

West London Mental Health NHS Trust

Quality Report

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

Summary of findings

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Community based mental health services for adults of working age	Hammersmith and Fulham Mental Health Unit and community services Lakeside Mental Health Unit and Hounslow community services St Bernards and Ealing community services	RKL79 RKL14 RKL53
Mental health crisis services and health-based places of safety	Hammersmith and Fulham Mental Health Unit and community services Lakeside Mental Health Unit and Hounslow community services St Bernards and Ealing community services	RKL79 RKL14 RKL53
Specialist community mental health services for children and young people	Hammersmith and Fulham Mental Health Unit and community services Lakeside Mental Health Unit and Hounslow community services St Bernards and Ealing community services	RKL79 RKL14 RKL53
Community based mental health services for older people	Hammersmith and Fulham Mental Health Unit and community services Lakeside Mental Health Unit and Hounslow community services St Bernards and Ealing community services	RKL79 RKL14 RKL53
Community health inpatient services	Magnolia Ward, Clayponds Hospital	RKL4D

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for services at this Provider

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



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

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Summary of findings

Overall summary

We have rated West London Mental Health NHS Trust as **requires improvement** overall:

We have rated nine of the eleven core services that we inspected as requires improvement and the other two as good.

The trust requires improvement for the safe; effective; responsive and well led key questions. We have rated the trust as good for the caring key question.

The inspection took place at a time when the trust was going through considerable strategic change. They were in the process of transforming their adult inpatient services to reduce the number of people needing inpatient beds. This involved increasing services in the community. Since the previous inspection the trust had created a single point of access, enhanced assessment and treatment teams and a new primary care mental health service.

The trust was also working to improve existing care and the processes that support this. We were able to see many areas of improvement however, there was more to do and the changes needed to be embedded and sustained.

The main areas for ongoing improvement were as follows:

- The trust continued to have a problem with staff recruitment and retention. Since the last inspection recruitment had improved but many new staff were leaving within a year. This was having an impact on the care received by patients. The most significant concern was in the high secure services where access to therapeutic activities and time with staff and other patients was restricted. This was an ongoing concern from the previous inspection and as a consequence a warning notice was served.
- The trust had made improvements in the assessment, monitoring and treatment of patients' physical health. This had been implemented well in some areas but in others still needed to improve. For patients cared for in the community, trust staff did not always establish effective working links with GPs and other professionals providing support with the person's physical health care.

- The trust was not always able to provide a bed on an acute ward for patients who had a clinical need for this service. This meant that at times, patients on the acute ward were being asked to sleep on a rehabilitation ward. This was disruptive for people's care and potentially unsafe.
- Some inpatient environments where patients received care were of a poor standard. Since the last inspection, the new Three Bridges medium secure unit had opened which had improved the care for patients. However, for other patients especially on the St Bernards site being accommodated in the Wolsey and Tony Hillis Wings, despite some building improvements, their privacy and dignity was impacted by the poor inpatient environments.
- The trust had made changes to the governance processes but more was needed. This was to ensure that from board to ward the correct information was available in an appropriate format to support assurance processes and management. Where there were potential risks identified, clear actions needed to be in place and timescales for improvements to be made.

The trust had made progress in many areas since the previous inspection.

Four areas stood out as being very positive:

- We found that staff morale was greatly improved. Staff talked about how the culture of the organisation had changed and most people felt this was now much more open. The area where this change was most notable was in the West London forensic services. There were still some pockets where further work was needed.
- Blanket restrictions had been reviewed, involving staff and patients. This had looked at 'rules' that had been in place and whether they were needed for everyone in the service or just based on individual patient need. This had led to a large number of restrictions being reviewed and where appropriate reduced.
- More incidents were being reported and the trust had promoted a culture where staff understood the importance of doing this. A new online reporting

Summary of findings

system had been introduced. The trust had also carried out its own review of patient deaths following the Mazars report and had an ongoing process for reviewing all deaths.

- Work with other agencies and partners had progressed. The trust was working closely with commissioners. The new single point of access was working with GPs and hospital doctors, the police and paramedics, prison staff and members of the public as well as others.

There had been a number of changes in the leadership of the trust. The new chief executive was received positively across the trust. The senior leadership team at the time of the inspection was capable and had the potential to make the necessary improvements, although there was a great deal to be done.

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

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

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

- At the last inspection, staffing levels were not maintained and this had an impact on the quality of life of patients. At this inspection, staffing levels had significantly improved in many areas. However, some wards especially in high secure and some forensic wards did not manage to fill all their shifts and sometimes there were not enough qualified nursing staff available. Further work was needed to recruit and retain more staff, especially qualified nurses.
- Doctors providing medical cover out-of-hours were required to support a number of different wards and teams. Junior doctors said that this resulted in them being extremely busy at times and there was a risk particularly on the St Bernards site that they might not be able to meet the needs of patients in a timely manner.
- At the last inspection, some ward environments, were not in a good state of repair. At this inspection the Three Bridges medium secure unit had opened. However, for other patients especially on the St Bernards site being accommodated in the Wolsey and Tony Hillis Wings, despite some building work, their privacy and dignity was impacted by the poor inpatient environments.
- At the time of our last inspection, there were some blanket restrictions which had not been assessed according to the type of service and individual patient needs. At this inspection, considerable work had taken place involving staff and patients to review and reduce blanket restrictions. This had led to some well received changes. However, there was more to do to consider if other restrictions could be reduced based on individual needs, especially for patients using low secure or rehabilitation services. These included use of a personal mobile phones, routine searches when entering the ward for patients and visitors and access to the internet.
- At the last inspection, work was needed to improve the safety of some environments in relation high risk ligature points. At this inspection we found that considerable work had taken place to reduce ligature points, assess ward environments and identify higher risk areas, train staff to be aware of potential risks and assess patients. However, in a few areas we did find that the

Requires improvement



Summary of findings

ligature assessments did not reflect all areas of the ward and so the identification of risk was potentially incorrect. There were also a few very obviously high risk ligature anchor points on acute wards and on the Tony Hillis Wing.

- There were potential risks to patients from acute wards who slept on the rehabilitation wards when there were bed shortages. The ward environment contained ligature points and may have been unfamiliar to agency staff or staff accompanying the patient from their existing ward. Patients sleeping over also posed a potential risk of conflict to existing patients on the rehabilitation ward.
- At the last inspection, the completion of thorough individual patient risk assessments was mixed. At this inspection we found that work had taken place to improve staff training and the completion and storage of risk assessments in the patient records. However, in the forensic wards and acute wards there were examples of risk assessments that did not address all the areas of risk or where they had not been updated following an incident or a change in the persons needs. In the crisis assessment and treatment teams risk was being carefully considered by the multi-disciplinary team but the risk assessments in the appropriate section of the patient records were not updated, just notes made in the person's progress record. This meant there was the potential for staff to not be aware of the risks for that person.
- At the last inspection it was found that the trust needed to make a number of improvements in relation to the use of physical interventions. This included recognising the use of restraint and reducing prone restraint. At this inspection the trust had improved the recognition and reporting of physical interventions; improved training using the Prevention and Management of Violence and Aggression specialists working on wards; carried out specific work in high secure and forensic services to reduce physical interventions such as the use of the 'Safe Wards' initiative. At this inspection between January 2016 and the end of June 2016 restraint was used on 568 occasions. In 39% of these incidents, patients were restrained in the prone position.
- At the last inspection, some seclusion rooms were not in a good state of repair and did not afford the maintenance of patient dignity. At this inspection, most seclusion rooms with the exception of the one on Finch ward, were in a good state of repair but some were still located in areas that did not ensure confidentiality, privacy and dignity of the patient being

Summary of findings

secluded. In acute and high secure services 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.

- At the last inspection it was found that in some community based mental health services there were not clear systems for home working, which could compromise the safety of staff. At this inspection the protocol for home working had been reviewed; arrangements were in place across the teams and staff had been provided with lone worker devices that could track their location if needed. However, some staff did not know how to use the new devices and further training was needed.

However:

- More incidents were being reported and the trust had promoted a culture where staff understood the importance of doing this. A new online reporting system had been introduced, although this was new and teething problems were being addressed. The trust had also carried out its own review of patient deaths following the Mazars report and had an ongoing process for reviewing all deaths. Most teams said they had the opportunity to learn from incidents, although in a few areas this could improve.
- Staff had a good knowledge of safeguarding and the safeguarding team were able to identify areas of low reporting so that additional support could be provided where needed.
- Medicines were managed well across the trust with just a few areas for improvement.

Are services effective?

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

- Staff supervision was variable across the trust. Some staff were not having regular 1:1 supervision, the content of the supervision was inconsistent and did not always cover essential areas, the recording was also mixed with some being saved on the intranet and others as a written record.
- Whilst staff working in inpatient services were monitoring patients physical health, in forensic, rehabilitation, older peoples and acute services this was not always done accurately and there was a risk that nursing staff would fail to identify when a patients health was deteriorating. For patients cared for in the community, trust staff did not always establish effective working links with GPs and other professionals providing

Requires improvement



Summary of findings

support with the person's physical health care. On some acute wards staff did not consistently monitor patients' physical health when they were prescribed high doses of antipsychotic medication.

- In high secure services, 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. Also staff 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.
- On the wards for older people with mental health problems, staff did not demonstrate that they were consistently competent in applying the MCA in their practice. Some patients did not have a record of having their capacity assessed for decisions about their admission where they were described as having fluctuating capacity. There were examples of delays of some weeks before ward staff made applications for a deprivation of liberty to be authorised. Documentation relating to DoLS was poorly maintained. Limited support was provided to staff in relation to the MCA and DoLS. There were not robust systems in place to monitor adherence to the Mental Capacity Act. On the child and adolescent mental health ward we found that staff did not know how to assess whether a patient had 'Gillick' competence.
- On some wards for older people, acute wards and adult community mental health services access to psychological therapies was limited, which impacted on the ability of the trust to deliver treatment in line with NICE guidance.

However:

- The induction and ongoing training was valued by staff and improving the quality of care. Staff were mainly well supported in their teams and there were opportunities across the trust for reflective practice.
- There were many positive examples of multi-disciplinary teams working together to support patients and also of teams working together as patients moved between the services.
- The trust was implementing the Mental Health Act and its code of practice well in most areas.

Summary of findings

Are services caring?

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

- Staff were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard-working, caring and compassionate staff.
- People and where appropriate their carers, were usually involved in decisions about their care. The trust was using the 'triangle of care' to understand the needs of carers.
- Opportunities were available for people to be involved in decisions about their services and the wider trust.
- The trust was working to ensure engagement with patients and carers, especially through its ongoing work with the West London Collaborative.

However:

- In rehabilitation mental health wards and wards for older people with mental health problems we found some examples where the dignity of patients was compromised. For example on Glyn ward glass viewing panels in bedroom doors had exterior curtains that could be opened by people in the corridor, allowing them to see into bedrooms and patients queued at a hatch for their medications which were called out by nurses, meaning that patients knew which medications others were taking. In some wards for older people with mental health problems we also observed interactions that were task orientated and instructional.

Good



Are services responsive to people's needs?

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

- As the last inspection, there were not sufficient staff in high secure services to ensure patients could access therapeutic and recreational activities. 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. This had not improved from the previous inspection and so a warning notice was served.
- At the last inspection, acute patients were sleeping on other wards as a result of bed pressures. During this inspection, this continued to take place and there had been 68 incidents of patients sleeping on other wards between 1 May and 31 October 2016.

Requires improvement



Summary of findings

- At the last inspection there were long waiting lists for psychological therapies in community mental health services for adults. At this inspection, no improvement had been made and waiting lists for psychology had become longer. The longest wait was 24 months in Ealing. In the specialist community mental health services for children and young people, some teams had internal waiting lists of over 18 weeks between an assessment and the start of their psychological therapy treatment.
- The trust data for the time taken for patients to be seen following emergency, urgent and routine referrals indicated that the crisis, assessment and treatment teams were on occasion, failing to meet their targets by a considerable margin, indicating that patients were waiting too long to be seen.
- Patients on rehabilitation wards were not being offered opportunities to develop skills associated with preparing for their rehabilitation. For example patients were not able to routinely self-cater or administer their own medication. There were also a significant number of patients who were not accessing vocational or educational opportunities.
- The food in the forensic wards at the Tony Hillis Wing was of poor quality and the portions were too small.
- Some ward environments did not meet the needs of patients. For example on all the forensic wards on the Tony Hillis Wing, the patients had to share bathrooms and toilets and sometimes there were too few for the number of patients on the wards. On Solaris ward, for example, there were two toilets for 16 patients which were situated in the bathroom and shower room. Patients on Finch, Hope and Horizon acute wards all said that their ward could be noisy and unsettled. Staff on Hope and Horizon said that the long, narrow layout of these wards was unsuitable for patients' needs and did not provide sufficient communal space. On the Wells unit for children and young people the ward environment was not laid out in a homely way as the sofa chairs were seated in rows in the communal area. Wards for older people with mental health problems were not sufficiently dementia friendly.
- Some community team environments needed improvements. For example at the Hammersmith and Fulham CAMHS there were not enough therapy rooms and the lighting and alarm system was disruptive. Also the lift providing external access for disabled people was not operating reliably.

However:

Summary of findings

- The recently opened 'single point of access' was improving access for patients and carers as well as care professionals.
- Patients and staff had a good understanding of the complaints process and learning was taking place.
- The trust supported very diverse communities and a range of arrangements were in place to meet patients' individual needs.

Are services well-led?

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

- The inspection found that whilst there were processes in place to manage risk and monitor performance these could be more robust. The trust brought together a range of indicators for the board in an integrated performance report. There was scope for this to be reviewed to include other information to provide the board with assurance on areas needing improvement. For example the report could include data around the use of physical interventions.
- The board assurance framework described the risks and monitored the progress with reaching an improved rating. This did not include details of what controls or actions were taking place to deliver the improvements. It also did not indicate whether these actions were completed within an acceptable timescale.
- At the last inspection, at a ward or team level the use of information to monitor the service or make improvements was very variable. At this inspection, there were variations between the different clinical service units and lines in terms of how information was provided to support managers. In addition, some more experienced managers were better at understanding how to find and use information to support their role. Examples of this were seen in some services where managers were unclear about admissions and discharges, whether they were meeting targets, waiting lists for services and numbers of patients with delayed transfers of care. Another example related to wards who were working to reduce physical interventions where they did not know how many seclusions or restraints had taken place and what the trend was over the last few months. We also had concerns about some data quality such as staffing shortages and patients having their therapeutic activities or leave cancelled where staff were not always

Requires improvement



Summary of findings

reporting this. The result of this was that managers may not recognise and make improvements in a timely manner. There was also a risk that the board may not be getting accurate data on which to gain assurance.

- Some of the key areas of work undertaken by the trust were supported by very few staff. Examples of this included management of incidents and complaints, audits and user involvement. This was potentially impacting on the capacity and capability to complete or develop the work in a timely manner and ensure good learning across the trust.
- The trust had not completed all the necessary fit and proper person checks.

However:

- Staff throughout the trust understood the trust's vision and values and how they could put these into practice in their work.
- There had been a number of changes in the leadership of the trust. The new chief executive was received positively across the trust. The senior leadership team at the time of the inspection was capable and had the potential to make the necessary improvements, although there was a great deal to be done.
- Significant work has taken place to improve staff engagement and morale. This had led to positive changes, especially in the West London forensic services, although there were still pockets of poor morale to address.
- The trust was working to stamp out discrimination and improve career progression for staff from black, minority ethnic backgrounds.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott, Deputy Chief Inspector (and lead for mental health), Care Quality Commission

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

The team of **73** people included:

17 CQC inspectors

2 CQC pharmacist inspectors

6 CQC assistant inspectors

5 Mental Health Act reviewers

1 inspection planner

3 CQC data analysts

4 CQC staff who joined the inspection for their development

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

7 allied health professionals

9 nurses from a wide range of professional backgrounds

5 doctors including the Principal Second Opinion Appointed Doctor

3 social workers

4 people with governance experience

Some of the team just joined for a few days to inspect specific services.

Why we carried out this inspection

We undertook this comprehensive inspection to find out whether West London Mental Health NHS Trust had made improvements to their services since our last comprehensive inspection of the trust that we undertook in June 2015. Following that inspection, we rated the trust as **requires improvement** overall.

When we inspected the trust in June 2015, we rated forensic inpatient services as inadequate overall. 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 forensic inpatient services:

In 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.

In medium and low secure forensic services:

- The trust must ensure that staffing levels are maintained to guarantee the safety of patients and staff and that the lack of staff does not have a significant impact on the quality of life of patients in the service in terms of access to therapeutic activities, escorted leave and meetings with named nurses. Staff must not work excessively long hours.
- The trust must ensure that all seclusion facilities are in state of adequate repair and consideration is given to the maintenance of the patients' dignity when using the facility.
- The trust must ensure that restraint and seclusion are appropriately recognised, only used when needed and recorded so that their use can be reviewed.

Summary of findings

- The trust must review blanket practices across the wards to ensure these only take place where needed and that as far as possible practices reflect individual patient need.
- The trust must ensure that where patients are prescribed medication above the recommended dose, that the national guidance is followed.
- The trust must ensure that more targeted work takes place to address the complex issues affecting staff engagement so that communication between management within the service and members of staff is facilitated. This is to improve morale and ensure that staff feel comfortable raising concerns with their managers and the senior managers in the organisation.

When we inspected the trust in June 2015, we rated acute wards for adults of working age and psychiatric intensive care units as requires improvement overall. We rated this core service as inadequate for safe, requires improvement for effective, good for caring, good for responsive and requires improvement for well-led.

Following the June 2015 inspection, we told the trust it must make the following actions to improve the acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that the use of rapid tranquilisation medication is clearly stated on patients' medication charts and that the necessary physical health checks take place and are recorded after this medication has been administered.
- The trust must ensure all fittings in the ward are included in ligature audits and where needed that works are completed. It must ensure that, on the psychiatric intensive care unit, patients' personal items which may present a ligature risk to other patients are appropriately stored when not in use.
- The trust must ensure that medicines are managed and administered safely.
- The trust must ensure that seclusion rooms are located so that they can be used safely and accurate records must be available when seclusion is used and of the checks done whilst the patient is in seclusion.

- The trust must ensure that staff clearly understand the incident reporting thresholds and report all incidents.
- The trust must ensure that patients have their physical health care needs assessed and ongoing checks where needed.
- The trust must ensure governance processes are working effectively to identify areas for improvement to support patient safety.

When we inspected the trust in June 2015, we rated the wards for older people with mental health problems as good overall. We rated this core service as requires improvement for safe, good for effective, good for caring, good for responsive and good for well-led.

Following the June 2015 inspection, we told the trust it must make the following actions to improve wards for older people with mental health problems:

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

When we inspected the trust in June 2015, we rated the community based mental health services as requires improvement overall. We rated this core service as requires improvement for safe, requires improvement for effective, good for caring, good for responsive and good for well-led.

Following the June 2015 inspection, we told the trust it must take the following actions to improve community based mental health services:

- The trust must ensure that there are a sufficient number of suitably qualified staff so that patients have a care co-ordinator rather than being held by duty staff and junior doctors are not holding large caseloads of patients, which creates a risk to the safety and welfare of patients. Recovery team patients must have a named clinician responsible for their care and treatment.
- The trust must ensure that patients have personalised crisis plans that reflect their individual circumstances and must ensure these are up to date. These must be stored in patient records where they can be found quickly by all staff.

Summary of findings

- The trust must ensure that the premises used by staff and patients are safe. The provider must ensure that staff safety alarms work and can be heard in an emergency
- The trust must ensure that accurate and complete patient care records are maintained.
- The trust must ensure that staff are trained to meet the specific needs of older patients.

When we inspected the trust in June 2015, we rated the mental health crisis services and health based places of safety as requires improvement overall. We rated this core service as requires improvement for safe, requires improvement for effective, good for caring, good for responsive and requires improvement for well-led.

Following the June 2015 inspection, we told the trust it must make the following actions to improve mental health crisis services and health based places of safety:

- The trust must ensure that the physical environment and the clinical practice relating to detentions under section 136 at Lakeside are in line with the Mental Health Act code of practice.
- The trust must ensure that accurate, detailed and consistent records are kept in respect of people's care including updating risk assessments.
- The trust must ensure that staff in the home treatment teams receive regular supervision.

- The trust must ensure that governance systems are implemented to ensure the home treatment teams are working consistently and safely to meet the needs of people using the service.

We also said trust wide that the trust must work to reduce the variation in the use of restraint and the high numbers of prone restraint.

The other core services were good overall.

We issued the trust with twelve requirement notices following the inspection in June 2015.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014: regulation 9 person centred care, regulation 12 safe care and treatment, regulation 13 safeguarding service users from abuse, regulation 15 premises and equipment, regulation 17 good governance and regulation 18 staffing.

Since the last comprehensive inspection, we carried out a focused inspection in August 2016 of the female forensic services in West London at The Orchard. The purpose of this inspection was to find out if improvements had been made since the last inspection in June 2015. This found that improvements had taken place, although there was more to do. This inspection did not rate the services. We also carried out a focused inspection of the gender identity clinic in January 2016. This was not rated and also identified the need for improvements especially to improve waiting times and ensure the administrative arrangements for appointments go smoothly.

How we carried out this inspection

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

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

Before the inspection visit the inspection team:

- requested information from the trust and reviewed the information we received

- asked a range of other organisations for information including NHS Improvement, NHS England, clinical commissioning groups, Healthwatch, overview and scrutiny committees, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups
- sought feedback from patients and carers through attending nine focus groups and meetings
- received information from patients, carers and other groups through our website

During the announced inspection visits from the 7-11 November 2016 and from further short notice announced visits the following week the inspection team:

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- visited **70** wards, teams and clinics
- spoke with **295** patients and their relatives and carers who were using the service
- collected feedback from **389** patients, carers and staff using comment cards
- spoke with the managers or acting managers for each of the **70** wards and teams
- spoke with **473** other staff members; including doctors, nurses and social workers
- attended and observed **58** hand-over meetings and multi-disciplinary meetings
- joined care professionals for eight home visits
- attended **20** focus groups at the trust headquarters and Broadmoor attended by **234** staff
- interviewed seven senior executive and board members
- looked at **480** treatment records of patients
- carried out a specific check of the medication management across a sample of wards and teams
- looked at a range of policies, procedures and other documents relating to the running of the service
- requested and analysed further information from the trust to clarify what was found during the site visits

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

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults

- Forensic inpatient/secure wards
- Other specialist services (high secure wards)
- Wards for older people with mental health problems
- Child and adolescent mental health wards
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community-based mental health services for older people
- Specialist community mental health services for children and young people

The team that inspected the community health services at the trust inspected the following core services:

- Community health inpatient services.

The community health service at Magnolia ward at Clayponds Hospital is new and is part of Home ward Ealing an integrated intermediate care service. This was inspected for the first time as part of this trust.

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

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

Information about the provider

West London Mental Health NHS Trust provides mental health services to a population of 700,000 people for local services and a wider population for specialist services. The trust supports adults, older people and children in the boroughs of Ealing, Hammersmith & Fulham and Hounslow. They also provide specialist community mental health services to children and young people in the London borough of Brent. The forensic mental health services provide a medium and low secure service to male patients from North West London. The male adolescent medium secure unit and women's enhanced medium secure

services have a national catchment area. The high secure services at Broadmoor, located in Berkshire, have a catchment of London and the south of England. Two other specialist services provide a national service.

Since the last inspection, the trust has started to offer integrated physical and mental health services. This has included Home ward intermediate care services and One You Ealing which has a focus on health promotion.

The trust has an annual turnover of £233 million, employs 3276 staff who support 62,570 patients each year at 25 main sites and in the community. Since the last inspection, the Three Bridges medium secure campus on the St

Summary of findings

Bernard's site has opened. The redeveloped Broadmoor is due to open in 2017. The trust works in a complex commissioning environment, with services commissioned on a local and national level.

The trust has eight locations registered with CQC.

What people who use the provider's services say

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

- A meeting of the West London Collaborative
- Women's forensic user group
- Men's forensic user group
- Hounslow carers 4 carers
- Ealing carers support group
- CAMHS user group
- Ealing, Hammersmith and Fulham Mind
- Hounslow dementia carers group
- Ealing newly diagnosed dementia support group

During the inspection the teams spoke to 295 people using services or their relatives and carers, either in person or by phone. We received 389 completed comment cards of which 209 were positive, 102 negative and 78 mixed. We also received individual comments from people through our website or by phone.

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

- Most staff were kind, supportive, tried to listen and meet people's needs, professional and helpful. Nursing and reception staff were regularly mentioned.
- People commented that they found their care and treatment helpful.
- There were positive comments about cleanliness in most places.
- There were positive comments about the food in some places.

- The therapeutic activities were valued in some areas such as Askew ward.
- Good support with medicines in some areas such as Meridian ward.

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

- The most negative comments were about the impact of staff shortages especially in the forensic services and Broadmoor and the impact this had on safety, activities being cancelled and leave not taking place as planned.
- We heard about the acute wards being very busy and noisy and patients feeling unsafe.
- There were comments about the recovery teams – long waits in reception for appointments, and appointments being repeatedly cancelled.
- There were a few comments about poor staff interactions with people using the service including staff not introducing themselves, cutting in conversations, or patients struggling to understand staff where the staff speak English as a second language.
- Some places mentioned shortages of therapy staff such as Magnolia ward or the need for more stimulating activities such as Mott House.
- Some comments said areas are unclean at times, especially bathrooms and toilets and also mentioned infestations of insects.
- There was also feedback about personal possessions being lost or stolen.

Good practice

Trust wide

- There had been innovative practice in terms of medicines management. For example a summary care record had been introduced which gave staff rapid access to an abbreviated GP record, detailing all the

medication prescribed by the patients GP and known allergies. There had also been the development of a leaflet about the use of unlicensed medicines to support discussions with patients.

Summary of findings

- The prevention and management of violence and aggression specialist team provided training and support on the wards. The training was delivered in collaboration with people who have used trust services. The training manual had been endorsed by the National Institute for Health and Care Excellence.

High secure wards

- 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 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.

Forensic inpatient wards

- The forensic wards had made significant progress in reducing the use of blanket restrictions. Staff had undertaken this work in partnership with patients. Patients were very positive about the changes which had taken place.

Community based mental health services for older people:

- The clinical trials unit contributed to staff development by arranging regular learning events. The unit also gave carers and patients the opportunity to participate in research programmes if they wished.

- There were effective arrangements to provide peer support to carers through their engagement in groups provided by the cognitive impairment and dementia services (CIDS) and other agencies.
- The trust's recovery college provided courses on dementia which were open to patients and carers.
- In partnership with other agencies, the CIDS had developed the new link worker role in Ealing and Hounslow. This initiative aimed to increase capacity within the CIDS teams for new assessments whilst ensuring patients and carers received support.

Specialist community mental health services for children and young people:

- The service had created a care plan document with young people who had used the service. This was written in clear language aimed at the young person, rather than clinician. It included areas for the young person to outline their personal goals, as well as treatments and risks. The consent to treatment section was very clear and included a space for a young person, or their parent if applicable, to sign it. Each section of the document was explained clearly and set out in a simple way.
- Hounslow CAMHS had specialist teachers who worked with children and young people experiencing difficulties at school relating to their mental health needs. They were able to work with young people at their school or at the CAMHS office and could support parents and school teachers as well.

Crisis mental health services:

- At the Hounslow crisis assessment and treatment team a staff member was working to improve patients' self esteem and fitness. He provided a role model for young men, encouraging regular gym attendance, and supporting people to remain drug free. He had supported one patient to start college.
- The Ealing crisis assessment and treatment team arranged a 'crafternoon' in every month, during which they would make items to sell and donate profits to MIND. This team also had a support worker who had taken on the role of physical health champion, and was also leading on smoking cessation therapy and mindfulness. He wrote to patients' GPs to inform them of progress, and had designed a new form for communicating findings effectively.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

Trust wide:

- The trust must continue to work to reduce the variation in the use of restraint and the numbers of prone restraint used across the trust.
- The trust must ensure the processes for staff supervision are implemented consistently across the directorates, to ensure this happens regularly, covers the appropriate areas for discussion and is recorded for future reference.
- The trust must ensure all the fit and proper person checks are in place for board members.
- The trust must review the arrangements for ward and team managers to receive timely, accurate information, presented in a meaningful format to support them with the management of their areas of responsibility.

High secure wards:

- The trust must ensure that there are sufficient qualified and experienced staff on the wards.
- 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 ensure that patients have access to activities and therapeutic engagement according to their care plans. This is subject to a warning notice.
- 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.

Forensic services:

- The trust must look at how the privacy and dignity of patients using the seclusion rooms in the Tony Hillis Wing can be further improved and ensure clocks are provided in all seclusion facilities.
- The trust must continue to look at how blanket restrictions can be addressed further especially for patients using the low secure services. This includes reviewing the use of mobile phones, access to the internet and routine searches especially linked to the smoke free initiative.
- The trust must continue to ensure staffing levels and the staff ratios of qualified and unqualified nurses are maintained and that the impact on the quality of life of patients, especially their access to leave is accurately monitored.
- The trust must look at the physical environment in the Tony Hillis Wing to see if changes can be made to improve the safety and quality of the environment. This includes the reduction of ligature anchor points and access to sufficient toilets and bathroom facilities.
- The trust must ensure patients in seclusion are reviewed by the appropriate professionals at the intervals indicated by the Mental Health Act code of practice. If a decision is made at night to not follow the guidance in the MHA Code of Practice in terms of a clinical review taking place in person, the reasons must be recorded.
- The trust must ensure that the national early warning scores are correctly completed, collated and calculated so that a patient whose physical health is deteriorating is identified in a timely manner.
- The trust must ensure that all staff receive adequate supervision and that there are systems in place to monitor this.
- The trust must ensure that the medical equipment used for the care of patients is in date and appropriate for use.
- The trust must ensure that patients on the Tony Hillis Wing have enough good quality food to eat.

Acute wards for adults and psychiatric intensive care unit:

Summary of findings

- The trust must ensure that sufficient beds are available for patients on each ward and patients are not admitted to one ward and then sleep on another ward during their admission.
- The trust must ensure that at the Hammersmith and Fulham mental health unit and Lakeside seclusion rooms are located so they can be used safely and that patient transfer to seclusion facilities does not compromise the patient's privacy and dignity.
- The trust must ensure that the seclusion room on Finch ward is clean and well maintained.
- The trust must ensure that the new ligature management policy is fully applied and comprehensive ligature audits for each ward and clear actions when the need for further improvements are identified.
- The trust must address the risks presented by the blind spots on Kestrel ward.
- The trust must ensure that Lillie ward is clean and all the furniture and fittings are well maintained.
- The trust must review the junior doctors out of hour's rotas to ensure the workloads are safe.
- The trust must ensure patient risk assessments are updated following incidents.
- The trust must ensure that action is taken whenever high temperatures are recorded on refrigerators to ensure medication is in an appropriate state to use.
- The trust must ensure that supervision and appraisals are completed and fully recorded. Managers must be able to assess both the competency of all staff and appropriateness of the supervision provided.
- The trust must ensure that ward managers have sufficient clear and accurate information to monitor the quality of services being delivered.
- The trust must ensure that staff at Glyn ward have access to regular supervision and appraisals.
- The trust must promote the privacy and dignity of patients at Glyn ward by ensuring that patient confidential information is out of public view, medications are administered in a dignified fashion, and viewing panels to bedrooms are only able to be opened by authorised staff when absolutely necessary and that patients can obtain keys to their bedrooms when appropriate.
- The trust must ensure that the wards offer opportunities for rehabilitation. For example they should improve access to educational and vocational opportunities, self-catering and the ability to self-administer medication.
- The trust must continue to work to improve staff engagement across the two rehabilitation wards. They must develop an open and supportive culture for staff at Mott House so that they feel able to raise concerns without fear of victimisation, and continue to improve staff engagement at Glyn ward.

Rehabilitation mental health wards:

- The trust must review the blanket restriction of searching all patients when they return from leave which was a consequence of the implementation of the smoke free policy.
- The trust must stop the practice of acute patients sleeping over on the rehabilitation wards. This is a potential risk to the acutely unwell patients and could also present a risk for the patients receiving rehabilitation care.

Wards for older people with mental health problems:

- The trust must ensure that staff are competent and confident in applying the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in their practice. Staff must be able to access appropriate support and guidance when applying the MCA and DoLS to individual patients. Accurate records relating to DoLS must be maintained and must be accessible to staff. Systems must be in place to ensure the correct implementation of this legislation.
- The trust must ensure that staff provide care in a way that recognises patient's individual needs and promotes their dignity and privacy.
- The trust must ensure that the ward environment and information provided to patients meets the needs of patients with dementia or other cognitive impairments.
- The trust must ensure that governance processes are robust, with a range of timely information available for ward managers to support their management role.

Child and adolescent mental health ward:

Summary of findings

- The trust must ensure all staff receive mandatory training in the Mental Capacity Act, ensuring the training includes the assessment of Gillick competence for young people.
- The trust must ensure staff on The Wells Unit have access to specialised training around providing care and treatment for patients in a forensic CAMHS setting.
- The trust must ensure they address ward maintenance issues, including fixing the shower which had been broken for over a year, which meant all the patients had to access one working shower. They must ensure all other repairs take place in a timely manner.

Specialist community mental health services for children and young people:

- The trust must ensure the systems for feedback and learning from incidents is effective.
- The trust must ensure there is a system in place to ensure medical and emergency equipment is regularly reviewed.
- The trust must ensure all clinic environments meet the needs of service users.
- The trust must ensure team managers have access to timely and accurate management information to support their role.
- The trust must continue to work to improve staff engagement across CAMHS.

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

- The trust must ensure all patients supported by the crisis assessment and treatment teams have thorough risk assessments, that are updated when needed and are easily accessible for staff.
- The trust must ensure that further improvements to governance systems are implemented to ensure the crisis assessment and treatment teams are working consistently and safely to meet the needs of patients and enable improvements to the service.
- The trust must ensure that there are systems in place to monitor the referral to assessment times for patients using the crisis assessment and treatment teams. Managers must have access to this information to ensure they are meeting the targets.

Community based mental health services for adults of working age:

- The trust must ensure that staff monitor and record patients' physical health consistently and on an on-going basis so that their physical health needs can be met.
- The trust must ensure that patients in the recovery teams are able to access psychological therapies in a timely manner.
- The trust must ensure all staff receive a performance appraisal annually.
- The trust must ensure that all staff at Ealing recovery team west receive one to one managerial supervision on a regular basis.
- The trust must ensure clear performance data is available and accessible to service and team managers so that they can clearly identify how to make improvements in services.

Community health inpatient services:

- The trust must ensure that all staff receive regular supervision and that this is recorded.

Action the provider SHOULD take to improve

Trust wide:

- The trust should continue to work towards the number of incidents being reported increasing, investigations being completed on time and for root cause analysis to be undertaken at a consistently high standard. The trust should also resolve the teething problems associated with the new incident reporting system.
- The trust should continue to work to improve the retention of staff. This should include trying to get a better understanding of why people are leaving, especially within the first year of employment, for example through the use of analysed exit interviews.
- The trust should ensure there are sufficient staff to support the programme of audits and that the results lead to improvements that are used by managers across the trust and are monitored by the board.
- The trust should continue to embed the new portals in the electronic patient record system to ensure staff know where to record information so it can be located with ease when needed.
- The trust should increase the number of peer workers employed by the trust.

Summary of findings

- The trust should extend the number of volunteers with lived experience of using services participating in co-production work with the trust.
- The trust should continue the work to embed the carer's 'triangle of care' approach to ensure carers are adequately informed, involved and supported.
- The trust should continue to improve the timeliness of the response to complaints and ensure complainants are always informed of their right to take the complaint to the ombudsman if they are not satisfied with the response.
- The trust should review if they have sufficient staff to support work in areas like complaints, incidents and user involvement.
- The trust should continue to improve staff engagement, for example with the junior doctors who felt they could participate and contribute more.
- The trust should review the integrated performance dashboard to ensure it covers all the needed areas and that the information is presented as well as possible.
- The trust should ensure the board assurance framework provides a summary of the actions taken to reduce the risks, with timescales are monitored.
- The trust should ensure feedback from non-executive director visits is collated and used as part of the assurance process.

High secure wards:

- 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.

Forensic services:

- The trust should ensure that systems are in place to ensure the safety of staff and patients. When panic alarms are pressed, staff should receive the necessary assistance quickly. The trust should ensure that staff raise incident reports every time they do not get adequate or timely assistance.
- The trust should ensure that plain English without jargon is used in patient care plans.

- The trust should ensure that patients with a learning disability have access care plans and other information in accessible formats where needed.
- The trust should take steps to address the morale of doctors in the men's medium and low secure services.

Rehabilitation mental health wards for working age adults:

- The trust should ensure maintenance and repairs are carried out in a timely way at Glyn ward and that maintenance equipment is stored appropriately at Mott House.
- The trust should ensure cleaning cupboards are kept tidy; contain the right equipment and that toilet areas are kept clean at all times.
- The trust should ensure incident data can easily be accessed by ward staff to facilitate staff learning and that staff are updated about investigations into incidents and the learning from them.
- The trust should ensure full consideration is given to safeguarding issues and whether alerts should be made to the local authority.
- The trust should continue to review whether restrictions can be reduced, such as access to snacks, bedroom keys and searching people where there are concerns they are bringing tobacco onto the ward.
- The trust should ensure that the trust uses outcome measures and other systems of assurance to ensure patients are making progress with their rehabilitation.
- The trust should ensure the psychologist on both wards is replaced as soon as possible.
- The trust should ensure physical health documentation is consistently stored in the same location in the patient records at Mott House.
- The trust should ensure staff have an understanding of Deprivation of Liberty Safeguards.

Community based mental health services for older people:

- The trust should ensure that the teams continue to implement actions to ensure nurse caseloads comply with the trust target.
- The trust should ensure there are clear actions in place in relation to improving the safety and suitability of the premises used by the Hammersmith and Fulham team.
- The trust should ensure that all staff receive supervision in line with trust policy.

Summary of findings

- The trust should ensure that action is taken to ensure waiting times for assessments do not exceed the agreed target of six weeks.

Wards for older people with mental health problems:

- The trust should ensure that wards are well decorated, well maintained and free from odours.
- The trust should ensure that ward environments meet the needs of patients, for example by providing alarms that patients can reach and appropriate shower facilities.
- The trust should ensure that staff are appropriately trained and competent in all areas of their practice, for example, ensuring that appropriate action is taken in response to the results of physical health checks.
- The trust should ensure that there is sufficient psychology resource for patients who need this input as part of their treatment.
- The trust should ensure that where patients' personal possessions or clothing goes missing that this is addressed.
- The trust should continue to work to improve staff morale.

Acute wards for adults and psychiatric intensive care unit:

- The trust should continue to recruit permanent staff to reduce the use of temporary staff and further improve consistency of care.
- The trust should ensure clinical equipment is well maintained and calibrated where needed so it provides accurate readings.
- The trust should ensure that care plans for patients on recovery wards focus on recovery and support patients in developing the skills they will need when they are discharged.
- The trust should ensure that steps are taken to mitigate the risks associated with prescribing high dose anti-psychotic medication and patients' physical health is monitored.
- The trust should ensure that patients have access to psychology services.
- The trust should ensure that staff completing national early warning score charts have sufficient skills and expertise to respond to deterioration in physical wellbeing.

- The trust should ensure that admissions to hospital are a positive experience for patients and that this is reflected in feedback. The trust should also involve patients in decisions about the development and running of the wards.
- The trust should ensure that staff avoid using medical jargon in care plans and treatment. The trust should ensure that staff speak to patients in a way patients can understand.
- The trust should aim to reduce the number of patients being placed outside their area during an admission.
- The trust should work with partners to continue to reduce the number of discharges that are delayed for non-clinical reasons.
- The trust should ensure that where needed, interpreters are arranged for individual patients.

Child and adolescent mental health ward:

- The trust should ensure staff document the length of time a patient is restrained for and type of restraint.
- The trust should ensure the work is completed so patients in seclusion are able to use the bathroom facility without having to wait for staff to unlock the bathroom door on request.
- The trust should ensure staff complete exit care plans for patients using seclusion.
- The trust should ensure staff plan patient CPAs appropriately, the meeting is structured and the necessary reports from the MDT are available during the meeting.
- The trust should continue to work with the team to further improve staff engagement.

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

- The trust should ensure that staff inform all patients admitted to the places of safety of their legal rights and record that they have done this.
- The trust should ensure, where there is delay in the assessment of people admitted to the places of safety that exceeds the limit set by the policy of the trust, that staff record the reason for this delay.
- The trust should ensure that staff working in the crisis assessment and treatment teams follow the trusts lone working protocols.

Summary of findings

- The trust should review storage arrangements for medicines at the Hammersmith and Fulham crisis assessment and treatment team to ensure that medicines are stored safely at an appropriate temperature and this is monitored.
- The trust should ensure that all staff in the crisis assessment and treatment teams receive relevant training for example, working with people at risk of suicide, or with substance misuse issues or eating disorders.
- The trust should review the caseloads of each crisis assessment and treatment team to ensure that this can be managed safely.
- The trust should monitor any missed appointments by the crisis assessment and treatment teams, or by patients, so that appropriate action can be taken for patients' safety.
- The trust should ensure that all staff have annual appraisals of their performance.
- The trust should ensure the crisis, assessment and treatment teams have formal ways to collect regular feedback from patients to improve service provision.
- The trust should try and improve the consistency of staff supporting patients using the crisis assessment and treatment teams.
- The trust should look at ways of improving staff morale across the crisis assessment and treatment teams.

Specialist community mental health services for children and young people:

- The trust should ensure that staff record when cleaning toys and resources has taken place and have a system in place to monitor this.
- The trust should ensure all staff know how to respond to a raised alarm in the therapy rooms.
- The trust should ensure mandatory training is completed.
- The trust should work to improve the patient record system to move away from multiple records and ensure information is recorded consistently so it can be located when needed.
- The trust should continue to roll out the new young person care plan format and to record the involvement of the young person and their family in the care planning process.

- The trust should ensure staff complete their appraisal and supervisions are recorded consistently and to a high standard.
- The trust should ensure training on the MCA includes Gillick competency for staff working with young people.
- The trust should ensure that consent to treatment and consent to share information is recorded.
- The trust should ensure staff know about local advocacy services so they can pass this information to young people when needed.
- The trust should continue to work with commissioners to reduce waiting times for neuro-developmental services, reduce waiting times for access to psychological therapies and ensure that young people are supported to attend their initial assessment within 18 weeks.

Community based mental health services for adults of working age:

- The trust should ensure initial and on-going training takes place for mental health support workers on the support and information telephone line in the single point of access team.
- The trust should take steps to reduce the number of patients who do not attend their appointments across all teams
- The trust should continue to encourage all staff to use their lone worker devices when conducting home visits or appointments outside of the office.

Community health inpatient services:

- The trust should ensure that staff on Magnolia ward have access to regular team meetings.
- The trust should ensure that ongoing work takes place to engage staff and keep them informed especially while the service is going through further review and change.
- The trust should ensure that the service moves towards well organised patient records without a combination of paper and electronic records.
- The trust should ensure that managers have access to clearly presented performance information about all aspects of the service in an easy to understand format to inform their management work.

West London Mental Health NHS Trust

Detailed findings

Mental Health Act responsibilities

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

The trust's systems supported the implementation of the Mental Health Act 1983 (MHA) and its Code of Practice. There was a head of mental health law who managed the Mental Health Act administrators and reported to the trust board through the committee system. The executive lead was the director for nursing and patient experience.

The Mental Health Act Law and Deprivation of Liberty Safeguards (DoLS) Committee reported directly to the trust board and was responsible for strategy and the analysis of trends in activity. Operational issues relating to the Mental Health Act and Mental Capacity Act were overseen by the Quality Matters Committee which in turn reported to the Quality Committee.

There were twenty associate hospital managers who considered the power to discharge under section 23 of the MHA. This function was overseen by the Mental Health Act Manager's Committee which was led by the chair of the trust. There were MHA administrators at each of the trust's inpatient sites. Administration of the MCA and the DoLS was also supported by the head of mental health law.

The Mental Health Act Law and DoLS Committee arranged for the completion of a number of audits each quarter. Recent audits highlighted significant issues. Seventy per cent of patient files scrutinised for one audit did not have evidence of thorough assessments of capacity to consent

to treatment upon admission. We also found this to be the case when we looked at this in detail at Broadmoor. There had been seven episodes of unlawful detention reported in 2015/16 and a further six episodes were reported in the current year. A backlog of MHA Manager's hearings had built up in respect of renewals of detention. There had been 76 such hearings outstanding at one point and this had been reduced to 46. The number of MHA administrators relative to the number of detained patients was significantly less than in some other London trusts and this may have contributed to the backlog of MHA Managers hearings.

Awareness of the MHA was part of mandatory training. Further training was provided on a variety of subjects available to staff via classroom sessions advertised on the intranet. The MHA administrators also provided some training locally. Staff had a good awareness of the MHA and Code of Practice.

The trust had reviewed all its policies and procedures to make them compatible with the Code of Practice. MHA activities were seen as integral to all other policies and procedures.

During this inspection, we completed ten Mental Health Act review visits pursuant to the CQC's duty under section 120 of the Act. We found evidence that detention paperwork was completed correctly, was up to date and was stored appropriately.

We found copies of consent to treatment forms were attached to medication charts where applicable. At Broadmoor we looked at this in detail and found that staff in the hospital were not robustly recording assessments of capacity relating to capacity to consent to treatment in a

Detailed findings

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.

There was evidence that most patients had their rights under the Mental Health Act explained to them. However on two of the wards we visited at Broadmoor it was not clear that all patients had been regularly reminded of their rights.

At Broadmoor we found that patients who were subject to long term segregation for over three months were not consistently being reviewed by a doctor from an external hospital every three months as indicated in the Mental Health Act Code of Practice. We also found that patients in forensic services who were in seclusion for longer periods of time did not have a record of having the appropriate reviews.

At Broadmoor we were told of ongoing work to reduce the use of long term segregation with complex patients. Staff on Ascot ward had had a paper published in an American psychiatric journal regarding the innovation and pragmatism required to reduce the use of seclusion.

We met with approved mental health professionals (AMHPs) from the London Borough of Hammersmith and Fulham. The major issue that the AMHPs raised was a continuing problem with identifying beds to which detained patients could be admitted. This had led to some instances of AMHPs being left with detained patients in the community waiting for beds to be found. They felt that this was unsafe. They acknowledged that an escalation process for the identification of beds had just been introduced but were concerned that possible further bed reductions were planned. The AMHPs also expressed frustration that assessments under the Act frequently took place with two doctors from the local section 12 list because trust doctors were unavailable. They pointed out that this was a very expensive process for the trust. They also expressed concern that many patients were discharged before formulations and care plans were completed and that they often received requests to attend discharge CPA meetings at such short notice that they could not comply. However the AMHPs felt that they had a robust system for the

tracking of referrals for MHA assessments. This group of professionals had considerable knowledge and experience and provided a responsive service under significant pressure.

Mental Capacity Act and Deprivation of Liberty Safeguards

The head of mental health law and clinical records held the responsibility for the management of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) within the trust.

From May 2016 MCA training had become mandatory for all clinical staff. The training figures for this was still low as the training was being rolled out. However, the mental health law update mandatory training which had been in place up to May 2016 and had included the MCA had a completion rate of 89%. In addition in the previous year tailored training had been rolled out to several hundred clinicians across the trust. The trust had wall charts and screen savers to support staff with using the MCA and DoLS. We found that knowledge of the MCA was generally good, although the recording of assessments could be improved in a few areas.

Between the 1 January 2016 and the 30 June 2016 there had been 11 DoLS applications of which six had been authorised. These all related to patients on wards for older people with mental health problems. A detailed look at the DoLS documentation on a mental health ward for older people, showed that this was poorly maintained and resulted in staff not being clear about who had an authorised DoLS in place. Work is needed to ensure the processes for using DoLS are working appropriately.

On the Wells Unit a child and adolescent mental health ward, staff were not clear about the meaning of Gillick competency in considering the capacity of a young person to make decisions. We were told this was addressed immediately after the inspection.

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean environments:

- The trust provided services from a very variable range of physical environments across 25 main sites. Since the last inspection a new 80 bed male medium secure unit called Thames Lodge had opened on the St Bernards site providing new accommodation that significantly enhanced the care and treatment received by the patients. This had been well received by the patients and staff. This secure campus also included the provision of a bank, library and café offering employment and social activities. The redevelopment of Broadmoor hospital was ongoing and will be completed in spring 2017 and will bring many improvements for patients and staff once it is operational.
- The trust, as part of its strategic planning process reviewed its investment in environments. The trust's 2016 annual report said that there were plans to re-invest £4 million over two years to improve the London estate. The work agreed with clinical staff included the removal of ligature anchor points, fire safety improvements, some new bathroom facilities and general redecoration. The trust recognised the potential risks of not adequately managing its estate portfolio and the impact this could have on the safety and quality of services. This was rated as a 'red risk' on the corporate risk register and the board assurance framework.
- At the time of this inspection there were still some very significant challenges in terms of accommodation being used by patients. Some medium and low secure forensic wards were still accommodated in the Tony Hillis Wing on the St Bernards site. Despite some interim building work, the environment was not suitable. For example there were on some wards insufficient numbers of toilets and showers and the poor condition did not support people's safety or recovery. Whilst there were plans to replace these wards with a clear plan to refurbish and move into Medway Lodge, there were still three wards remaining with no current clear plans for their replacement. Also the two acute inpatient wards, Hope and Horizon, on the St Bernards site did not provide sufficient communal space including access to quiet areas. This meant the wards were very noisy and this could distress patients using the service. The trust was planning for these wards to close next year as part of a wider strategy to transform services by supporting more people in the community and reducing the need for inpatient beds. The dates for these wards to close were not confirmed. In addition wards for older people with mental health problems did not all provide environments which were dementia friendly or offered easy access to alarms to call staff, or suitable bathing facilities for patients who were less mobile. At the previous inspection on Meridian ward which supported people over the age of 55 there was no equipment to help with moving and handling patients who had mobility issues. At this inspection appropriate equipment to help with patient moving and handling was in place.
- During the inspection we heard from staff that there could be challenges in the timely completion of building and equipment repairs or renovations that was impacting on the quality of the service available to the patients. This culture of completing repairs in an unacceptably slow timescale was identified at the previous inspection and remained an area for improvement. For example in the Wells Unit a shower had been broken for nearly a year and this meant the seven patients were having to use the one remaining working shower. This had been raised repeatedly by the patients as something they wanted addressed.
- The facilities that we visited were generally clean. The exceptions to this were in a few bathrooms and toilets such as in the rehabilitation wards. It was also noted on Meridian ward that there were some unpleasant odours. Infection control and health & safety was monitored across the trust through a system of nurse walk-about

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using safety checklists. An annual infection control audit took place and this showed improvements from the previous year. Actions were in place where further improvements were needed. The inpatient services had patient led assessments of the care environment (PLACE). Overall the PLACE assessments for the trust gave a high cleanliness score of 92.5%. The outlier was The Limes, a ward for older people with mental health problems which had a score of 85.9%. Broadmoor which had been an outlier at the last inspection with a score of 77.8% had improved at 89.1%.

- The clinical service units had health and safety committees. These reported through the trust wide health and safety committee to the quality committee that reported to the board. In addition each directorate had a quality matters governance meeting that reviewed data relating to infection control.
- At the previous inspection the trust had undertaken environmental risk assessments in the mental health inpatient areas and these identified high risk ligature points. In high secure and forensic services these had mostly been removed or were being managed with the exception of the Tony Hillis Wing where more work was needed. At the previous inspection we found in the local services especially the acute wards that the audits did not cover all areas of the ward accessed by patients. There was not a clear programme on acute wards of when high risk ligature point reduction work would take place. At this inspection we found that building work had taken place to reduce ligature points, on acute wards safer rooms had been created for patients who were assessed as being a higher risk, wards environments had been assessed and heat maps created to identify areas where staff needed to be more vigilant and staff were more aware of potential risks. In addition patients had individual risk assessments that included their potential risk of self-harm. In most cases we felt confident that the trust was mitigating the potential risks associated with ligature anchor points. However, in a few areas we did find that the ligature assessments did not reflect all areas of the ward and so the heat maps were potentially incorrect. There were also a few very obviously high risk ligature anchor points on acute wards and on the Tony Hillis Wing.
- We looked at whether patients using mixed gender inpatient services were provided with 'same sex

accommodation' to promote their privacy and dignity. The trust had reported no breaches in same gender care, which we confirmed at this inspection. At the previous inspection at Lakeside the health based place of safety was located on a male ward. This meant the provision was not suitable for females and they were taken to a female ward and offered room in an interview room which was not appropriate. At this inspection, female patients needing to access a health based place of safety were taken to the St Bernards facility in Ealing. At the previous inspection the only seclusion room in the Hammersmith and Fulham mental health unit was located on the male psychiatric intensive care unit. This could compromise the dignity of female patients who need to access the facility. At this inspection the trust was just opening a separate de-escalation suite on the female ward.

- Medical devices across the trust were mostly well maintained and checked regularly to ensure they were fit for purpose. They were also appropriately located to ensure they could be accessed when needed. At the previous inspection some of the acute wards and Meridian ward had emergency equipment which had not been checked on a weekly basis and equipment was broken and if needed would have to be brought from another ward which could be dangerous in an emergency situation. At this inspection emergency equipment across the trust was mainly in good condition and had been regularly serviced. A few minor exceptions to this were in the CAMHS teams where some equipment had not been maintained to ensure it was working correctly and on a small number of acute and forensic wards where a few pieces of equipment had not been recently replaced, serviced or calibrated.

Safe staffing:

- The trust recognised that one of its main challenges was the recruitment and retention of staff. At the time of the inspection the overall trust vacancy rate was 17%. The vacancy rates for the first six months of 2016-17 had been slightly higher than the previous year. The two staff groups where this was the most significant concern were qualified nurses where the vacancy rate was 28% and the middle grade speciality doctors where the vacancy rate was 21%. The staff turnover rate for the 12 months up to October 2016 was 14%. This had reduced slightly from August 2016 onwards from 15%. From July

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to September the turnover rate had been slightly below the rates for the previous year. The trust had noted that many of the staff leaving were doing so within their first year of employment. They also noted a higher than usual turnover of allied health professional staff. This highlighted that whilst recruitment needed to continue, further work was needed to promote retention. The trust's sickness levels were at 4% in October 2016 which was low. There were however variations between services with for example staff sickness in high secure services at 5.6%. There were no significant outliers for staff sickness.

- Across the trust safe staffing levels were being achieved most of the time although there was a high use of agency staff which represented just over 12.3% of staff expenditure just prior to the inspection. In September 2016 the fill rate of qualified nurses and unqualified care staff on wards was mostly around 100%. Where wards were unable to access qualified staff they would book additional unqualified staff. Ward staff said they could book additional staff based on patient need. They tried where possible to use regular bank and agency staff who knew the patients. The exception to this was in the high secure services where there were frequent breaches in safe staffing levels. For this service, the trust does not use agency staff. In September the fill rate of qualified and unqualified ward staff at Broadmoor was between 84% to 99%. However at night, nine of the fifteen wards had below 80% of qualified staff and six of these were between 50-65%. This was a concern as it meant there were not enough qualified staff working at especially at night to provide experienced nursing care.
- The trust had recognised recruitment and retention particularly of qualified nurses as a high risk on the trust risk register and this was included in the board assurance framework. Since the last inspection, the trust had recruited a director of workforce and organisational development who was an executive director. A work-force strategy had just been completed and a work-force and development committee had just been established reporting directly to the board. This was overseeing a number of areas of work including, recruitment and retention, staff engagement, leadership development especially for middle managers, work-force productivity and ensuring a diverse and representative workforce at all levels on the organisation.
- The trust was using a number of measures to improve recruitment. This included strengthening links with over 20 feeder universities and offering placements and jobs to student nurses; introducing a new recruitment website and reducing the time to hire to an average of twelve weeks; recruiting from further afield; introducing a package of staff benefits such as car lease and cycle scheme; having a dedicated recruitment lead to attend recruitment fairs and host open days; working with other trusts to look at opportunities for shared posts and rotations; introduced a relocation package for nurses moving from over 40 miles away.
- The trust was also introducing measures to improve the retention of staff. This included improving preceptorship and career development for band 5 and 6 nurses; offering opportunities for healthcare assistants to progress to assistant practitioner roles and a nursing qualification; re-introduced the use of overtime payments at Broadmoor and introduced an accelerated increment for band 5 nurses on completion of their preceptorship. At the last inspection the trust had introduced 90 day checks for new staff to receive feedback and exit interviews. The 90 day checks in particular were not well embedded and so there was scope to improve the feedback from staff.
- The trust recognised the need to improve work-force productivity and had appointed a manager to lead on this work. The trust had a system of electronic rostering. The trust knew that they needed to improve their use of bank nurses and reduce the spend on agency staff. They needed to recruit more bank staff and introduce systems such as self-booking of bank staff, and use of text messages to book staff linked to the electronic rostering. Bank staff completed mandatory training and after they had worked for more than 60 hours their training hours were paid. Bank staff were supervised by a manager from the bank team.
- At the last inspection it found that insufficient staffing levels were having the greatest impact in the high secure services, forensic services and community based mental health services. At this inspection, the staffing levels on forensic and adult community mental health services had improved. In the adult community mental health services this meant that staff had more manageable caseloads and there were only a small number of patients waiting to be allocated to a care co-

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ordinator. The staffing in forensic services was also much improved, however patients were still saying that leave was cancelled or delayed quite often. We found that wards did not always report not having enough staff or patient leave being cancelled and so the accuracy of the assurance was not guaranteed. In the high secure services we found that the vacancies were almost the same as the previous inspection. Whilst some staff had been recruited there were challenges with staff retention.

- The trust recognised that a review of medical staffing was needed and this was planned to take place in early 2017. This was linked to 21% vacancies of middle level speciality doctors. This was largely covered through the use of long term locums so the impact on patient care was minimal. Of more concern was the medical cover at night, especially provided by junior doctors. Of particular concern was the night time on-call responsibilities of the junior doctor on the St Bernards site. Here there could be up to 14 ongoing seclusion reviews, assessments of patients brought by the police to the health based place of safety, assessing out of hours admissions, responding the physical healthcare needs of inpatients and providing support to the liaison team in A&E. The medical director had shadowed the on-call junior doctor for a night but at the time of the inspection no further changes had been made. Prior to the inspection we also received feedback from Health Education England who had been informed by junior doctors, particularly in Hammersmith and Fulham about doctors not having the time to meet for out of hours handovers and to pass on the on-call bleep. This had been addressed at the time of this inspection.
- Mandatory and statutory training provided by the trust had a completion rate of 85% in September 2016. This consisted of 26 training courses including fire safety, infection control, health and safety, moving and handling and basic life support. There were a few topics where the numbers completing the training needed to improve. This included 'Prevent' (counter terrorism) at 68%, information governance at 78% and the recently introduced mandatory Mental Capacity Act training at 49%. Plans were in place to extend this training.

Assessing and managing risks to patients and staff

- At the last inspection the trust was aware that work was needed to improve assessing and managing risk to

patients. The trust had red rated this on the trust risk register. The trust has continued to include the risk of clinicians not conducting high quality clinical risk assessments on the board assurance framework.

- The trust monitored as part of its integrated performance report the percentage of inpatients with a risk assessment completed within 72 hours of admission. This was at 93.5% in September 2016 but had been over 95% for the rest of the previous year. The previous inspection looked at the availability and content of risk assessments across the core services and found a mixed picture. Within the forensic wards and acute wards there were examples of risk assessments that did not address all the areas of risk or where they had not been updated following an incident or a change in the persons needs. In the crisis assessment and treatment teams risk was being carefully considered by the multi-disciplinary team but the risk assessments in the appropriate section of the patient records were not updated, just notes made in the person's progress record. This meant there was the potential for staff to not be aware of the risks for that person. Since the last inspection the trust had reviewed the training provided on assessing and managing risk and also reviewed the electronic patient record system to improve the recording and storage of risk assessments.
- We also found many examples of teams carefully managing risk. In the forensic services, there had been a significant improvement in the assessment and management of risk. However, in a few cases, especially on the acute wards and the crisis assessment and treatment teams, these were not always updated following incidents and the latest copies were not stored in the same place so they were not always easy to find. This was a particular concern as there was a high use of temporary staff who may not know the patients well.
- The trust had a suicide and self-harm reduction strategy 2014-18. This followed the national suicide prevention strategy 2012. The trust had implemented a number of actions in response to this in each of the clinical service units. Examples of this included mandatory training on managing risk for front line staff; also mandatory training on recovery orientated clinical risk management; ongoing work with partner agencies for local services such as the police; a supportive observation policy was in place. The measures varied across the trust to reflect the needs of the patients.

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- The trust had systems in place to safeguard people from abuse. Most staff we spoke to understood the importance of safeguarding vulnerable adults and children. Safeguarding training was mandatory and took place at different levels according to the staff members role. The compliance with safeguarding training in September 2016 was safeguarding adults 91%, safeguarding children level one 99%, safeguarding children level two 88% and safeguarding children level three 85% and safeguarding children level 3 specialist training 84%. Nine trainers across the trust were delivering the Prevent (counter terrorism awareness) training. The trust was in the process of identifying leads to deliver training on domestic violence across the trust. For the first two quarters of the year from April 2016, there had been 270 safeguarding adult alerts. This was a 100-150% increase in alerts from the previous year. We were told the number of children's safeguarding alerts were harder to measure as these went directly to the local authority. There had however, been an increase in alerts associated with the 'think family' approach, especially from the adult community teams and psychiatric liaison teams in accident and emergency departments. The trust monitored for adult referrals the numbers and types of alerts by team each month. Where no alerts were made this was reported to the clinical director and support was available to ensure the team had sufficient safeguarding awareness. It was however, hard to see if this was leading to change. There were different arrangements in each borough for making safeguarding referrals. The trust safeguarding policy included a flow chart and aide memoire to remind staff of the process. There were also leads in the safeguarding team who offered advice. Since the last inspection the trust had worked with teams to help them understand the thresholds for making an alert. This included attending team meetings and a new handbook was just being finalised. Local authorities fed back that the trust was actively engaged in local multi-agency safeguarding boards and associated work. Each clinical service line had a clinical improvement group which reviewed safeguarding. This was also discussed at ward and team clinical improvement groups. There was a trust wide safeguarding forum which reported quarterly through the quality committee to the board. The safeguarding team had identified some more areas for itself where improvements could be made. This included continuing to learn from safeguarding incidents, further improving the safeguarding governance, making the training more engaging, putting the safeguarding leaflet for patients and carers on the trust internet and translating it into other languages and improving reporting about female genital mutilation.
- At the previous inspection it was found that the trust needed to make a number of improvements in relation to the use of physical interventions. This included recognising the use of restraint and reducing prone restraint; ensuring the facilities, practice and recording of seclusion was appropriate; continuing to reduce the use of long term segregation. This was reviewed at this inspection. The trust had carried out a number of actions which included improving the recognition and reporting of physical interventions; improved training using the Prevention and Management of Violence and Aggression specialists working on wards; improvements to the environment of seclusion facilities; specific work in high secure and forensic services to reduce physical interventions such as the use of the 'Safe Wards' initiative.
- At the last inspection we found that between 1 July 2014 and 31 December 2014 restraint was used on 432 occasions. In 179 (41%) of these 432 incidents, patients were restrained in the prone position. In 31 (7%) of the 432 incidents of restraint rapid tranquilisation was administered. At this inspection between the 1 January 2016 and 30 June 2016 restraint was used on 568 occasions. In 223 (39%) of these 568 incidents, patients were restrained in the prone position. In 82 (14%) of these incidents of restraint rapid tranquilisation was administered. This meant that the numbers of reported incidents of restraint had increased and the percentage of prone restraint had only slightly reduced. The trust stated that the increase in the numbers of restraint is largely down to more accurate reporting. We found that at this inspection the prevention and management of violence and aggression (PMVA) training had continued tailored to the needs of different services. This meant that staff were clear that restraint should only be used as a last resort. Staff awareness and reporting had improved. For example in older peoples inpatient services staff were fully recognising restraint. However the use of restraint, especially prone restraint remained

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significant and further work was needed. Also the detail of the recording still needed to improve in a few areas to ensure the progress with this work could be closely monitored.

- At the last inspection we found that between 1 July 2014 and 31 December 2014 there were in total 361 incidents of use of seclusion. At this inspection between the 1 January and 30 June 2016 seclusion had been used 557 times of which 200 were in the forensic services.
- At the last inspection we were concerned about the use of seclusion for a number of reasons. First of all some of the facilities were not located suitably or appropriately maintained for people who had to use them. For example in each of the mental health units with acute wards, patients were being moved between wards and in some cases between floors to access seclusion rooms. At this inspection we found that this was still a problem at Lakeside and Hammersmith and Fulham mental health units. At the last inspection some seclusion rooms were located so that other patients on the ward could see the person who was secluded which did not promote their privacy or dignity. At this inspection this was much improved due to the new medium secure unit. However on the Tony Hillis Wing and Wells Unit more work was needed. At the last inspection some seclusion rooms needed environmental improvements such as the seclusion facilities in some of the acute units where the room was not very clean or needed some maintenance work. At this inspection most were much improved apart from the seclusion rooms on Finch ward where repairs were needed.
- At the last inspection we found that the records of seclusion were not all fully completed, which meant it was not always possible to know if patients had received appropriate medical and nursing monitoring during their time in seclusion. The trust had created a new section on the electronic patient records to ensure this was recorded correctly. In most areas of the trust, records were much improved. In the forensic services the recording was mixed. In the women's service the recording was excellent and in some medium and low secure wards the records did not always show whether medical and nursing reviews were happening at the correct time intervals, or when the length of seclusion had extended if the reviews by the appropriate professionals had taken place.
- At the last inspection, there were also some seclusion practices which were not appropriate. For example on a female forensic ward all the patients had to wear protective clothing in seclusion whether they individually needed this or not. Also in forensic services, some patients were being asked to remain in rooms as part of their planned care without it being recognised that seclusion was taking place and therefore without the necessary safeguards. These had been addressed. We did however find at this inspection that some night-time medical reviews when the patient was asleep were not taking place in person. It is recognised that a decision may be made not to wake the patient, but a record of this decision should be made.
- At the time of our inspection, in Broadmoor, 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. Prior to the inspection there had been work taking place at Broadmoor to reduce the use of long-term segregation. A pilot project on Ascot ward was leading to changes in practice and the reduction of the use of long term segregation. This had excellent feedback from staff and patients. This pilot project had involved patients in their care planning for exiting from environments of long term segregation. There was also positive work which had taken place on Epsom ward in minimising the restrictive practices within an environment where all patients were subject to conditions of long term segregation. This had shown that staff were thinking about ways to reduce restrictive practices and challenge some of the culture around the use of long term segregation.
- At the last inspection it was found that the trust had a high number of blanket restrictions in place, especially within the forensic services at St Bernards. Since then a piece of work had taken place to review all the blanket restrictions and consider if they could be removed. This had led to a significant reduction in blanket restrictions. This work had also been a good example of clinicians and patients working together to review the arrangements. In the rehabilitation wards this has led to improved access to mobile phones. There were still some areas where restrictions could be reduced and the trust was working to address this.

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- The trust was carrying out an ongoing piece of work looking at access arrangements for patients in locked wards. The aim was to ensure that these were not over-restrictive and were managed well. This work has led to ongoing training around the risk assessment of individual patients having leave. The trust had also reviewed arrangements for recording people entering and leaving wards to ensure appropriate levels of clinical input. Signage was provided to ensure informal patients understood their rights to leave the ward. The trust was monitoring and taking steps to reduce the numbers of patients who were absent without leave (AWOL). These were discussed at the quality committee. It was noted that the number of patients who were AWOL had spiked after the introduction of the 'smoke free' initiative at the trust, due to patients leaving the wards to smoke.
- At the last inspection it was found that in some community based mental health services including some home treatment teams there were not clear systems for home working, which could compromise the safety of staff. At this inspection we found that the protocol for home working had been reviewed, that arrangements were in place across the team and that staff had been provided with lone worker devices that could track their location if needed. Some staff did not know how to use the new devices and further training was needed. On the wards and in clinics this inspection found that suitable alarms were available for staff to request help in an emergency. Some junior doctors said that they had not been fully briefed by wards on how to access and use the alarms and during the inspection the trust said they would build this into their local inductions. Some staff, especially in the Tony Hillis wing and the Wells unit said that staff did not respond in a timely manner to alarms. The trust had carried out checks which showed appropriate response times but this needed to be monitored on an ongoing basis.
- At the last inspection we found in the community mental health services for adults that some patients did not have a crisis plan. At this inspection we found that patients were supported to have a crisis plan with details of local services to contact. In some cases these had been completed with the patient in more detail to consider and reflect their individual wishes.
- There were effective arrangements for the supply of medicines across the trust. The dispensaries were pharmacy technician-led, allowing the pharmacists to spend more time in clinical areas. Medicines were stored securely across the trust in locked cupboards within locked clinic rooms. Clinic rooms were clean with hand washing facilities. Pharmaceutical waste (including sharps) was handled appropriately throughout the trust. Controlled drugs (CD) were stored securely and managed appropriately across the trust. All the CD cupboards complied with the Misuse of Drugs Regulations 1971.
- Medicines were not always stored at the required temperatures to remain safe and effective. Staff recorded minimum, current and maximum fridge temperatures and ambient temperatures where medicines were stored. However, when readings were out of range, staff did not always take the correct action. This was despite pharmacy staff communicating the importance of this. Senior staff knew that some clinic rooms exceeded the maximum recommended ambient temperature of 25°C, and had introduced contingency plans to mitigate any possible patient risk. In addition, this was listed on the pharmacy risk register. The chief pharmacist had produced a business case for mobile air conditioning units but it was not approved.
- Some clinical teams were visited by a pharmacist daily, whilst other teams received less frequent visits. This was dependant on patient turnover and need. Pharmacy technicians stocked up medicines in ward areas. Staff across the trust could access medicines out of hours via the emergency drug cupboard, and could contact an on-call pharmacist. We saw examples of positive clinical input by pharmacists who gave advice to both staff and patients to improve medicines optimisation.
- All prescriptions included information relating to patient demographics and allergies. Where appropriate, documentation regarding legal authority to administer medicines to individual patients was readily available. We saw evidence that a pharmacist had screened all inpatient prescription charts, and had made appropriate clinical interventions. When depot injections were given, staff rotated the injection site for each dose. On one ward, we saw that the correct paperwork was available for the covert administration of medicines. (When medicines are given covertly, it means that they are hidden in food or drink without the knowledge of the patient.) A consultant, a nurse and

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next of kin were contacted before medicines were given covertly. However, staff did not always follow trust guidelines and ensure that a pharmacist was approached for specific administration advice on how to give the medicines covertly.

- Staff knew how to report medicines incidents. The incident reporting system was recently redeveloped by the trust governance team. It allowed staff reporting incidents to track the development and outcome of their incident report in real time. The chief pharmacist planned to use this information as part of supervision in the pharmacy department, so that learning needs could be identified and the 'no blame culture' could be upheld. The pharmacy department updated the medicines optimisation page that was accessible by all staff on the intranet. They also produced a monthly medicines bulletin and circulated to all staff in the trust as well as staff in local CCGs.
- At our last inspection it was noted that patients were being prescribed medication at levels higher than the recommended maximum dose, without the national guidance for this being followed. As a result of our findings, the trust had raised awareness among clinical staff of this issue. During this inspection, we saw progress in this area. There was a new online system for monitoring the use of high dose antipsychotic (HDAT) medicines which was being rolled out across the trust, and new stickers that pharmacists placed on drug charts to alert doctors to HDAT use and when monitoring was needed. The most progress with this work stream was observed within forensic inpatient areas, where patients could access a physical healthcare GP-led service. We saw that physical monitoring was not always completed on the high dose antipsychotic monitoring forms.
- At the last inspection it was noted that when patients were given injectable medicines for rapid tranquillisation (RT), routine observations were not always recorded. Whilst work was completed to increase staff awareness in this area for example the issuing of a safety alert, we found that it was still an issue at this inspection. The trust was aware of this, and had completed an audit on the use of RT. As a result of the audit, recommendations were made to staff on how to improve the post dose physical health monitoring when RT was administered.

Track record on safety

- NHS Trusts are required to submit notifications of incidents to the national reporting and learning system (NRLS). In total 3217 incidents were reported to NRLS between the 1 April 2015 and 31 March 2016. The majority of these incidents were classified as resulting in 'no harm' 81%, or 'low harm' 13%, with 5% resulting in 'moderate harm' and 1% 'severe harm' and 1% 'death'. Of these incidents, the highest percentage 37% related to medication incidents. When benchmarked at that time with other similar trusts, the trust was one of the lowest reporters of incidents in data published by the NHS national reporting and learning system.
- For the same time period the trust reported 158 serious incidents to the strategic incident reporting system. Of these 30% related to self-inflicted harm and 15% were incidents of aggressive behaviour.
- The trust had carried out a mortality review in response to the Mazars review looking at patient deaths. This had identified 261 deaths between April 2015 and the end of March 2016 which should have been reported. Most had other agencies who were also involved with the patients and the information was not shared. From these, forty two records were randomly selected for further review. This had led to the establishment of a trust wide mortality review group, chaired by the medical director and director of nursing with input from commissioners. This was now reviewing all unexpected deaths.
- One previous inpatient death resulted in the trust receiving a report from the coroner during this time, raising concerns about the hospital observation policy not being followed properly at Broadmoor. There was also one multi-agency review relating to a homicide carried out by patient receiving support from the trust.
- The NHS Safety Thermometer measures a monthly snapshot of four areas of harm including falls and pressure ulcers. This was monitored in the wards for patients over the age of 65 and Magnolia ward which provides intermediate care. There were no services where the number of reported incidents were a particular concern.

Reporting on incidents and learning from when things go wrong:

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- The trust was very aware that they needed to further improve the incident reporting culture and the timescales for reporting incidents to NRLS. Since the previous inspection, the trust had continued to encourage staff to report incidents through a number of forums including a programme of roadshows and we found that staff felt confident to do this. The numbers of incidents being reported was increasing according to the trust, but there had been issues with uploading them in NRLS. The total number of incidents reported was not monitored on the trusts integrated performance report, only the numbers of investigations commissioned and overdue reports.
- Following staff consultation the trust had introduced a new electronic incident reporting process. This should be easier to complete. This had started operating two weeks prior to the inspection and was accessed through the trusts intranet. As the system was in the early stage of being implemented there were some teething problems including managers not being able to access the results of incident investigations. The incident reporting system aimed to improve the delays in the categorisation of incidents within services. The system had been developed to generate automated reports of themes of incidents to inform learning across the trust and share with stakeholders. The system contained an actions zone to prompt staff on actions they needed to take. There was also a root cause analysis section within the reporting template.
- The trust had an incident reporting and management policy. Incidents were categorised into levels with the input of the medical director and director of nursing. Level 1 investigations included less complex incidents, level 2 were more complex and level 3 required an independent investigation. There was a target of completing investigations within 60 days. The trust was not completing and closing level 1 and 2 incident reviews on time. In September 2016 there were 26 level one incident reports that were overdue and 13 level 2 reports all associated with local services. These were mainly in Hammersmith and Fulham and was also of concern to local commissioners. There was a risk that learning from incidents was not being captured and shared in a timely manner across services to ensure patient safety and improve standards of care.
- The trust stated that a contributory factor to the high number of serious incidents not being investigated on time, was the performance of staff in these areas who had received suitable root cause analysis training in completing the investigations. The trust had set a target of clearing the backlog of outstanding incidents by October 2016 but had not achieved this.
- The trust had introduced an action plan with a number of measures to mitigate the risk associated with the high number of serious incidents which had not been investigated. The action plan included monthly meetings with clinical service units and commissioners to review the completed incident report and the actions from investigations. Weekly reports of the number of incidents which were outstanding were being reviewed by the central governance team and clinical service units to address potential delays.
- We reviewed eight serious untoward incident investigation reports which were categorised as either a level 1 or level 2 investigations. Four of the incidents reports were well written and included investigation notes, root cause analysis, service user and carer involvement, an action plans which included lessons learnt and how these lessons were to be shared. Supplementary evidence and notes of the investigation were not included in two of the serious incident investigations. Three of the incidents did not contain details of a root cause analysis being completed.
- The central clinical governance team met monthly with the clinical service units to discuss learning and actions from incidents. Learning from incidents was captured in overview reports which were submitted to the quality matters committee and quality committee. An annual report looking at themes was reviewed by the board. 'Make it safe' bulletins were communicated across the trust by email and on the trust intranet where there was an urgent need to communicate immediate lessons from an incident to trust staff. Feedback and learning from investigations into incidents was being shared and discussed in monthly clinical improvement group meetings within the service areas. Most staff said that they felt confident that they were learning about lessons from incidents in their area of work and from across the trust. In some areas the feedback to teams was less consistent such as the rehabilitation wards and some specialist community mental health services for young

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people. Learning lessons conferences took place. An example of a trust wide improvement that had taken place was the development of the therapeutic engagement and supportive observation policy.

- Staff said that after incidents in their place of work, a debriefing was offered to staff and in most cases also to the patients. This was done individually and as a team. Staff were also supported to access the occupational health team and counselling service where needed.

Duty of Candour:

- The trust had a duty of candour policy in place that was understood by staff across the trust. The new incident recording system ensured that staff record if the duty of candour had been applied.

Anticipation and planning of risk:

- The trust considered risk as part of its board assurance framework. The top ten risks were reviewed and discussed at committees reporting to the board.
- The trust board received an annual report on emergency planning and business continuity. The purpose of this report was to provide an account of emergency planning, resilience and response and business continuity arrangements for the year. The trust participated in the NHSE annual assurance exercise. The trust was assessed as being partially compliant although the score had improved from the previous year. Further work was needed in terms of evacuation plans and business continuity procedures and a draft action plan had been prepared. The trust hopes to achieve full compliance by next year.

Are services effective?

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

Summary of findings

Our findings

Assessment of needs and planning of care:

- Most of the areas we visited completed comprehensive assessments of the people they were supporting. The assessments varied dependent on the needs of the individuals.
- The trust was very committed to improving the physical health of patients. They were wanting to offer more integrated mental and physical health services and since the previous inspection were providing Home ward intermediate care services in Ealing. Other actions that had taken place had been the appointment of a nurse consultant for physical healthcare, the development of standards for physical healthcare and ongoing monitoring of these standards. The trust had physical healthcare outcome measures agreed with the commissioners incentivised by the commissioning for quality and innovation (CQUIN) framework. At the end of quarter one all of these areas of work had been met.
- At the last inspection the trust had set a target that all patients would have a recorded physical health check within 72 hours of admission. Up to July 2016 the board integrated performance report showed a compliance each month of over 96%. Since this point the trust had introduced new physical healthcare standards. These had extended the physical healthcare checks that are completed and these are now reported into a new physical health portal for each patient in the electronic patient record system. This was at a fairly early stage and at the inspection we found that the completion of the physical health portal was mixed. The rates of compliance were not yet reported to the board although the trust said compliance was gradually improving.
- Another improvement in the provision of physical healthcare was the introduction of the National Early Warning Score (NEWS) standards. These allow deteriorations in the patients' physical health to be identified early and acted on. At the time of the inspection 92% of the nurses in local services had been trained to use NEWS. We found that most records were completed well, however there were a few cases in acute and forensic inpatient wards where this was not the case. We also heard from junior doctors who said there were ongoing cases where nursing staff did not use NEWS correctly and did not contact them in a timely manner about patients whose physical health was deteriorating. Further work is needed to embed this system and ensure nursing staff complete this correctly.
- There were different arrangements in place across services to support people with their physical healthcare. In local inpatient services people were assessed by a ward doctor on admission. A trust wide lead for physical healthcare had also now been appointed for these services to further promote physical healthcare. For patients at Broadmoor primary healthcare was in place and the hospital had been able to consistently achieve the standards set out in the Quality Outcome Framework model. On the forensic wards, the trust had a liaison physician to improve their overall physical health.
- The inspection found that in the community mental health teams for adults that staff considered the physical health care needs of patients but this was often poorly recorded and difficult to monitor and track over time. The lack of clear joined up working with GPs and where needed regular physical health checks meant there was a risk that patients physical healthcare needs might be overlooked.
- Since the last inspection the trust had become smoke free in January 2016. The trust had a stop smoking facilitator who had overseen the training of staff, the development of smoking cessation clinics and the use of nicotine replacement products. At the time of the inspection the feedback from patients and staff about the implementation of smoke free was mixed. We heard about how some patients could not access nicotine

Are services effective?

replacement products in a timely manner and how patients from the forensic services were burying their tobacco in the grounds as they did not wish to stop smoking and did not have storage facilities. The trust were arranging for storage facilities in some areas of the trust.

- Pharmacists conducted medicines reconciliation for each patient admitted to inpatient areas. (Medicines reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, or GP). Staff recorded this activity on prescription charts. Pharmacy staff used smart cards to access GP held 'summary care records'. This allowed them access to an abbreviated GP record, detailing medication prescribed and known allergies.
- The trust acknowledged that the quality of care planning as variable across the trust. We found that there was a lot of ongoing work taking place to improve care planning and in many of the areas we visited the quality of care planning had improved and they were more personalised such as across the community mental health teams for adults. We found that there were good examples of where services were working with patients to develop their care plans. We did find examples in the forensic services of some really good jointly produced care plans. We also found examples of care plans that used technical language that patients might not understand. Where some patients had a learning disability, the care planning process did not meet their needs such as through the use of easy read care plans.

Best practice in care and treatment:

- The trust had a wide range of measures in place agreed with commissioners, other stakeholders such as NHS England and in partnerships with social care with the aim of improving the outcomes of people who use their services. Commissioning for quality and improvement targets are set each year by commissioners to incentivise the trust to make improvements. In 2015-16 the trust had met all the targets for that year with the exception of improving mental health services for people with a learning disability using local services and this target was partially met.
- The trust medical director was accountable to the board for clinical audit. A trust lead assisted by a colleague managed the clinical audit programme. The trust had no other dedicated audit support staff. Each of the service lines had its own clinical audit group. These were comprised of representatives from the main clinical disciplines. The service line groups reported in to a trust-wide audit group which reported to the board through the quality matter and quality committee. The trust lead for audit oversaw the trust's participation in national audits and clinical service accreditation schemes as well as the programme of locally determined clinical audits. Each year, the trust-wide audit group and the service line audit groups drew up forward plans. The trust categorised its clinical audit programme into three main themes - patient safety, patient experience and clinical effectiveness. The plan for 2016/17 included more than 50 audits. These were a mix of national audits (such as audits coordinated by the prescribing observatory for mental health), audits that were trust-wide priorities including 'rolling audits' and audits determined to be priorities by local clinical teams. The trust repeated a number of audits annually. These included audits of hand hygiene, omitted medication doses, controlled drugs and quality of clinical documentation. Both national priorities and local events, for example the recommendations of serious case reviews, influenced the priorities for audit topics.
- Some of the clinical audits had resulted in changes in processes. For example, the trust had made changes to forms used to record physical health checks. However, few audits had clearly demonstrated lasting improvements in practice. The trust board received a report on clinical audit every six months. The board reports focused more on the number and topics of audits completed than on improvements made. The board did not receive regular updates on clinical performance as reflected in the data collected through the clinical audit process.
- The trust lead for audit also led on the production of the quality account and the implementation and monitoring of NICE guidance. The trust has set up a 'scoping group' for NICE guidance. The lead for audit scanned the websites of NICE and other standard-setting bodies and presented the results of this to the scoping group each month. The scoping group would

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decide which guidance was applicable to the trust and, if so, which parts of the trust should be notified of the guidance and the degree of urgency for doing this. The lead for audit would produce a one-page summary to support the dissemination of relevant guidance. The main area where the trust was often not meeting NICE guidance was in the access to evidence based therapeutic interventions. Throughout local services we heard about the long waits and limited availability of psychological therapies.

- At the last inspection we found that the arrangements to monitor the prescribing of high dose antipsychotics were not always robust. At this inspection, we found that the clinical staff were very aware of NICE guidance on the use of antipsychotics. For example older people with dementia were only rarely prescribed antipsychotics. The pharmacy team had introduced a green coloured sticker which they placed on the medication administration record to indicate when an antipsychotic was being prescribed above the normal limits. In most cases there was then a record of the health checks that had taken place for the patients. On the acute wards at Lakeside it was not possible to find records to show this was taking place consistently. The pharmacy had also introduced a leaflet about using unlicensed medicines and off-label uses to support discussions with patients when considering using medications in this way.
- The trust was starting to measure outcomes for patients, but similarly to other trusts this was a work in progress. In terms of measuring outcomes for individuals the trust was using the health of the nation outcome scales to measure the health and social functioning of people with a severe mental illness and over time how the patient outcomes. Different professional staff also used a range of other outcome measures to see how patients were progressing. Further development was needed, for example on the rehabilitation wards it was found that outcome measures were not being used to robustly measure whether patients were benefitting from the rehabilitation on the wards.

Staff skills

- The trust provided a corporate induction for all staff. We heard from a range of staff that this training was very helpful. Staff said they valued meeting the chief

executive and also having training from service users and carers. In addition staff received a local induction that supported them to understand their specific role in the services. This was valued by staff.

- The trust had processes for delivering medicines training to staff as part of their induction. The trust had implemented mandatory training for all nurses. They had to pass an online medicines competency assessment, which was repeated every three years. Pharmacists contributed to the junior doctor training programme. This included training on medicines reconciliation and how to use summary care records. At the last inspection, the pharmacy team had developed a junior doctor's induction handbook. The trust had since developed a version tailored to nurses.
- Staff talked positively about the training opportunities they received. At the last inspection we found that staff working in the 'ageless' community mental health teams for adults had not had training on supporting older people. This had been provided and staff said it was useful.
- We heard about how the trust tried to promote opportunities for people to join the trust and then progress their learning and development. This included the apprenticeship scheme and pathways for healthcare assistants to progress to assistant practitioners and a nursing qualification. Staff commented that the opportunities for this, whilst welcomed, were very limited. The first cohort of 15 assistant practitioners had completed their training and the second cohort was underway.
- The trust was also introducing a foundation nursing programme with the first 24 nurses starting in February 2017. This will offer newly qualified nurses an 18 months programme, consisting of 3 six month placements. They will be given mentorship and have access to a learning set.
- The trust was in the process of setting up a learning and development committee. Further work was taking place in thinking about the organisational needs and aligning training requests to this.
- The junior doctors said they had access to regular training sessions.
- At the end of the last year 82% of trust staff had a completed appraisal. The staff survey said the quality of

Are services effective?

this process needed to improve and so this year the trust was looking at the completion of objectives. At the end of September 2016, 76% of staff had completed an appraisal. The completion rates varied between services and was lower in local and corporate services.

- The trust complied with the medical revalidation statutory requirements. From the 1 July 2015 to 30 June 2016, 36 out of the 37 doctors due to be revalidated had completed the process. The trust had submitted data which showed how many doctors were due for revalidation between July 2016 to June 2019.
- The trust had an expectation that staff will have access to monthly clinical and managerial supervisions. At this inspection we found that in a number of areas that regular individual supervision was not taking place and the recording of supervision was very variable. Supervision could be arranged and recorded using a trust on-line process, but this was not embedded. This made it hard to monitor how often staff were supervised. Some supervision records were very brief and gave the impression that the topics covered were limited.
- The trust expected staff to have access to regular team meetings and we found that these were usually taking place and in most services there were also meetings providing opportunities for reflective practice which was well received. On Magnolia ward team meetings were not taking place regularly.
- A number of teams were having team away days as opportunities to discuss their service and undertake some learning and development.

Multi-disciplinary and inter-agency team working

- Staff spoke favourably about internal multi-disciplinary work. We observed multi-disciplinary meetings and staff handovers. This reflected some good practice and we saw staff working well together in a respectful manner making the most of each others skills and experience. It was noted on the Wells Unit that the patient review meeting attended was not very well organised.
- We also saw many examples of how different teams in the trust worked together to support patients as they moved between services. This was particularly evident

for patients who were moving from inpatient services to receiving support from community teams. We heard about how information was shared and staff from community teams attended meetings on the ward.

- The trust works with local clinical commissioning groups, local authorities and NHS England. The feedback from stakeholders was that the trust worked well with external organisations to meet the needs of patients.
- Since the previous inspection, the trust had started to operate a single point of access that operated 24 hours a day. This worked with NHS 111 services, GPs, hospital doctors, the police, paramedics and prison staff. Trust teams also worked with the courts, Ministry of Justice and ambulance service to help people having a mental health crisis.
- We heard of examples of good inter-agency work and also some challenges. For example the trust recently partnered with Ealing community transport to help patients with dementia to travel to their memory groups. Another example is trust staff working with the London Ambulance Service to train staff on how to support patients experiencing a mental health crisis in return for them training staff in the crisis assessment and treatment teams on how to carry out an ECG. We were also told by staff about the impact of reductions in social care funding on access to social workers to support the discharge planning process and on social services.
- The trust had also worked effectively with other trusts in partnership with other agencies. For example in partnership with Central and North West London NHS Trust, the Priory Group, NHS England and local commissioners the trust had been selected to deliver a pilot to reduce the number of children and young people in crisis going to out of area beds and to deliver care safely in the community where possible.
- In the last year there was also the development of a primary mental health service across the three main local service boroughs. This involved community nurses working in close collaboration with GPs and other colleagues in primary care to support patients who would previously have required treatment from traditional community mental health teams. The trust had also developed a shared care protocol with GPs to

Are services effective?

increase assessments of patients at risk of dementia in Ealing and Hounslow. There was then follow up care and support largely through new dementia link workers who visited patients at home and helped them access health and social care as needed.

Information and Records Systems

- Since the last inspection, the trust had added new screens in the electronic patient record system. This was to provide a place to record physical health input and seclusion checks so they were easy to locate. This was taking time to embed and at the time of the inspection were not being completed consistently. This meant that it was still hard to find records. There was also a risk that with high numbers of temporary staff, essential information relating to patient care might not be used.
- In most areas we also found that there was a mix of paper and electronic records which also presented similar risks.

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

- In the 12 months prior to the inspection the trust had 31 visits from Mental Health Act reviewers. The most common issues were patients not being advised of their rights, care plans not reflecting the views of the patients and lack of assessment of capacity.
- The trust's systems supported the implementation of the Mental Health Act 1983 (MHA) and its Code of Practice. There was a head of mental health law who managed the Mental Health Act administrators and reported to the trust board through the committee system. The executive lead was the director for nursing and patient experience.
- The Mental Health Act Law and Deprivation of Liberty Safeguards (DoLS) Committee reported directly to the trust board and was responsible for strategy and the analysis of trends in activity. Operational issues relating to the Mental Health Act and Mental Capacity Act were overseen by the Quality Matters Committee which in turn reported to the Quality Committee.
- There were twenty associate hospital managers who considered the power to discharge under section 23 of the MHA. This function was overseen by the Mental Health Act Managers Committee which was led by the

chair of the trust. There were MHA administrators at each of the trust's inpatient sites. Administration of the MCA and the DoLS was also supported by the head of mental health law.

- The Mental Health Act Law and DoLS Committee arranged for the completion of a number of audits each quarter. Recent audits highlighted significant issues. Seventy per cent of patient files scrutinised for one audit did not have evidence of thorough assessments of capacity to consent to treatment upon admission. We also found this to be the case when we looked at this in detail at Broadmoor. There had been seven episodes of unlawful detention reported in 2015/16 and a further six episodes were reported in the current year. A backlog of MHA Managers hearings had built up in respect of renewals of detention. There had been 76 such hearings outstanding at one point and this had been reduced to 46. The number of MHA administrators relative to the number of detained patients was significantly less than in some other London trusts and this may have contributed to the backlog of MHA Managers hearings.
- Awareness of the MHA was part of mandatory training. Further training was provided on a variety of subjects available to staff via classroom sessions advertised on the intranet. The MHA administrators also provided some training locally. Staff had a good awareness of the MHA and Code of Practice.
- The trust had reviewed all its policies and procedures to make them compatible with the Code of Practice. MHA activities were seen as integral to all other policies and procedures.
- During this inspection we completed ten Mental Health Act review visits pursuant to the CQC's duty under section 120 of the Act. We found evidence that detention paperwork was completed correctly, was up to date and was stored appropriately.
- We found copies of consent to treatment forms were attached to medication charts where applicable. At Broadmoor we looked at this in detail and found that staff in the hospital were not robustly recording assessments of capacity relating to capacity to consent to treatment in a way that demonstrated that

Are services effective?

comprehensive conversations had taken place with each patient, with the exception of Kempton ward where there were very clear assessments of capacity recorded.

- There was evidence that most patients had their rights under the Mental Health Act explained to them. However on two of the wards we visited at Broadmoor it was not clear that all patients had been regularly reminded of their rights.
- At Broadmoor we found that patients who were subject to long term segregation for over three months were not consistently being reviewed by a doctor from an external hospital every three months as indicated in the Mental Health Act Code of Practice. We also found that patients in forensic services who were in seclusion for longer periods of time did not have a record of having the appropriate reviews.
- At Broadmoor we were told of ongoing work to reduce the use of long term segregation with complex patients. Staff on Ascot ward had had a paper published in an American psychiatric journal regarding the innovation and pragmatism required to reduce the use of seclusion.
- We met with approved mental health professionals (AMHPs) from the London Borough of Hammersmith and Fulham. The major issue that the AMHPs raised was a continuing problem with identifying beds to which detained patients could be admitted. This had led to some instances of AMHPs being left with detained patients in the community waiting for beds to be found. They felt that this was unsafe. They acknowledged that an escalation process for the identification of beds had just been introduced but were concerned that possible further bed reductions were planned. The AMHPs also expressed frustration that assessments under the Act frequently took place with two doctors from the local section 12 list because trust doctors were unavailable. They pointed out that this was a very expensive process for the trust. They also expressed concern that many patients were discharged before formulations and care

plans were completed and that they often received requests to attend discharge CPA meetings at such short notice that they could not comply. However the AMHPs felt that they had a robust system for the tracking of referrals for MHA assessments. This group of professionals had considerable knowledge and experience and provided a responsive service under significant pressure.

Good practice in applying the Mental Capacity Act

- The head of mental health law and clinical records held the responsibility for the management of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) within the trust.
- From May 2016 MCA training had become mandatory for all clinical staff. The training figures for this was still low as the training was being rolled out. However, the mental health law update mandatory training which had been in place up to May 2016 and had included the MCA had a completion rate of 89%. In addition in the previous year tailored training had been rolled out to several hundred clinicians across the trust. The trust had wall charts and screen savers to support staff with using the MCA and DoLS. We found that knowledge of the MCA was generally good, although the recording of assessments could be improved in a few areas.
- Between the 1 January 2016 and the 30 June 2016 there had been 11 DoLS applications of which six had been authorized. These all related to patients on wards for older people with mental health problems. A detailed look at the DoLS documentation on a mental health ward for older people, showed that this was poorly maintained and resulted in staff not being clear about who had an authorised DoLS in place. Work is needed to ensure the processes for using DoLS are working appropriately.
- On the Wells Unit a child and adolescent mental health ward, staff were not clear about the meaning and use of Gillick competency in considering the capacity of a young person to make decisions. The trust acted quickly to provide training on this a week after the inspection.

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- The staff we spoke to across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was largely delivered by hard working, caring and compassionate staff. Many patients shared with us their positive experiences of the care they had received. The majority of feedback we received from comment cards was positive about the care provided.
- We observed many examples of positive interactions between staff and patients throughout the inspection visit. For example when we inspected the cognitive impairment and dementia teams we found many examples of staff taking the time to reassure patients and their carers and talk to them about the diagnosis. The care provided by these teams also recognised the holistic needs of each patient. For example they thought about each person's religious and cultural needs when planning appointments to ensure these were at a suitable time.
- We heard about how staff attitudes had improved since the previous inspection. This was particularly apparent in the West London forensic services, where patients told us how much this had improved. We heard how staff were genuinely interested in the well-being of the patients and how they worked with them in a supportive manner.
- There were a few places where there was room for improvement. For example on the wards for older people, some patients needed more thoughtful support at mealtimes. For example if a patient was given a carton of drink with a straw, making sure they can use this. Also ensuring the privacy of patients was maintained when using bathroom facilities. Also on Glyn ward which is a rehabilitation service, patients were

queuing at a hatch to receive their medication which did not promote their privacy and dignity. The ward were aware of this and there were notices to remind staff to be mindful when discussing confidential information.

- The feedback from various surveys about the quality of care showed varying results. In the patients, family and friends test for February 2016 to July 2016 the trust scored above the England average for recommending the trust as a place to receive care for five of the six months. However, the response rate for the trust was below the national average during that period. For the patient led assessment of care experience the 2016 score for privacy, dignity and well-being was 80.2% which was below the England average of 89.7%.

Involvement of people using services

- Throughout the inspection we saw examples of patients and carers being involved in their care. The trust had a service user and carer experience committee, chaired by two service users supported by the director of nursing which reported to the quality committee. The trust was working with the West London Collaborative, which is a community organisation that had established a trust wide service user and carer forum to enable people to meet with board level representatives from the trust to highlight issues of interest. At the time of the inspection the trust was working with the West London Collaborative to refresh the service user and carer strategy.
- The arrangements for engaging with people who use services and carers varied across the different clinical service units. For example forensic services had reviewed user and carer involvement. They had established a monthly women's service user forum, monthly men's service user forum, monthly carers forum, quarterly service user and carer experience forum and quarterly carer event. The high secure services had a patient forum and carers meetings. The trust had a few involvement leads / carer support worker posts. Some of these posts were staff directly employed by the trust. Other post holders were employed by the local authority or third sector organisations, or through joint arrangements.

Are services caring?

- Patient involvement in their care happened in a range of different ways throughout the trust. On an individual basis we saw that patients and their carers were involved in assessments and on-going decisions about their care and management of risk. In forensic services, patients used 'my recovery plans' and in Broadmoor 'wellness recovery and action plans' to facilitate their involvement. The number of patients being offered copies of their care plan was improving. Patients and carers were invited to ward rounds and care planning meetings. We saw a few examples of patients chairing their own care programme approach meetings or staff being thoughtful about how to support patients to engage with these meetings. Information about how to access advocacy services was clearly displayed and patients were supported to access these services where needed.
- Wards and teams were providing a range of useful information to help patients understand and feel welcomed to the services. Most wards and teams had information packs sharing essential information about the service. Wards had photos of the staff. The pharmacy teams also provided information to patients, for example patient information leaflets were available in a number of languages via the choice and medication website. The trust had also developed patient information leaflets for patients taking off-licence and unlicensed medicines.
- The trust was working to improve the involvement of carers. Across a number of services carers were given lots of support including access to carers groups and training courses. The trust was using the 'triangle of care' as a means of understanding carers needs although further work was needed to embed this approach. Carers were also being supported to have carers assessments so their need for support could be considered. We found some specific issues at Broadmoor where the processes for communicating, involving and informing carers could improve.
- Feedback was sought from patients. Since the last inspection the trust had moved over to using a new 'patient opinion' tool. This allowed feedback on-line, by telephone and using leaflets. At the time of this inspection, this revised approach was fairly new but we heard the feedback was gradually increasing and summary of themes were sent to teams every two months. Some wards and teams had suggestion boxes. Also most wards had regular user groups where patients could discuss what was happening in the service and suggest areas for improvement. At the time of the inspection these were mostly chaired by staff although training was being provided for patients who want to develop the skills to chair meetings. There were also groups providing feedback on specific topics such as catering in the forensic services. Wards and teams had 'you said, we did' notice boards that described improvements that had been made as a result of suggestions.
- At the time of the inspection we met a few peer workers. For example in some of the community teams we saw a few peer workers were part of the teams. In local services, in Hounslow a peer worker promoted service user involvement. At Broadmoor we found a peer worker supported patients who were moving onto rehabilitation wards. Compared to other trusts the numbers of peer workers are still quite low and is an area for further development.
- Volunteers were also working in the trust. There was an involvement register in place where volunteers with lived experience of using services could offer to help with recruitment, training and reviewing trust policies. Much of this work took place through the recovery college. Examples of the training where there was user involvement included induction training, managing violence and aggression and clinical risk taking. In the child and adolescent mental health services, young people had co-designed care planning documentation. We also heard about patients being extensively involved in the work to reduce blanket restrictions.
- Patients and carers were encouraged to be involved in trust wide issues. There were patient representatives in the clinical improvement groups and quality matters and quality committee. There was a patient story at each board meeting. All these developments were very positive, although we did hear that the numbers of volunteers with lived experience of using the services provided by the trust was quite small and that the same people would undertake these roles. The numbers of people involved in these roles needed to be extended to gain wider range of feedback.
- There were also a number of audits and other areas of work with user involvement. An example of this was the patient led assessments of care experience. There was also a trust wide group looking at how improvements can be made in staff attitude.

Are services responsive to people's needs?

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

Summary of findings

Our findings

Service planning

- The commissioners in North West London had worked together to produce a whole system mental health and well-being strategic plan. This had looked at the population needs, available services, activity and funding. This informed the strategic direction for the trust.
- The trust also produced an annual report explaining each year how it had met its strategic aims. The current plan clearly stated the trust's commitment to work as part of an accountable care partnership in which different providers work together to care for the population. This also stated that the trust would work with partners on the sustainability and transformation plan as well as supporting the implementation of NHS England's five year forward view. This would be supported by bringing about transformational change to address variation in care. It identified future plans for the trust including turning research into practice; investing in people, estates and technology; listening and learning from patients, carers, staff and the public; and working to implement the principles of recovery.
- The inspection took place at a time of significant strategic change. The adult inpatient transformation programme was being finessed with the aim of reducing the numbers of people needing inpatient beds and reducing lengthy stays. The trust was aiming to further integrate mental and physical healthcare and provide care closer to or in people's own homes. At the time of the inspection, the trust was reviewing its written strategy to clarify how these transformations will be achieved.
- Prior to the inspection we received feedback from a wide range of stakeholders. This included commissioners, professional bodies, NHS Improvement, local authorities, Healthwatch and other local

organisations. They all said that the trust worked well with external stakeholders and were willing to actively contribute to plans to improve services, even if that was very challenging at times.

Access and discharge

- Overall the trust was working to improve access and discharge arrangements across the different services. A key part of this had been the launching of a single point of access (SPA) and 24 hour telephone helpline. From the start of April 2016 up to mid October 2016, the SPA had received around 5500 referrals. Of these 70% of the referrals were from GPs and about 50% of the referrals were discharged to primary care plus or to GPs following professional advice. Senior nurses screened all emergency referrals to confirm the level of urgency. The team knew that a higher volume of calls was received between 12 and 2pm, so more staff were available to answer the calls at this time. If patients were not transferred to another team immediately, they were contacted by telephone for a triage assessment. The team aimed to contact emergency referrals within one hour, urgent referrals within three hours, routine plus in 24 hours and routine referrals in 72 hours. If high-risk referrals could not be contacted, they were transferred to the crisis and assessment team for an urgent home visit. Following a clinical triage almost 43% were referred on to the crisis assessment and treatment teams. These teams had been extended since the last inspection, although these changes were still bedding in. The crisis assessment and treatment teams were gate keeping admissions to the acute inpatient beds.
- The trust had senior nursing staff who oversaw the bed management and since the last inspection, they were available also at weekends. Despite bed management processes the trust was still facing a challenge at times in relation to patients who had a clinical need for acute inpatient care having access to a bed, especially when there were peaks in demand. Average bed occupancy across all the acute wards, between 1 January 2016 and 30 June 2016 was 94%. Within these figures, Grosvenor had the highest occupancy rate at 109% and Finch had the lowest at 72%. However, during our inspection, occupancy on Finch was 100%. Ward managers told us

Are services responsive to people's needs?

that all the wards were usually full. Between 1 January 2016 and 30 June, the service placed 30 patients in other hospitals outside the local area. The trust tried to admit patients to the hospital ward within the borough where they lived, but when this was not possible, they were placed at another of the sites. On the day of our inspection, 50% of patients on Avonmore in Hammersmith and Fulham were residents from Ealing.

- At the last inspection we said that the trust should limit patients sleeping on wards as a result of bed pressures. At this inspection we found that patients on Horizon ward were frequently required to sleep on the rehabilitation ward due to a high demand for beds. This had happened on more than 60 occasions in the six months before the inspection. Patients who stayed on Horizon but slept on a different ward did not have a room or any private space to use during the day. This disrupted the patients' continuity of care and also presented potential risks for the patient who slept on another ward and the patients and staff on the rehabilitation ward. The trust said that they mitigated this risk by assessing patients for suitability and risk prior to the sleepover.
- During the six months prior to the inspection we found that 122 patients on the acute wards had experienced a delayed discharge. The trust had recently employed discharge co-ordinators at each of the three main sites to help to improve this area of work.
- The trust operated an ageless service for older people needing acute care, although Meridian ward at Hammersmith and Fulham mainly took patients over the age of 55. There were also two other wards providing special care to older people with behavioural problems and dementia. There were sufficient beds for older people needing an admission. For the six months between 1 January and 30 June 2016 Meridian ward had 12 delayed discharges. The trust said Jubilee and the Limes had no delayed discharges during this period, although this did not appear to be accurate. During inspection, the ward manager for Jubilee ward told us that ward staff had monthly delayed discharge meetings with the clinical commissioning group and social services. At the time of this inspection, eight out of the current eighteen patients were ready for discharge but could not be discharged for a variety of reasons. These included repairs required to a patient's home, a pending decision about a care package and difficulties with finding a suitable residential or nursing home placements for patients.
- In the two high dependency rehabilitation units there had been a reduction in the patients' length of stay since the last inspection. A number of patients had moved to more suitable continuing care services. The service was working towards a model consisting of a two year and a three year pathway with a single point of access. Further work was needed as there were six patients at Glyn ward who had been there for longer than three years, the longest having spent nine years on the ward. Two patients at Mott House had stayed there for four years. This indicated that some patients may have been better suited to alternative placements. At the time of the inspection bed occupancy was 65% at Glyn ward and 70% at Mott House.
- In the forensic services, to coincide with the opening of Thames Lodge the trust had introduced a clinical model centered around two care pathways. This provided a treatment framework and guidance for each pathway with proposed progression milestones. This encouraged staff and patients to work together to work towards step down and discharge plans.
- In high secure services 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 a number of patients waiting for an admission who were not assessed as being emergencies. What could be harder was arranging moves between wards for patients moving towards rehabilitation or moving patients out of the hospital into medium secure services. At the time of the inspection 16 patients were waiting for a bed in a medium secure service.
- The child and adolescent mental health ward only had planned admissions that did not take place at the weekend. There was no waiting list for children waiting to be admitted to the unit and the average length of stay in the service was 9 months. Discharge meetings were held prior to discharge.
- At the last inspection we raised concerns that the assessment teams were not achieving their target for seeing new referrals (emergency - 4 hours; urgent - 24 hours; routine plus - 7 days; routine - 4 weeks). Since the inspection the teams have expanded and extended

Are services responsive to people's needs?

their role as crisis assessment and treatment teams. Obtaining accurate data following these changes was hard but from looking at data and speaking to staff it appeared the targets were still not being met, which could present a risk for patients. In Ealing the team was supporting patients using the recovery house which was managed by a third sector provider.

- The arrangements for patients to access input from the recovery teams had improved since the last inspection and the number of patients waiting to be allocated to a care co-ordinator was low. New routine referrals into the recovery teams were reviewed by a transitions team embedded within each recovery team. Recovery teams prioritised cases based on risk. High-risk patients were discussed in the zoning meetings. Patients considered high risk could access a doctor rapidly. In some teams, those patients with a lower risk who did not need care co-ordination waited for a medical review from the doctor. The duty worker provided support to patients if they needed it whilst waiting for their appointment. The recovery teams aimed to work with patients for up to two years, depending on patients' needs. The recovery teams had identified discharge co-ordinators who supported the team to discharge patients, although they had only recently come into post. The discharge co-ordinator worked with the primary care mental health teams to facilitate the transfer of patients back to the care of their GP.
- At the last inspection we found that community patients were facing long waits to receive psychological therapies. At this inspection we found that recovery team patients had long waits to be seen by a psychologist and assessed. Overall, patients in Ealing were waiting 24 months to be seen. In Hounslow, the waiting time was 19 months and in Hammersmith and Fulham 15 months. The trust had plans to improve the availability and accessibility of psychological therapy for those who needed it most. Proposed strategies included offering more group interventions and the introduction of a process to approve the provision of therapies delivered for longer than average NICE recommendations. However, in the meantime nearly 200 patients had to wait for approximately two years.
- The cognitive impairment and dementia community teams (CIDS) had an agreed referral pathway with GPs which specified the information CIDS required about the patient and the physical health checks they expected

the GP to carry out prior to referral. In all of the teams, urgent cases were allocated straight away but we were advised that there could be a wait which exceeded the standard of four weeks for some routine referrals. The trust advised us that in October 2016 Ealing west was the team with the longest waiting times for patients to be seen for a first assessment. The trust said the waiting time averaged nine weeks for non-urgent referrals. This led to a waiting list of 58 non-urgent referrals awaiting allocation to be seen. We were advised that the recent appointment of link workers would enable nurses to reduce their caseloads freeing up more time for initial assessments with the aim of reducing the waiting list. The trust supplied data for the CIDS on referral to assessment and assessment to treatment times between 1 July 2015 and 30 June 2016. This stated that the trust target of 77 days from referral to assessment was met by all four CIDS teams. However, the target of 35 days from assessment to treatment was not met by any of the CIDS teams. The actual performance was slightly below the expected standard at 35-56 days.

- Young people could access the specialist CAMHS service through a referral from their GP, school or social services. All referrals were screened and triaged by the duty worker with urgent cases allocated to a team and the young person and their families informed. Staff were able to start treatment for most young people within 18 weeks. The trust reported on how many young people were or were not seen within this time to their commissioning groups and had a target of meeting this 18 weeks for 85% of young people. Where the number of young people not seen with 18 weeks fell below 85%, the trust listed reasons for commissioners. The longest waiting times of up to 39 weeks from referral to assessment was for young people accessing the neurodevelopmental teams in Hounslow and Ealing. Some teams had internal waiting lists for psychological therapies, where young people who had been fully assessed had to wait to start their agreed treatment. These young people were waiting up to 34 weeks to access treatment.
- We found that services were aware of the need to engage with patients who might find it hard to attend appointments and follow up patients who missed appointments. Most services tried to offer flexible appointments and were aware of the need not to cancel urgent appointments and to be on time for appointments.

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- The recovery teams were flexible when they offered appointments to patients and would visit patients at home when this was appropriate. The number of patients who did not attend (DNA) appointments was quite high in all of the teams. In the six months from April to September 2016 in Ealing recovery team east, 15.5% of appointments had not been attended by patients. In Hammersmith and Fulham recovery team, the number of DNAs was higher at 18.9%. The average DNA rate in the Hammersmith and Fulham early intervention team was 16% and 17.7% in the Ealing early intervention service. In Ealing, recovery team west 15.3% patients did not attend appointments. Hounslow recovery team east it was 12.4% and in Hounslow recovery team west it was 14.4%. Staff sent reminder letters to patients and telephoned the day before their appointment to remind and encourage them to attend. Staff in the early intervention teams made home visits to patients who did not attend. The DNA rates had remained the same over the last six months in all of the teams. The teams did not have specific plans in place to address the relatively high rate of DNAs and improve patient attendance at appointments.
- At a separate inspection we looked at the gender identity clinic provided by the trust and highlighted the long waiting times for assessment and treatment. A separate action plan was in place for this and was leading to improvements.

The facilities promote recovery, comfort, dignity and confidentiality

- The trust provided services from a wide range of buildings. Since the last inspection the Three Bridges Unit had opened at the St Bernard's site providing mens medium secure forensic services. For the patients who had moved into this new facility, they now all had bedrooms with ensuite bathrooms which promoted their privacy and access to a wide range of facilities such as gardening space, gym and sports facilities and kitchens to develop cooking skills.
- Many of the facilities at Broadmoor do not promote dignity, comfort and recovery but this will be addressed when the new building opens in 2017.
- Most of the services where care was provided were clean and comfortable environments. Most inpatient services had access to quiet lounges, rooms for therapeutic activities and outside space. However, for other patients, especially those in the Tony Hillis Wing, the facilities were very poor often with insufficient bathroom facilities. The acute wards on the St Bernard's site were also challenging in terms of layout and space. At the child and adolescent mental health ward we found the lounge was institutionalised with chairs in rows and the football pitch needed to be resurfaced.
- The wards which were caring for older people including patients with dementia did not always provide environments appropriate to meet their needs. For example there were few examples of where the environment had been adapted to be dementia friendly to help people to orientate themselves around the ward. There was not always access to alarms which less mobile patients could reach if they needed to call a nurse, although patients would have bedrooms near the nurses station. Showers and baths were not always suitable for patients who needed staff assistance with their personal care. For example showers could not be hand-held.
- Most of the patients using inpatient services had access to an appropriate programme of therapeutic activities. The main area of concern was in high secure services, where there were an excellent range of activities available but staffing levels impacted on patients being able to benefit from this input. At the last inspection we found that Broadmoor used night-time confinement on some wards and this was put in place where it was considered that this would maximise therapeutic benefit for patients in the hospital. For example, confining a group of patients at night released staff to facilitate greater therapeutic input for patients during the day. Where patients were subject to night time confinement, some did not have access to the offer of a minimum of 25 hours a week of therapeutic input which was recommended as the minimum. At Broadmoor the staffing levels impacted on access to association time, therapeutic and leisure activities and resulted in restrictive practices being used for longer periods of time than might otherwise be needed. This had not improved at this inspection and so enforcement action was being taken due to the high level of concern about the ongoing impact on patients.
- Services were mindful about providing appropriate facilities to support people with their recovery. For example in the forensic services patients had access to employment opportunities and access to courses at the

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recovery college. Further work was needed on the rehabilitation wards as patients were not routinely offered opportunities to self cater or manage their own medication.

- Wards provided spaces for families and friends to visit. There were arrangements for children to visit family members, where appropriate, which meant they did not come onto the wards.
- Each ward had facilities for patients to make phone-calls. Most had a pay phone. Where these did not provide sufficient privacy, patients could access the cordless phone from the staff office. In the rehabilitation wards, as part of the reduction in restrictions patients were starting to use their own mobile phones.
- Wards provided places for patients to store their valuables. These included bedrooms that could be locked, a lockable space in the bedroom or the facility to pass valuables to the ward staff for storage.
- The feedback about meals in inpatient services varied. Most people said they were satisfied with the food. The main exception was the forensic wards in the Tony Hillis Wing. Here the food was observed to be of a poor quality with small portions. Patients were eating lots of take-aways. In the Three Bridges Unit where the other forensic wards were located, food was cooked on site and was of a much better quality. On each ward there was access to hot drinks and snacks.

Meeting the needs of all people who use the services

- The trust served a very diverse population across each of the areas it covered. The trust recognised and celebrated the diversity of the patients and staff and worked to meet the needs of people using the service.
- The trust had a head of diversity. The trust completed an annual diversity profile report. Equality and diversity training was mandatory and most staff were up to date with this training. The trust had an equality, diversity and human rights (EDHR) steering group. This had undertaken a large piece of work to develop an EDHR strategy though this was still being reviewed before it's publication. The strategy had been based on the principles of inclusion, transparency, fairness and ownership and was at the beginning stages of being implemented.
- The strategy aims included developing stronger links with third sector organisations and community groups

to extend towards hard to reach groups. Posters were displayed around the trust with statements of how patients could ask for more information about anything related to their care in number of different languages.

- The trust had begun to introduce measures to meet legislative requirements of meeting the needs of people with a disability or learning disabilities ensuring information was accessible. Appointment letters were sent to people with a learning disability in easy to read formats, and PALS information was available in easy read formats.
- The trust planned to roll out LGBT champions across services to promote inclusion, and had introduced a rainbow coloured Identification holder to show that staff were inclusive and open to people from LGBT backgrounds.
- Within Broadmoor hospital there was a programme of calendar events which marked and celebrated cultural and religious events, and we saw examples of diversity activities taking place across the trust. These included services engaging with patients from sub-Saharan African backgrounds, working with people in local communities from Iranian backgrounds in workshops to improve understanding of mental health, and a learning disability inclusion project set up to better understand the reasonable adjustments required for people with learning disabilities.
- The department of spiritual and pastoral care provides multi-faith support for patients and staff.
- The trust ensured there were arrangements in place for when interpreters were needed. There were a couple of examples of where interpreters had not been arranged and this would have improved the communication with the patient. Staff had access to copies of information leaflets in a wide range of languages and formats that could be printed off to give to patients.
- The trust catering arrangements were appropriate for patients who came from different religious and cultural backgrounds.
- In some areas the environment was not sufficiently accessible. For example at the Hammersmith and Fulham CAMHS team there were not sufficient adjustments for physically disabled young people.

Learning from concerns and complaints

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- Information about how to complain was on the trust website, and displayed on posters inside inpatients wards and in community services. The trust provided a central complaints telephone line and email address for patients and the public to make complaints.
- In the 12 months period up to the 30 September 2016, 513 complaints were received by the trust. Of these 48% of these were partially or fully upheld. Whilst a small number of complaints had been referred to the ombudsman none were upheld. The service with the most complaints was Broadmoor, with 166.
- The top three themes were all aspects of clinical treatment, attitude of staff and communication with patients.
- The trust aimed to acknowledge formal complaints within three days of receipt of the complaint and to investigate and respond to the complainant within 30 days. We reviewed the response times for complaints across all services between from August to November 2016. All of the complaints had acknowledged receipt to the complainant within the 3 day period.
- During 1 July 2016 – end September 2016 a total of 129 complaints were raised across all services. Of this number 22 were withdrawn and of the remaining, 50% were responded to in time and 50% were addressed outside the timescale. The trust identified there was a high number of complaints that were not being investigated within the trust timescales, and complaints were not being investigated promptly. The trust stated that this was due to a lack of capacity of staff who had received necessary training to investigate complaints and complete reports.
- Complaints were managed and investigated by each clinical service units and two complaints managers were based in both local services and high secure and forensic service. Each formal complaint was handled formally by a senior member of staff (investigating officer) within the clinical service unit and the complaint was overseen by the local governance team. The executive director of the service was responsible for signing off the complaint investigation.
- Many concerns were dealt with informally by front line staff and the patient advice and liaison service (PALS). Information on how to make a complaint was provided in an easy read format for patients. Information about complaints was not displayed in other languages on trust sites though this could be requested and downloaded from the exchange, along with audio versions of how to make a complaint.
- A recent deep dive of complaints was conducted for community based local services within the trust. This identified that there had been an increase in the number of complaints received within the services at Hammersmith and Fulham. The trust had begun a piece of work to analyse and pull together information from three sources; the community patient survey, themes from serious untoward incidents and patient opinion to inform and share learning. The trust had also introduced customer relations training sessions to improve staff communication skills.
- We reviewed eight complaints files and responses provided to complainants by the trust. Investigation notes were included in all the files and we could see how responses had been reached by the investigation officer, who were senior members of staff. All formal complaints were closed and signed off by a letter from the chief executive to the complainant. All of the complaints included an initial letter which had been sent to the complainant within 3 working days of making the complaint. The records showed variations in the thoroughness of the investigation notes and variations in patient involvement. Three of the complaints had information about investigations undertaken during the complaints process, and in two of the complaints there was evidence of meetings with patients and staff associated with the complainant.
- The trust informed all complainants of the estimated timeframe for the investigation into the complaint. Delays in completing the complaint investigation within the trust timescales were communicated with the complainant by email or letter and the complainant was usually kept informed during the process. One complaint reviewed was not completed within the timeframe of 30 days and there was no correspondence between the trust and the complainant to keep them informed of the progress of the complaint.
- Four of the final outcome letters which were reviewed did not contain information on how the complainant could follow up any further complaints with the

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Parliamentary and Health Service Ombudsman. Two of the eight complaints reviewed contained a clear apology to the complainant and evidence of candour being shown in the letter complaints outcome.

- We reviewed two complaints which were specific to a particular service area and saw that complainants were informed of the actions and developments already being put in place within the service to address the concerns raised in the complainant.
- The service user and carer group, and the service user subcommittee received regular updates on complaints across the trust.
- The trust provided support for staff that had a specific allegation or repeated complaints about them through the health at work team. Prior to the inspection the trust had fed back that a review of the complaints process was due to begin to develop more structured process. The trust aimed to ensure family and carer involvement in the complaints process was meaningful from the start of complaint process, to the conclusion of the complaint investigation.

Are services well-led?

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

Summary of findings

Our findings

Vision values and strategy

- The trust's mission was 'promoting health and wellbeing together'. The vision was 'to be an outstanding healthcare provider, committed to improving quality and caring with compassion'. The trust's values were 'togetherness, responsibility, excellence and caring'.
- The trust had produced a quality strategy from 2011-18 which was a five year plan for quality improvement and then annual quality accounts which outlined their achievements and their priorities for the following year.
- The trust had reviewed its quality priorities for 2015-16. This found that there had been a reduction in the use of restrictive practices across the trust such as long term segregation at Broadmoor, but there was more to do; incident reporting was increasing but again there was more to do; work had taken place to achieve better patient and staff engagement and enhance the patients recovery and transition through the services and this had led to improvements such as more 1:1 sessions taking place between the patient and their primary nurse but again there was more to do; to have good quality care plans and work collaboratively with patients on their care plans and this had led to improvements; to improve the environments so they were safe, clean and therapeutic which was again in progress; to improve the physical health of patients and become smoke free and the smoke free had been achieved although work to ensure it was operating smoothly was still in progress.
- The quality priorities for 2016-17 reflected the previous years and the areas for ongoing progress.
- The inspection found that staff throughout the trust understood the trust's vision and values and how they could put these into practice in their work.

- The quality priorities for the trust also reflected the findings of the inspection and showed that the trust had insight into the areas where further improvement was needed.
- At the time of the inspection the trust was working closely with commissioners to transform services and manage its budget. At the end of September 2016 there was an overspend of £5.1m. The trust were struggling to achieve their cost improvement plans. They had introduced a new model to review the progress with cost improvements and were ensuring full trust management team input. They were still forecasting reaching a £3.4m surplus by the end of the year.

Governance

- The inspection found that whilst there were processes in place to manage risk and monitor performance these could be more robust. The trust brought together a range of indicators for the board in an integrated performance report. It was positive to note that the indicators reflecting areas for improvement aligned with some of the inspection findings such as the red RAG rating for staff vacancies and agency spend. There was scope for this to be reviewed to include other information to provide the board with assurance on areas needing improvement. For example the report could include data around the use of physical interventions. The board had also discussed refreshing the presentation of the data, including the use of run charts which would be of benefit so that trends over time could be clearly displayed.
- Sitting alongside this was the trust risk register and board assurance framework. This enabled risks to be identified at different levels in the organisation and inform the trust wide risk register. Changes to the trust risk register which reflected the most serious risks, were discussed and agreed at the board meeting. The board assurance framework described the risks and monitored the progress with reaching an improved rating. This did not include details of what controls or actions were taking place to deliver the improvements. It also did not

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indicate whether these actions were completed within an acceptable timescale. An internal audit report in summer 2016 also highlighted the number of non-completed actions from the previous year.

- There were structures in place across the trust to support good governance, although some of these were new and there was the potential for overlap between the areas covered by committees especially within the clinical service units. At the time of the inspection there were five main committees that were sub-committees of the board. These were the trust management team, audit committee, finance and performance committee and the quality committee. Since the last inspection the trust had added a workforce and development committee in recognition of the work needed in this area. There were also other committees such as the remuneration and charitable funds reporting into the board. The quality committee provided the board with assurance in relation to clinical quality. They received reports from the committees covering health and safety, research and development, clinical design, safeguarding and service user and carer experience. Sitting beneath the quality committee was a quality matters group which pulled together many of the operational areas being considered by the quality committee.
- The organisation of the trust was arranged into two clinical service units with seven clinical service lines sitting beneath them. Each clinical service line had a clinical director. Each clinical service line had a clinical improvement group, as well as every ward and team. We saw these operating across the services, although we recognised that these governance processes were relatively new and still being embedded and so the detail of what was discussed was still variable. It was positive to note the patient involvement in the clinical improvement groups.
- In addition there was a quality matters committee in local services, high secure and West London forensics. These again looked at data relating to a wide range of operational aspects including incidents, medicines management, NICE guidance, safeguarding, research and development, physical healthcare, medical education and other quality priorities.
- At the last inspection we found that at a ward or team level the use of this information to monitor the service or make improvements was very variable. At this inspection, some wards and teams were making good

use of information about staffing, feedback from patients, results of local audits to ensure the service was operating well. In other areas this was not happening effectively. There were variations between the different clinical service units and lines in terms of how information was provided to support managers. In addition, some more experienced managers were better at understanding how to find and use information to support their role. Examples of this were seen in some services where managers were unclear about admissions and discharges, whether they were meeting targets, waiting lists for services and numbers of patients with delayed transfers of care. Another example related to wards who were working to reduce physical interventions where they did not know how many seclusions or restraints had taken place and what the trend was over the last few months. We also had concerns about some data quality such as staffing shortages and patients having their therapeutic activities or leave cancelled where staff were not always reporting this. The result of this was that managers may not recognise and make improvements in a timely manner. There was also a risk that the board may not be getting accurate data on which to gain assurance.

- It was also noted that some of the key areas of work undertaken by the trust were supported by very few staff. Examples of this included management of incidents and complaints, audits and user involvement. This was potentially impacting on the capacity and capability to complete or develop the work in a timely manner and ensure good learning across the trust.

Fit and Proper Person Requirement

- The trust was not yet meeting the fit and proper persons requirement (FPPR) to comply with Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This regulation ensures that directors of health service bodies are fit and proper persons to carry out the role.
- A fit and proper persons policy was approved by the trust board in March 2015. The trust policies outlined the checks required for directors on appointment and on-going annual checks of fitness. These included checks of criminal record where appropriate, identity, right to work, employment history, professional registration, qualifications and an internet search to check for insolvency and bankruptcy.

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- The checks on current executive directors were mostly in place.
- At the last inspection we found there were gaps in the checks for non-executive directors. We were assured by the trust that they would be obtaining these records from the then Trust Development Authority. At this inspection we found these records were still not in place. The trust had determined that they did not require a disclosure and barring check for all NEDs as they were only visiting patient areas under supervision. At this inspection it was established that NEDs independently visit different parts of the trust and yet disclosure and barring checks had not been obtained.
- The feedback from stakeholders was that the senior management changes were positive, that there was a good relationship with stakeholders and the clinical leadership was also viewed positively.
- The trust had done considerable work since the last inspection to improve staff engagement and morale. This was particularly evident in the forensic services in West London, where most staff talked about the improvements over the last year. Staff were very positive about the new chief executive and the changes being made. Most staff said that there was a much more open culture and they felt able to raise concerns. The trust recognised that whilst there had been really positive progress, there was still more work to do to create a healthy culture in the organisation that promoted the safety and well being of staff.

Leadership and culture

- The inspection found that the trust leadership team had many strategic and operational issues to address. There was confidence that the leadership team in post at the time of the inspection, had the skills to deliver the necessary improvements. There were however concerns about their capacity as there were many areas for improvement. Since the last inspection there had been a number of changes in the senior leadership team. A new chief executive had been appointed and had been in post for 8 months. In addition there was a new medical director and director of workforce and organisational development. The director of nursing and patient experience who had come into post shortly prior to the previous inspection was now well established at the trust. In addition there had been changes in clinical directors. Four of the seven posts were either new appointments or interim / acting appointments since the last inspection.
- The trust chair joined the trust in 2015. There were seven other non-executive directors. Two of the non-executive directors were new in post since the last inspection. The trust was working to make the board more diverse to better reflect the local communities. A board meeting was observed and this was efficiently managed and participants asked a wide range of questions and provided appropriate challenge. A board development programme was in place and regular away days took place. Non-executive directors made visits to services, but these did not ensure all areas had a visit and feedback was not shared in a consistent manner.
- The trust NHS staff survey in 2015 had mixed results. In seven areas the trust was better than average for a mental health trust. This included training and development, effective use of patient feedback, improving staff motivation and reducing violence and discrimination. However, there were 16 areas where they were below the average including recruitment, equal opportunities for career progression, flexible working, bullying and harassment and ensuring that staff are regularly appraised and have development plans. The family, friends and staff score for staff recommending the trust as a place to work or received treatment was unchanged from last year and still below the national average for mental health trusts. The score for staff reporting good communication with senior staff had improved but was still below the national average. The number of staff completing the family, friends and staff survey was very low.
- We heard about the different ways in which the trust was working to improve staff engagement. This included monthly staff listening events. Teams were also supported to have team building sessions and away days. In addition the trust used a range of means to communicate with staff. This included the monthly chief executives blog, newsletters and making good use of the well developed trust intranet. Senior staff and board members also spent a lot of time visiting services and speaking to staff and patients.
- The trust recognised the importance of recognising the hard work of staff across the trust. There was a monthly staff and team award. There was also an annual award ceremony.

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- The trust was investing in middle manager, leadership training. Much of this was delivered by senior managers in the trust. At the time of the inspection the first cohort of 50 people was underway. The trust had also introduced quarterly leadership events attended by staff from across the trust. There were also monthly trust wide nurse leadership meetings and regular updates were provided on the intranet. Since the last inspection the trust had introduced a trust wide strategic lead for allied health professionals.
- Most of the staff we spoke to during the inspection were positive about their teams and local leadership. Staff told us how morale had improved. There were however still pockets of less happy staff who felt they were being bullied or not supported in a manner that reflected the values of the organisation. These generally related to relationships with a manager in their area of work and were often long-standing concerns. We passed these concerns to the trust so that additional support could be provided as needed. It was also noted that the junior doctors felt that the engagement could further improve. They were now meeting occasionally with the chief executive and medical director. They felt that they had lots of useful ideas and would value increased engagement opportunities.
- Staff working in the trust were aware of the whistle-blowing process, although most said they would speak to their line manager if there were issues. The trust had just appointed a non-executive director as a 'freedom to speak up guardian' for the trust, although work was still needed on how this role would operate in practice. The trust was also putting in place 'befrienders' to support staff who feel they need support especially with bullying. The chief executive had clearly stated that bullying was not acceptable.
- As part of this inspection we looked at how the trust were implementing the Workforce Race Equality Standard (WRES). The trust held detailed information on the equality characteristics of its work force and this was published in two annual reports. An equality and diversity demographic report outlined how the trust was meeting its legislative duties to meet nine indicators of workforce equality. This report also included an accompanying action plan of how future objectives would be met. An equality and diversity report was also submitted annually to the trust board.
- Staff from black minority ethnic groups (BME) made up 47% of the total workforce of the trust. The largest single minority within this group were staff from Black African backgrounds. During the inspection we spoke with the trust equality and diversity lead. We heard of a number of initiatives and actions the trust had started to tackle discrimination, advance equality and foster good relations.
- The trust had two networks, these were for people who are BME and lesbian, gay, bi-sexual and trans-gender. There was also an equality and diversity steering group specifically for high secure services and low/medium secure forensic services.
- The trust gathered data from the 2015 NHS staff survey, to measure how the WRES were being met. The results showed that there was a consistently higher proportion of BME staff reporting harassment, bullying or abuse. The trust was above the national average for this score for 2015. However the score for BME staff reporting this type of bullying and harassment from other members of staff had decreased by 4% since 2014 which was positive. A higher proportion of BME staff reported experiencing discrimination from a manager or team leader. The score for 2015 was slightly higher compared with the national average for mental health trusts though had decreased by 4% since 2014 which was positive.
- In 2015, 66% of staff from BME background believed that the trust provided opportunities for career progression, compared with 77% for staff from white backgrounds. The response from BME staff was an increase of 4% from the findings in 2014 which was positive. The trust had made recent changes to recruitment practice, introducing unconscious bias training as mandatory for staff responsible for recruitment. Equality and diversity champions had also been appointed to sit on interview panels for all senior members of staff to provide an independent viewpoint on decision making and unconscious bias when appointing senior members of staff.
- The trust had introduced BME leadership programme to provide training and support for staff to apply for senior management positions in Band 7 and above. Three cohorts had been delivered which focussed on developing skills and expertise and to provide mentorship to BME staff. BME staff were positive about the BME leadership programme. However, the overall feedback was that even though there had been a number of BME staff completing the leadership

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programme this had not translated enough to successfully gaining employment in senior positions. Since the BME leadership programme commenced, a total of approximately 30 staff had completed the programme. Of this number, nine had successfully gained jobs in senior management positions. Several members of BME staff fed back they did not feel that there was the opportunity to gain employment in senior management positions and two members of staff fed back that they had applied for senior jobs for several years and had not been successful in gaining employment in a senior management position.

- The trust delivered equality and diversity training which was tailored to roles. New staff received a 1 hour session at trust induction, estates staff received a 2 hour bespoke training session, a half day workshop was provided for band 3 clinical staff and for staff with line management responsibility. An e-learning module was provided for staff as part of mandatory training.

Quality improvement, innovation and sustainability

- The trust participated in a small number of external peer reviews with the Royal College of Psychiatrists. This included the quality network for inpatient CAMHS where the service at the Wells Unit was registered and the quality network for community CAMHS which had also

led to peer visits. Other accreditations included the memory services national accreditation programme where they are accredited. Cranfield ward at Broadmoor was also accredited through the adult inpatient wards scheme (AIMS). The electroconvulsive therapy accreditation service where the Broadmoor service was accredited as excellent. The forensic inpatient services had completed peer visits as part of their accreditation. Broadmoor hospital is accredited through the national offender management service audit. This audit was carried out by an assessment team from HM Prison Service.

- The trust had a strong dementia research portfolio and had participated in over 100 research projects. The trust was also part of the health science network partnership with Imperial College London and well as links with other universities. Senior staff said they would like to see research extended. The trust was in the process of appointing two consultants jointly with Imperial NHS Trust which will increase research.
- The trust was starting to work towards implementing a quality improvement approach. This involved the initial training of some staff in the quality improvement methodology and the implementation of a few quality improvement projects such as those linked to the reduction of long term segregation at Broadmoor.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	<p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>The trust had not provided care and treatment that was appropriate and met the needs of patients.</p> <p>This was because:</p> <p>In forensic inpatient wards: There were some blanket rules and restrictions that were continuing to take place.</p> <p>On Tony Hillis Wing the food was in insufficient quantities and the quality was low.</p> <p>In rehabilitation mental health wards: The wards did not provide sufficient access to educational and vocational opportunities and for patients to self-cater and self-administer their own medication.</p> <p>At Glyn ward patients' individual needs and dignity was compromised by people not having keys to their own rooms, people having glass panels in their bedroom doors and curtains on the outside that could be opened by staff and people queuing for their medication.</p> <p>In community based mental health services for adults: Service users in the recovery teams did not always receive care and treatment that met their needs in a timely way.</p> <p>Waiting lists for psychological therapy were very long. Patients were waiting up to 24 months to be seen in some teams.</p> <p>This is a breach of regulation 9 (1) (a)(b)</p>

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 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:

In high secure services:

The 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 care and treatment was provided in a safe way for patients.

This was because:

In forensic inpatient wards:

On the Tony Hillis Wing there were ligature anchor points throughout all the wards and areas which were not in the line of sight of the nurses' stations.

Medical equipment used for resuscitation and basic life support had passed its expiry date on the women's forensic services.

Staff were not correctly using the national early warning scores which could result in staff not recognising that a patient was deteriorating and arranging timely medical input.

In acute wards:

The trust was not ensuring the ward environments were safe and the risks to the health and safety of patients were being assessed and mitigated.

This section is primarily information for the provider

Requirement notices

The seclusion rooms at the Hammersmith and Fulham mental health unit and Lakeside were not located to ensure the safe movement of patients from the ward to the seclusion room.

The new ligature management policy had not been fully applied, with comprehensive ligature audits for each ward and clear actions for when improvements needed to take place.

The blind spots on Kestrel ward had not all been mitigated through the use of mirrors.

Not all patient risk assessments had been updated following incidents.

Some medication fridge temperatures were outside the correct ranges and this had not been addressed.

Patients from acute wards were sleeping on rehabilitation wards, which compromised the consistency of their care and presented risks as the rehabilitation wards were not appropriate environments.

In rehabilitation mental health wards:

Patients who were from the acute wards were sleeping on the rehabilitation wards. This presented potential risks for both groups of patients.

In community mental health services for adults:

Staff did not consistently assess, monitor and record the physical health of service users. This meant that physical health risks may not have been identified and therefore appropriately mitigated.

In the crisis mental health services:

The crisis assessment and treatment teams did not always complete patient risk assessments thoroughly, keep them updated and ensured they were stored consistently.

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

The trust had not ensured that systems and processes were established and operated effectively to prevent abuse of patients.

This was because:

In forensic inpatient wards:

Reviews of the patients in seclusion were not undertaken by professionals at the intervals stated in the Mental Health Act Code of Practice. Medical reviews at night did not always take place in person and the reasons for this were not recorded.

In high secure services:

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.

In wards for older people with mental health problems:

The trust had not ensured that staff provided care in a way that was safe, recognised patients individual needs and promoted their dignity and privacy.

The trust was not consistently using the MCA and DoLS appropriately. Staff were not able to access appropriate support and guidance when applying the MCA and DoLS to individual patients.

Trust wide:

39% of restraints were still in the prone position.

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

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The premises was not suitable for the purpose for which they are being used.

This was because:

In forensic inpatient wards:

The seclusion rooms in the Tony Hillis Wing did not preserve the privacy and dignity of patients. Clocks were not available in all the seclusion rooms.

This section is primarily information for the provider

Requirement notices

Some wards in the Tony Hillis Wing did not have sufficient numbers of toilets or bathing facilities.

In acute wards:

The seclusion room on Finch ward was not well maintained and was unclean.

Furniture and fittings on Lillie ward were not well maintained and parts of the ward were unclean.

In the child and adolescent mental health ward:

The trust had not ensured that the premises and equipment was properly maintained.

A shower had been broken for over a year and the patients had to share one working shower.

In specialist community mental health services for children and young people:

There was no effective system to ensure emergency medical equipment was in date and regularly reviewed.

Some premises were not suitable. Adaptions for people with a disability were not effective. Sessions were disturbed by ringing alarms and lights going on and off.

In wards for older people with mental health problems:

Ward environments were not dementia friendly.

This was a breach of regulation 15(1)(c)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The 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:

In the high secure services:

Staff did not feel adequately engaged and reported feeling demoralised and so further improvements in communication were needed.

This section is primarily information for the provider

Requirement notices

In acute wards:

The trust was not ensuring that staff had appropriate systems and process to monitor the quality and safety of the service.

Ward managers did not have had sufficient clear and accurate information to monitor the quality of services being delivered.

Ward managers did not have comprehensive information about seclusions, restraints and other information.

In rehabilitation mental health wards:

Staff did not feel adequately engaged and improvements in staff being able to give feedback and open communication were needed.

In wards for older people with mental health problems:

The trust had not ensured that governance processes were efficient and robust and improved the quality of services provided.

In specialist community mental health services for children and young people:

Learning and feedback from incidents was not embedded.

Managers did not have access to timely and accurate management information to support their role.

Further work was needed to improve engagement with staff.

In crisis mental health services:

The trust did not have governance systems and processes which were operated effectively in the crisis assessment and treatment teams to ensure compliance and address areas where improvements needed to take place to mitigate risks to the health, safety and welfare of patients.

Team managers were not aware of their teams' performance data regarding time taken to see emergency, urgent, and routine referrals to ensure that these were met.

This section is primarily information for the provider

Requirement notices

In community based mental health services for adults:

Clear performance data was not available and accessible to service and team managers so that they could clearly identify how to make improvements in services.

Trust wide:

Managers of teams and wards did not always have access to the right information in a timely and accessible manner to support the management of the services.

This is in breach of regulation 17(1)(2)(e)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The trust had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patients.

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

This was because:

In forensic inpatient wards:

Some staff shifts were not filled and the ratio of qualified and unqualified staff was not as planned. Patients said they were not getting their leave as planned.

Not all staff were receiving adequate supervision and there was no system in place to monitor the effectiveness of supervision.

In acute wards:

Supervision sessions were not taking place regularly or were consistently recorded. Managers were unable to review the quality and content of supervision sessions.

Some staff had not completed appraisals.

Junior doctor out of hours workloads were potentially too high and needed to be reviewed.

This section is primarily information for the provider

Requirement notices

In rehabilitation mental health wards:

Staff at Glyn ward were not receiving regular supervision and at the end of September 2016 only 56% had a completed an appraisal.

In the child and adolescent mental health ward:

The trust had not ensured all staff providing care or treatment to patients had the training or competence to do so.

Staff did not received training on Gillick competence and its application to young people.

Staff did not have access to specialised training around providing care and treatment for patients in a forensic CAMHS setting.

In community based mental health services for adults:

Many staff had not received an appraisal in the last year. In one team, no staff appraisals had been completed.

Staff in Ealing recovery team west did not receive one to one managerial supervision.

In community health inpatient services:

Staff were not having regular individual supervision and supervision was not recorded.

Trust wide:

The trust did not have robust systems in place to ensure staff had access to regular individual supervision, covering appropriate topics and recorded.

This is a breach of regulation 18 (1)(2)(a)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

The trust had not completed all the necessary checks to ensure the non-executive directors were fit and proper persons.

This was a breach of regulation 5 (1)(2)(3)(4)(5)

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	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Treatment of disease, disorder or injury	<p>In high secure services: 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.</p> <p>Patients did not have access to activities and therapeutic engagement according to their care plans.</p> <p>This was a breach of regulation 18(1)</p>