that morale in the hospital was poor or that it had become worse over the year prior to the inspection. Fifteen members of staff told us that the morale in the hospital was fine or that it had improved in the year prior to the inspection. Some of the comments that staff told us included that they felt undervalued and that communication from management was poor and that they felt disengaged from the management within the hospital. However, some staff told us that the organisation was supportive, and that there was 'less of a blame culture'. We received very positive feedback across the hospital about the impact of the clinical director who had been in post since March 2016. Medical staff, including both junior doctors and consultants were positive about the hospital and the trust, particularly about changes in the last year. We found that staff were concerned about the staffing levels and that this had had a significant impact on morale.
- We received comments cards from staff and patients. Some comments from the comments cards were left in the main reception area. Most of the negative comments referred to shortages in staffing levels.
- Staff in three focus groups specifically mentioned allegations of bullying.
- In the year between January 2016 and November 2016, CQC received five concerns directly from members of staff at Broadmoor. Three of these concerns related to staffing levels in the hospital, one related to treatment of staff and one related to patient care. We ensured that we followed up the issues which were raised either during the year or in the course of the inspection.
- Staff across the hospital were very positive about opportunities for professional development and training which was beyond the mandatory training programme. We spoke with staff who were attending the Aspire leadership programme which was focussed at nurses who were either clinical team managers or moving into roles at that level. The staff we spoke with who were taking part or who had taken part were very positive about this programme.
- There was a regular staff forum that ran monthly. This had been newly established at the time of our inspection in June 2015 and had been run continuously for over a year. We spoke with some staff who attended and they were positive about it. However, some of the ward-based staff we spoke with told us that they did not have opportunities to leave the ward to attend. Information and feedback from these meetings were shared around the hospital. We saw that information that was shared among staff following the staff forums. We saw that it reflected current issues such as the redevelopment programme and recruitment updates. This meant that staff who attended the forum had the opportunity to share and receive information from the hospital and the trust.
- We held focus groups in the hospital during the inspection for both clinical and non-clinical staff. We had mixed feedback in the focus groups which were attended by 85 members of staff. Four focus groups particularly noted poor morale in the hospital. Staff also reflected in three focus groups that new staff were asked to work on wards they were unfamiliar with before they were confident in their substantive role and they felt that this was a potential concern. Staff in one focus group stated that they felt unsafe at times on the wards they worked on. Staff across the hospital were positive about ward level management. We observed on some wards we visited that there was a strong team ethos and nursing staff were eager to do well for specific clinical team leaders, for example, the clinical team leader on Ascot ward and Canterbury ward were praised specifically by staff working there in terms of the support they provided. Medical staff told us that the clinical director was open and shared information with them and they felt confident raising concerns and issues.
- The trust had appointed a 'Freedom to Speak Up' guardian prior to the inspection. Some staff were aware of this appointment and told us that the appointee, who was a non-executive director of the trust, had visited Broadmoor Hospital.

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Commitment to quality improvement and innovation

- The deputy director of nursing at Broadmoor was a quality improvement lead across the trust. There had been considerable work put in specifically on Epsom and Cranfield wards regarding work on reducing long term segregation which had achieved a reduction in the numbers of patients on these wards who were subject to LTS but had also increased staff awareness of the impact of LTS. These programmes had been developed using quality improvement methodologies.
- There was a strong research ethos based at the hospital and we saw papers which had been written and contributed to by staff at the hospital as well as looking at ways in which technology and research based evidence could promote the well-being and treatment pathways for patients within the hospital.
- Cranfield ward, participated in the Royal College of Psychiatrist's accreditation scheme for acute inpatient wards.
- We had mixed feedback regarding the development of structure to ensure that learning and good practice was shared between the West London Forensic Service and Broadmoor Hospital. For example, there were regular meetings between the respective clinical directors and there was a shared executive director of high secure and forensic services. There were some shared learning forums across the trust, such as the 'learning lessons' conference where information and best practice was shared. This meant that more staff were able to take advantage of learning within the trust as a whole.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

The trust had not ensured that care and treatment was only provided with the consent of the relevant person and that where the person was unable to give consent because they lack capacity to do so, the registered person must act in accordance with the 2005 act.

This was because capacity to consent documentation was not sufficiently robust to establish clearly that patients had given their consent to the treatment which had been determined by their doctors.

This was a breach of regulation 11(1)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The trust had not ensured that systems were established and operated effectively to prevent the abuse of patients and care and treatment which included acts intended to control or restrain a patient.

This was because there were gaps in seclusion and long term segregation records and three monthly external reviews of long term segregation, for patients who were in long term segregation for over three months, were not routinely happening.

This is a breach of regulation 13(5)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

The trust did not have effective systems in place to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of a regulated activity for the purposes of continually evaluating and improving such services.

This was because staff did not feel adequately engaged and reported feeling demoralised and so further improvements in communication were needed.

This was a breach of regulation 17(1)(2)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust was not ensuring that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the patients.

Patients did not have access to activities and therapeutic engagement according to their care plans.

This was a breach of regulation 18(1)