

Investigation

# Investigation into West London Mental Health NHS Trust

## About the Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care services in England. We also protect the interests of people detained under the Mental Health Act.

Whether services are provided by the NHS, local authorities, or private or voluntary organisations, we make sure that people get better care. We do this by:

- Driving improvement across health and adult social care.
- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.

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# Summary

## Introduction

This investigation into West London Mental Health NHS Trust was triggered by concerns from a number of sources about the trust's response to suicides within the trust. There appeared to be delays in completing investigations into these incidents and staff seemed unclear about the kind of internal investigation required. Also, recommendations for action were being repeated in each report, suggesting that the trust was not learning from the incidents – vital if it was to protect people from harm in the future.

We asked for information from the trust and carried out an unannounced visit to two of its sites, to see the environment in which care was being delivered, see how staff engaged with the people who used its services, and interview clinical staff and managers. From the information we obtained during this screening process, we did not believe that the causes of the problems could be readily identified without an investigation.

Our initial focus was on the trust's response to suicides and other serious incidents. However, to judge whether this might be symptomatic of wider problems at the trust, we also looked at a number of areas relating to the quality of care provided by the trust. Although we reviewed information about a range of services at the trust and carried out unannounced visits to a number of sites, overall our investigation focused on services at Broadmoor Hospital and on community and inpatient services in Hounslow. This decision was based on the information available about the number of suicides at each site and the trust's response at the time the investigation was approved.

Our key findings are summarised below and set out in full in the body of this report. All references to the work we carried out as part of the investigation include work by the Healthcare Commission, one of our predecessor organisations.

## Providing a safe environment and protecting people from harm

It is the responsibility of all mental health trusts to provide safe care that promotes health and wellbeing and to protect people who use their services from harm.

### Investigating and learning lessons from incidents

When things go wrong, or could have gone wrong, with the care of people – incidents such as suicides, self-harm, medication errors or physical assaults to staff or people who use services – it is important that trusts have clear procedures for reporting and investigating incidents, so that lessons can be learned.

We found that the trust had a number of different policies in place for the reporting and investigating of incidents. They contained conflicting information about the classification of the different types of incident, the type of investigations available and when they should be used. This led to confusion among staff, and hindered rather than helped them.

The trust was aware of this confusion and, in October 2006, began to introduce a new overarching policy to resolve it. However, it was 18 months before the policy was approved, in April 2008. The trust decided to delay the policy in order to incorporate information from the national high secure reporting policy (which was signed off in April 2007) and the NHS Litigation Authority that were in development at the time. Rather than allow the confusion to be prolonged for a year and a half, the trust should have taken some interim action.

We reviewed 37 of the trust's investigation reports and found that 22 were undated. The reports that did have dates showed significant delays from when the incident occurred to when the report was completed. The time to complete ranged from two months to 23 months from the date of the incident; the average time was nine months. The trust was aware of the

delays but, until recently, took little action to improve the process.

We also found that the quality of the reports was variable. Sometimes, findings did not match the evidence and important lines of enquiry were not pursued. For example, one investigation failed to examine in detail the staffing levels on what was a very busy ward when the incident occurred, while others failed to include recommendations about ligature points, even though the deaths involved had occurred by hanging.

Recommendations were often repeated, which implied that lessons from previous incidents had not been learned or put into action. For example, the need to improve observations of inpatients was recommended in seven reports into incidents in different services: once at Hounslow in 2005, five at Broadmoor Hospital from 2005 to 2007 and once, in 2007, in the service for older people at Hammersmith and Fulham. This included the need for observations to be carried out in line with the trust's policies, for training and assessment of staff undertaking observations, and for regular checking of people who were on enhanced observations.

Risk management featured most frequently in the investigation reports: 56 recommendations in 24 reports. Nine recommendations were related to the trust's approach to risk management, including that assessments should focus on the risk of self-harm as well as harm to others.

We found that the focus of risk assessments was too narrow. They needed to be expanded to identify potential problems and the more subtle signs of behaviour that may indicate a person was at risk of self-harming or causing harm to others.

Action plans were developed without involving key staff, and staff were unclear about who was responsible for implementing them. And although there was some discussion about incidents and the findings from investigation reports, there was no systematic mechanism to ensure learning across the different services and sites within the trust. Considering that action plans were key documents to bring about change, they should have been given more attention.

At board level, there was discussion at the risk management committee about investigations into

serious untoward incidents and members of the committee were aware of some of the problems. However, they were slow to push for action: they asked for information about delays to be included in quarterly incident reports but this did not happen. The non-executive directors should have been more challenging about the delays and why the reasons for delays were not documented as requested.

At trust, directorate, service and team level there were a number of groups/committees in place with responsibility for clinical governance. While there was much activity, the effectiveness of it was questionable. The trust should have redirected some of its energy to consider if the arrangements were too complex and were hampering progress.

In summary, the trust's arrangements for investigating and learning from incidents and near misses were seriously flawed.

### **Other serious concerns about safety**

We found several other issues that gave us cause for concern about the safety of the care provided by the trust:

- Many of the trust's buildings are old and considered "not fit for purpose". Although some refurbishment has taken place, the redevelopment plans for Broadmoor Hospital have been in progress since 2003, with 2016 as the proposed date for completion. The layout of the wards at Broadmoor makes it difficult for staff to observe patients and, when staffing levels are low, sections of the wards are closed off.
- Some of the buildings at St Bernard's Hospital in Ealing date back to 1830 and are in urgent need of upgrading. There have been infestations of mice and cockroaches in the inpatient areas.
- Between 2005 and 2006, the trust carried out a review of ligature points on 56 wards across the trust. Following this, suicides occurred on four of the wards included in the review. The trust does not have an ongoing programme to remove or reduce the number of ligature points – instead, they are addressed as part of the yearly capital works programme.
- There have been problems with bed occupancy, particularly at the Hammersmith and Fulham site.

Insufficient beds resulted in inpatients sleeping on sofas rather than in a bed on a ward, and some people had to stay longer than necessary on the psychiatric intensive care unit. Staff did not recognise or report the potential risks of having some inpatients sleeping on sofas. It was an ongoing problem from late 2005 and, although the trust took some interim action, it was only in late 2008, during the investigation, that the trust and PCT agreed that a review of bed usage was required.

## Enabling good outcomes for people through high quality care

Providers of services should enable good outcomes for people with mental health needs by ensuring that they receive high quality assessments, care and interventions.

We looked at some of the wider quality of care provided by the trust, to see whether the issues set out above were isolated or part of a bigger problem. They included the environment in which care is delivered, staffing levels and training, access to therapeutic activities and medicines management. These areas have been identified in national reports such as The National confidential enquiry into suicide and homicide by people with mental illness (December 2006) and the national audit of violence as factors that will increase the likelihood of incidents occurring. We found several issues that the trust needs to address:

- The trust has experienced low staffing levels, accompanied by high levels of absence due to sickness. Although it has tried to recruit staff, this has been hampered by long delays, partly due to the completion of necessary employment checks. Despite trying to find ways to reduce the delays, the problems persisted. The low staffing levels also resulted in low attendance at mandatory training and reduced access to escorted leave for inpatients.
- Managing the physical healthcare of people who use the trust's services at Broadmoor Hospital – a basic right for people with mental ill-health – has taken a backwards step. In 2003, the GP service at Broadmoor Hospital was highlighted as an area of good practice. The GP left in early 2007 and since then the service has deteriorated. The GP was replaced in August

2008, with the temporary appointment of a GP one day a week. This is supplemented with practice nurses for specific services. The trust has only recently gone out to tender for a primary care service. Although people who use the trust's services are having annual physical healthcare checks, the arrangements for physical healthcare are fragmented and much reduced.

- Medicines management is another area where the trust was making improvements, with the appointment of a chief pharmacist in 2003, but since then progress has been slow. The role of the chief pharmacist has not been given sufficient authority or opportunity to be involved in decision-making at the trust. Pharmaceutical advice, although valued by staff where it is available, was a scarce resource, with services in the community being the worst affected.

## Conclusions

Like all NHS trusts, West London Mental Health NHS Trust has many competing priorities and nationally set performance targets to achieve. We do not underestimate the energy and time it takes to meet these requirements, and the staff who were responsible for delivering care were working in difficult conditions.

However, one of the fundamental things that a trust must do to ensure that services are safe and people are protected from harm is to learn the lessons from serious incidents and take action to prevent the same things happening again. The system that the trust had in place to do this was seriously flawed.

Many of the trust's buildings are old and deemed "not fit for purpose". In particular, parts of the environment at Broadmoor Hospital are neither safe nor conducive to high quality care. The redevelopment of Broadmoor Hospital is complex and has difficult planning issues related to the listed buildings on site. However, it is hard to see that the timescale proposed for the completion of the redevelopment is satisfactory for service users.

In Hammersmith and Fulham, many people slept on sofas on a number of occasions or stayed too long on the intensive care unit due to insufficient beds – practices that posed a significant risk to safety and

unacceptable healthcare in the 21st century for the most vulnerable people.

The trust had significant problems with staffing levels and recruitment and, in some areas, the actions taken by staff to manage the low staffing levels put themselves and the people who used services at risk. The people using the services were aware of the staffing shortages and the impact it was having on their care and treatment.

Finally, users of mental health services have a right – like all people – to receive good care and treatment for their physical health, yet the trust’s approach to this was slow and fragmented.

In summary, the particular position that this trust holds, and the nature of the services it provides, means that the public has a right to expect that the services are of a high quality. But, rather than being determined to be a leader in the field of mental healthcare, the trust tolerated mediocre and, in some instances, low standards of care. People accessing its services were entitled to better than this.

## Action taken by the trust taken since the start of the investigation

Since the investigation was announced in April 2008, the trust has made several changes.

In October 2008, the trust introduced a revised service delivery unit (SDU) structure, having been initially agreed in May 2007. The aim of the new reorganisation was to improve the governance of the organisation. The five SDUs are Ealing, Hammersmith & Fulham (including the gender identity service), Hounslow (including the Cassel Hospital in Richmond), West London forensic and High secure. Each SDU is managed jointly by an SDU director and a clinical director, who are both accountable to an executive director of the trust.

The trust has also introduced forums to govern the quality incident reviews and promote learning across the organisation.

A new policy for reporting and investigating incidents, together with new monitoring arrangements, was introduced in April 2008. This includes a new classification system for incidents, with level 1 being the

most serious. The trust has told us that, between April 2008 and March 2009, a total of eight level 1 reviews were commissioned: of these, two were completed within 60 days, and two exceeded 80 days. Of the 23 level 2 reviews commissioned, 18 have been completed: of these, nine were within 60 days, six between 60 and 80 days and three over 80 working days.

The trust has undertaken to recruit additional medical staff to senior management positions. All five clinical directors of the SDUs are currently medical staff and the new structures also include clinical leads who will be part of the senior management teams.

Since early 2008, visits to clinical areas by the trust board have been focused on patient safety, and feedback has been noted at the clinical and research governance committee and executive directors meetings. In February 2009, the trust achieved level 1 in the NHS Litigation Authority standards for risk management (there are three levels, with level 3 being the highest).

## Recommendations

We expect the trust to consider all aspects of this report, including all our findings, which detail serious concerns across different parts of the trust’s services. Here we highlight what is particularly important.

Overall, the trust’s board must develop and promote a more dynamic, innovative culture that encourages staff to be enthusiastic, up-to-date with current practice and motivated to provide the best care for people and their carers. Staff should be encouraged and enabled to speak up and speak out, and treated fairly. The trust must aspire to become a leader in, and an example of excellence in, mental healthcare, and in particular forensic mental healthcare.

### Providing a safe environment and protecting people from harm

1. The trust must improve its management of risk. This should include:
  - Appropriate reporting and proper investigation of incidents.
  - Analysis of the risks raised by incidents and near misses to identify patterns or persistent concerns.

- Exploring how the learning from incidents can be shared and embedded in practice with staff who already have busy workloads.
2. The trust must ensure that the actual and potential risks that users of services pose to themselves or others are properly assessed and reflected in the risk management or treatment plans.
  3. Commissioners of the trust's services need to develop mechanisms for monitoring the reporting, investigating and learning from incidents in the services they commission, and give more priority to this as part of commissioning.
  4. In collaboration with commissioners, the redevelopment plans for Broadmoor Hospital and Ealing must be progressed without further delay.
  5. The trust and commissioners must ensure that there are sufficient beds for each patient group and a sufficient range of alternatives to hospital admission. However, all inpatients must have a bed and, where possible, this should be in a unit designed to meet their needs.

### Enabling good outcomes for people through high quality care

6. For people to receive safe and therapeutic care, the trust must ensure that it has sufficient numbers of staff, with the right skills, in all staffing groups.
7. The trust needs to ensure that staff attend mandatory training and that attendance is monitored and accurately reported.
8. The physical healthcare of people who use the trust's services needs to be given a higher priority across the trust, particularly in forensic services. The trust must ensure that all people have access to the same range of primary and secondary services as other people.
9. Medicines management should be given a higher priority by the trust. The role of the chief pharmacist needs to be strengthened by positioning it at the appropriate management level. Resources for pharmaceutical advice needs to be reviewed and, where appropriate, strengthened with investment, to ensure that staff and people who use services receive appropriate advice and support in relation to medicines management, wherever they are accessing or delivering care.

### National recommendations

In addition to our specific recommendations for the trusts, we think that there are a number of lessons that have a wider application to all mental health trusts and commissioners:

10. Providers of mental health care, along with the relevant NHS, statutory, professional and user-led organisations should work together to devise a robust, clear and proportionate framework for internal and external investigations and reviews. The framework should focus on good practice in nationally published guidance and issues identified in this report, such as the classification of incidents, clear accountability within the organisation for the investigation/review and the sharing of knowledge and outcomes that will lead to continuous service-wide learning, and promotion of understanding and best practice.
11. Strategic health authorities and/or consortia PCTs should work, together with providers, to develop shared mechanisms to manage reviews where a degree of external scrutiny is required. This could include providers identifying experienced and appropriately trained clinicians who would be available to act as external reviewers and share learning from investigations.
12. Commissioners of services need to develop mechanisms to monitor the arrangements for the reporting, investigating and learning from incidents in the services they commission, and give more priority to this as part of commissioning.
13. Mental health trusts need to ensure that the physical healthcare of people who use services is given a high priority, particularly in forensic services. They must ensure that all users of services have access to the same range of primary and secondary service as the rest of the population.
14. Mental health trusts need to ensure that medicines management is given a high priority, with due consideration of the recommendations made in *Talking about medicines* (Healthcare Commission, 2007).

# Introduction

We undertook this investigation at West London Mental Health NHS Trust following concerns about the responsiveness of the trust to serious untoward incidents within the trust, such as suicides, and its arrangements for investigating, reporting and learning from these incidents.

The concerns came to our attention in late 2007 and we started our screening process, known as an initial consideration. We asked for information from the trust about the number of suicides and the outcome of the subsequent investigations. We carried out an unannounced visit to two sites within the trust, to see the environment in which care was being delivered, observe how staff engaged with the people who used its services, and interview clinical staff and managers.

We reviewed recent reports by the Mental Health Act Commission, which had found concerns about the levels of staff, the environment, and delays in responding to recommendations that it had previously made. In addition, the trust had recently been assessed as “weak” in the Healthcare Commission’s review of NHS acute inpatient mental health services (the report of which was published in July 2008).

Our initial consideration revealed a number of serious concerns:

- Staff were not clear about the classification of incidents: some suicides were classified as “critical incidents”, while others were classified as “serious untoward incidents”.
- There were concerns about the management of critical and serious untoward incidents, particularly the length of time it took to complete investigations – with some taking more than a year to complete and report to the trust’s board.
- A review of the investigation reports provided by the trust found a pattern of recommendations being repeated, which implied that the recommendations were not being implemented.

- We did not believe that the likely causes of the problems were readily identifiable without investigation.

These concerns were noted by our investigation committee, which agreed that a full investigation was necessary.

All references to actions that we carried out in the investigation include work by the Healthcare Commission, one of our predecessor organisations, up to 31 March 2009.

## Terms of reference

The investigation committee approved the terms of reference for the investigation in March 2008.

The investigation was to focus on the systems that the trust had in place to ensure the safety of patients, and the quality of the services provided by the trust, covering the period from April 2005 to the end of 2007. This would include an examination of:

- The trust’s arrangements for investigating serious incidents and ‘near misses’, the length of time taken to begin and complete investigations into serious incidents, and the communication of the outcomes once they were completed.
- The number and type of incidents occurring in recent years, relating to the services provided by the trust.
- Arrangements at the trust to protect the safety of people and to assure the quality of care within the trust and its community services.
- The governance arrangements within the trust and in the NHS locally for managing risk and scrutinising the quality of care provided by the trust.

Although we reviewed information about a range of services at the trust and carried out unannounced

visits to a number of sites, the investigation focused on services at Broadmoor Hospital and on community and inpatient services in Hounslow. This decision was based on the information available about the number of suicides at each site and the trust's response at the time the investigation was approved.

## Key elements of the investigation

Our investigation team worked with a team of expert advisers. The membership is listed in appendix A.

During the investigation, we:

- Carried out eight site visits to the trust (five planned and three unannounced), to interview staff in relation to the investigation.
- Conducted more than 290 face-to-face and telephone interviews with past and present staff from the trust, people who had used services at the trust and their relatives, local organisations representing them, members of the public and voluntary organisations (see appendix B for further details).
- Analysed more than 1,000 documents provided by the trust and other organisations (see appendix C for a summary of sources of information and evidence).

## This report

In this report, we set out the context of mental health services in England, including changes in national policy. We describe the background of the trust and the range of services it provides.

Since the concerns that triggered the investigation were related to the trust's arrangements for the management of risk and the actions it took following serious untoward incidents, we describe the trust's arrangements for the management of risk and clinical governance.

We also look at the quality of care provided by the trust, including the levels of staff, the range of activities available for people, and the physical environment in which people received care and treatment. In considering the quality of care provided by the trust,

we asked people who used the trust's services for their views, including those detained under the Mental Health Act, and their relatives and carers.

We look at the management and leadership, including clinical leadership, of the trust and how the trust's board and other agencies were assured about the safety of people. We also consider how the trust worked and engaged with other NHS organisations and local authorities.

# National context

Mental health problems are common and diverse. One in six people in England and Wales will have a mental health problem, ranging from more common problems, such as anxiety or depression, to conditions that tend to be more severe and enduring, such as schizophrenia.

Not everyone with a mental health problem experiences severe symptoms all of the time, and most people with mental health problems are treated in the community and do not require admission to hospital.

People with mental health problems are the principal group within the healthcare system who can be compulsorily detained, under a section of the Mental Health Act. This places a significant moral obligation on services to ensure that the rights and wellbeing of these individuals are safeguarded.

## Mental health care

Over the last 50 years, mental health services have gone through significant changes. The 1950s saw a further move away from care provided in institutions known as long-stay hospitals or asylums, to care that is based in the community.

Towards the end of the 1990s, mental health services attained a higher profile among Government policies. The National Service Framework (NSF) for Mental Health, issued in 1999, set an ambitious 10-year agenda for improving mental health services in England. The NSF laid down seven standards in five areas of care: the promotion of mental health, better access to primary mental health care, effective services for people with severe mental health problems, support for carers, and the prevention of suicide. This was supported by a huge range of policy guidance and national targets.

*The NHS Plan* in 2000 identified mental health as one of three clinical priorities (along with cancer and

coronary heart disease). It described new services and promised additional funding of more than £300 million by 2003/04 to help implement the NSF.

These changes heralded significant investment and reform in mental health services which was welcome. However, it was recognised that many services were starting from a low baseline and, despite these initiatives, the need for modern mental health services remains a relatively low priority in society. *The Journey to Recovery*, published by the Department of Health in 2001, described mental health services as the poor relation among services, with “shabby and depressing wards that would never have been tolerated in medicine or surgery” and care in the community that “too often became a bleak and neglected environment”.

## Our national findings

In 2003, one of our predecessor organisations, the Commission for Health Improvement (CHI), published *What CHI has found in mental health trusts*, a report on its findings from 35 clinical governance reviews carried out in mental health trusts in England and Wales. It found that, although there was evidence of progress, mental health services “still lagged some way behind the acute sector in developing clinical governance arrangements – those systems and processes that promote high quality care and continuous improvement”.

The Healthcare Commission’s review of specialist community mental health services for adults of working age, *No voice, no choice*, published in July 2007, found a wide variation in the quality of services. There was considerable scope for improvement in a number of key areas, including improving people’s experiences of using community mental health services by involving them more directly in decisions about their care, and designing

services in a way that improves recovery and social inclusion for the people who use them.

The Healthcare Commission's subsequent review of NHS acute inpatient mental health services, *Pathway to recovery*, published in July 2008, concluded that renewed policy focus on acute care services, together with a range of national initiatives, had started to facilitate progress in some areas. These included an increase in the proportion of mental health staff trained in diversity issues and well established access to independent advocacy and other engagement activities. However, more work was required in involving people in their own care, ensuring the safety of people who use services, staff and visitors, providing appropriate and safe interventions for people and increasing the effectiveness of the acute care pathway.

# The trust's history and role

West London Mental Health NHS Trust was formed in 2001 from the merger of Ealing, Hammersmith and Fulham Mental Health NHS Trust with Broadmoor Hospital Special Health Authority. In April 2002, the majority of mental health services for the borough of Hounslow were transferred into the trust from the dissolving Hounslow and Spelthorne Community Mental Health NHS Trust. In April 2003, services for the Feltham area of Hounslow were also transferred to the trust.

The trust provides a range of inpatient and community mental health services for adults, older people, adolescents and children living in the boroughs of Ealing, Hammersmith and Fulham, and Hounslow, serving a population of nearly 700,000 people. It also provides specialist forensic services (see below). The trust operates from 32 sites and employs 4,196 staff. Fifty-six per cent of staff are women and 44% are men. Forty-one per cent of staff are from minority ethnic groups.

The trust has a higher proportion of inpatients from a black and minority ethnic background (56% are not White British, compared with a national average of 22%), but a similar ethnicity mix as the rest of London. It has a much higher proportion of male users of services compared with both London and the national average.

## Leadership

The trust's board, consisting of executive and non-executive directors, is responsible for the governance of the trust. The chief executive was appointed in January 2004 and had previously held the post of deputy chief executive/director of finance. The chairman, who had been in post for eight years, retired towards the end of 2008. The other executive and non-executive directors had mostly remained on the board throughout the period covered by the investigation.

## Structure

For the period covered by the investigation, the trust was divided into three divisions: local services, forensic services and corporate services. The local and forensic divisions were led by a director, associate medical director and deputy director of nursing. In May 2007, the trust revised the delivery of services and agreed that the divisions would become service delivery units. This was implemented in October 2008 and more information is provided later in the report in the section on progress.

### Local services

Local services, provided in Ealing, Hounslow, and Hammersmith and Fulham, comprise a range of inpatient and community mental health services for adults, older people, children and adolescents.

Local services also include some specialist services. For example, the Cassel Hospital is a national specialist tertiary service that provides inpatient and day services for adults, young people and families with severe personality disorders and family problems. The Gender Identity Clinic is a national service for people who experience distress about their gender.

### Forensic services

Forensic mental health services are provided in a range of secure settings or community specialist placements to people who generally have committed a criminal offence. However, some people are cared for in such settings, not because of criminal offences, but because their behaviour has proved so challenging that they are unable to be cared for in general mental health services. There are three levels of secure services: low, medium and high. In England, high secure services are provided by three trusts, of which the trust is one. A person is cared for and treated in the setting that represents the deemed level of risk they pose to the public and/or themselves.

The trust provides forensic services at Ealing and at Broadmoor Hospital.

Broadmoor Hospital is located in Crowthorne in Berkshire. It provides forensic mental health services in conditions of high security for men who have severe mental health problems. The hospital is divided into three parts: the south of England directorate for people from the south of England and the London directorate for people from London, and the dangerous and severe personality disorder unit, which is part of a pilot programme of services across prisons and high secure hospitals.

High secure services at Broadmoor Hospital are commissioned on a regional basis by specialised commissioning groups. Oversight of the commissioning process is provided by the national High Secure Commissioning Team, which is accountable to the National Specialist Commissioning Group.

St Bernard's Hospital in Ealing provides forensic services for men, women and male adolescents in a mix of medium secure (the largest in London), low secure and specialist rehabilitation wards. They cover Central and North West London, Hertfordshire and Bedfordshire.

People in medium and high secure services may have a greater propensity to aggression and violence than in the general mental health patient population as a whole, as well as a higher than usual male patient population. This means that staff are more likely to see or witness violence and safety issues, and be subject to violence/intimidation.

The trust provides inpatient services at Feltham Young Offenders Institute, and outreach services in the prison. The Wells Unit provides a service for adolescents and young men aged between 12 and 18 years. The Orchard, opened in September 2007, is an enhanced medium secure service for women located on the Ealing site. It provides care for women who need specialist forensic services, but not high security, including many who were previously detained in Broadmoor Hospital and also new admissions from custody and from services across the south of England.

## Corporate services

Corporate services include nursing, medical, finance, information management and technology and procurement, human resources, estates and facilities, security, communications and strategy, performance and corporate development.

## Local agencies

The services provided by the trust are contracted by commissioning bodies such as Ealing Primary Care Trust (PCT), Hammersmith and Fulham PCT, Hounslow PCT and local authorities on behalf of local residents. The trust also provides services to other PCTs. High secure services are commissioned on a cluster basis by specialised commissioning groups, and linked as a national service by the High Secure Commissioning Team. This team is accountable to the National Specialised Commissioning Group, and reports on its activities to the National Oversight Group. The National Oversight Group's overall remit is to ensure that the Secretary of State's specific duties under Section 4 of the NHS Act 1977 (now the NHS Act 2006) to provide high security psychiatric services is being properly discharged.

From July 2006, the trust has been in the area covered by NHS London, the strategic health authority (SHA) for London. The role of the SHA includes establishing and managing annual performance agreements with PCTs and other NHS trusts that provide services.

## Previous reviews involving the trust

In 2003, the Healthcare Commission's predecessor, the Commission for Health Improvement, carried out a clinical governance review of the trust. The report, published in November 2003, found that, although the trust had made progress in developing systems to support clinical governance, there was still much to do. The key areas for action included an urgent review of bed capacity in the local adult services and addressing the sleeping out arrangements (where people are cared for on one ward, but must sleep elsewhere due to shortages of beds).

The Healthcare Commission's review of community mental health services for adults of working age, published in October 2006, rated the trust as "fair". This was a joint review with the Commission for Social Care Inspection and looked at the way in which mental health and social care services were provided in local communities for adults between the ages of 18 and 65.

In the Healthcare Commission's review of NHS acute inpatient mental health services, published in July 2008, the trust was rated as "weak". The review assessed mental health services for adults aged 18 to 64 on inpatient wards, including psychiatric intensive care wards.

The Healthcare Commission's annual health check of the trust's performance in 2007/08, published in October 2008, was based largely on the trust's self-assessment. This rated the trust as "excellent" for quality of services and "good" for use of resources. In publishing this assessment, we noted that this investigation was underway and that the assessment would be reviewed in light of the report. In the previous assessment for 2006/07, the trust also received "excellent" for quality of services and "good" for use of resources.

# Providing a safe environment and protecting people from harm

It is the responsibility of all mental health trusts to provide safe care that promotes health and wellbeing and to protect people who use their services from harm. In this chapter, we look in detail at the arrangements the trust had in place for reporting and investigating incidents, and the quality of these arrangements. We also report on several issues concerning the environment in which care was provided.

## Sources of evidence

- Interviews with staff
- Interviews with relatives
- Trust documents including policies, and minutes from a range of committees: risk management committee, local clinical governance committees, incident monitoring and review group, and incident reports
- Review of investigation reports commissioned by the trust
- Review of investigation reports carried out by external advisors to the investigation
- Results of the national surveys of NHS staff for 2005 to 2007

Trusts should have arrangements in place for staff to report all incidents, when something has gone wrong or could have gone wrong with the care of patients. The investigation of serious untoward incidents should result in lessons being learned and implemented, and the risk to people who use services in the future being reduced.

In 2006, the National Patient Safety Agency (NPSA) found that, nationally, the majority of incidents reported by mental health trusts were from inpatient services and a third of incidents were from services for older people (*With safety in mind: mental health services and patient safety*).

## Arrangements for managing clinical risk

During the period covered by the investigation, the director of nursing had responsibility for clinical risk management, supported by two associate directors: one for patient safety and one for non-clinical risk. A number of other staff had responsibility for some aspect of the management of risk, for example reducing violence and preventing suicide.

Although the director of nursing was responsible for the systems related to the reporting of incidents, the directors of local services and forensic services were responsible for the management of risk within their respective services.

The trust had a range of policies for the reporting of incidents and for the safety of patients, some of which overlapped. From September 2003 until December 2007, the “serious untoward incidents and resulting inquiries” policy (U1) was in place. From December 2003 until December 2007, the “incident reporting” policy (I1) was also in place. Both of these policies were the responsibility of the director of nursing.

In August 2006, a third procedure was introduced: the “patient safety incident reporting and inquiry” procedure (P2). This was the responsibility of the medical director and was introduced in response to guidance from the NPSA.

All of the policies included information about the action to take following the death of a person by either natural causes or suicide.

The trust has commented that it did not withdraw the serious untoward incidents and resulting inquiries policy, as there remained a need for guidance for investigating non-patient related incidents. However, the policy makes reference to incidents in “both clinical and non-clinical areas” and clinical incidents.

The policies described the different classification systems used by the trust and other organisations for reporting incidents. Internally, incidents were classified either numerically, alphabetically or by description. For example, the 2003 policy for incident reporting classified incidents as 1-5 (5 was "catastrophic"). The serious untoward incidents and resulting inquiries policy classified incidents alphabetically: A-D with category A as the most serious and defined as any death however caused. In the patient safety incident reporting and inquiry procedure, incidents were classified as "death", "severe/major", "moderate" or "no harm/low harm", in line with guidance from the NPSA.

The trust explained that the different categorisation of incidents led to confusion among staff and was caused by the trust adopting the NPSA categories in the patient safety incident reporting and inquiry procedure. It has sought to clarify this, but the differing categories used by the strategic health authority in the policy for reporting incidents in high secure services continue to make it difficult to use one system for categorising incidents.

In all of the policies, the death of a person (except when from natural causes) was rated the most serious category of adverse incident. The patient safety incident reporting and inquiry procedure made specific reference to "suicide on an in-patient unit, suicide in the community..." as the most serious category of incident. From a review of the policies, it is clear that all suicides should have been reported as a serious untoward incident and received the highest level of enquiry.

The serious untoward incidents and resulting inquiries policy described the actions to be taken following a serious untoward incident, including the inquiry procedure. The policy stated that the panel for investigations should include three or more members, and that the investigation should take "normally no longer than six weeks". The terms of reference would be agreed by the chief executive with the chair of the investigation panel. The policy also referred to "more limited enquiries for incidents not falling into the serious untoward incident category". The same timescales applied, but the findings from the enquiries would be considered by the executive

directors and not the trust's board, as in the case of serious untoward incident investigations.

There was also a third review: a "critical incident/peer review" which should have been completed, with a report submitted to the executive director within one month of the incident. The exception to this was if a serious untoward incident investigation had been initiated. We found that many of the reports into suicides that occurred in the community were titled "critical incident review". We were told that critical incident reviews were usually chaired by a senior manager or clinician and were not usually reported to the trust's board. They were reported at divisional meetings and service meetings.

The patient safety and incident reporting and inquiry procedure included information about the review procedure for "severe/death patient safety incidents". It stated that they should be commissioned by the trust's board, that the review team should include five or more members and that the investigation should take place within the shortest timescales "that allows thorough investigation... normally no longer than six weeks". Again there is reference to a review procedure for moderate, low harm and no harm incidents. They should be completed, including the report, within one month of the decision to hold the review.

In 2006, the issue of the number of policies for reporting incidents was raised at the forensic divisional clinical research committee. In October 2006, at the meeting of the clinical and research governance committee, the director of nursing reported on the introduction of a new incident reporting policy, explaining that this would become the overarching policy for patient safety and critical incidents. Comments were requested but it was 18 months before the policy was approved in April 2008. The trust explained that they decided to delay the policy in order to incorporate information from the national high secure reporting requirements and the NHS Litigation Authority (NHSLA) that were in development at the time. The Department of Health has told us that the high secure reporting policy was signed off in April 2007 (the high secure operating framework, of which the reporting policy is a part, was signed off in April 2008). However, a paper

outlining the reason for the delay was not circulated until December 2007 and the trust's new policy was not introduced until April 2008.

### Findings of fact

- Responsibility for the arrangements for the management of clinical risk was shared between the director of nursing and the directors of local and forensic services.
- The trust had a number of different policies in place for the reporting of, and subsequent enquiries into, incidents.
- The trust was using different classification systems for reporting incidents.
- The policies contained inconsistent information about investigations and reviews.
- The trust was aware of the confusion caused by the different policies.
- According to the trust's policies, all deaths (except those by natural causes), suicides, homicides, attempted suicides and serious self-harm incidents should have been classified as serious untoward incidents and investigated as such.

## Incidents at the trust involving death or serious self-harm

We asked the trust for reports of serious untoward incident investigations and critical incident reviews from April 2005 to the middle of 2008.

The trust provided 95 reports into incidents where the death or serious self-harm of a person was reported. Sixty-three of these reports were completed within the timescales covered by this investigation. Thirty-one of these were suicide, three were homicides and 11 were attempted suicide/serious self-harm. Eighteen were classified as "death" – these were due to choking, drowning or cardiac failure; seven of them were classified as "unknown cause" (see table 1).

Of the cases of suicide, hanging was the most common method used.

Fifteen of the incidents were investigated as serious untoward incidents. Forty-six incidents had critical incident reviews (15 of which were suicides that had occurred in the community) and two had both a serious untoward incident investigation and a critical incident review.

The issue of inconsistency in reporting and investigating serious untoward incidents was raised at

**Table 1: Reports into incidents involving death or serious self-harm, 2005-2007**

|                   | 2005      | 2006      | 2007      | Totals    |
|-------------------|-----------|-----------|-----------|-----------|
| Suicide           | 11        | 8         | 12        | 31        |
| Death             | 3         | 8         | 7         | 18        |
| Serious self-harm | 4         | 2         | 0         | 6         |
| Attempted suicide | 1         | 4         | 0         | 5         |
| Homicide          | 0         | 1         | 2         | 3         |
| <b>Totals</b>     | <b>19</b> | <b>23</b> | <b>21</b> | <b>63</b> |

the trust's risk management committee in 2005, and at the local services clinical governance committee in 2006. Responses to the issue were that the new investigation policy would clarify the level of enquiry required. The minutes state that, in local services, the death or suicide of a person in community services would usually require a critical incident review, whereas the death or suicide of inpatients, including those on leave, would require a serious untoward incident investigation.

Although many of the staff that we interviewed knew there was a distinction between a serious untoward incident investigation and a critical incident review, some were unable to tell us the difference. Some said that a critical incident review was more serious than a serious untoward incident investigation, "a CIR was for critical use on the ward" or a "CIR involved serious injury and an SUI did not involve serious injury to anyone". Others said that it was related to the severity of the incident. Some staff told us that the information in the reports generated 24 and 72 hours after an incident, as demanded by the policies, determined the level of review, or that the decision was made by the head of the service in which the incident occurred.

When asked about the difference between a serious untoward incident investigation and a critical incident review, executive directors told us that it wasn't determined by where the incident occurred, that the level of contact the person had had with the service was a factor and that the decision had on occasion been hampered by difficulties in having people in local services who could access the information about what had happened and make the correct decision.

The director of nursing was aware that there was confusion among some staff, and told us that the trust had recently changed the policy in an attempt to reduce the level of confusion.

### Findings of fact

- Staff at all levels of experience and professional background were unclear about the differences between a serious untoward incident investigation and a critical incident review.
- Some suicides that occurred in the community services had a critical incident review.

## Review of serious untoward incident investigations and critical incident reviews

We decided to review the reports to provide information about the quality of investigations. We also wanted to ascertain whether the trust had systems in place to learn from incidents and make improvements for the benefit of users of its services.

We reviewed the reports of 35 incidents, of which two had had both a serious untoward incident investigation and a critical incident review – making 37 reports in total. Five of the reports were into incidents that occurred outside the timescales for the investigation and had been received prior to the investigation being approved. The incidents occurred in 2003 and in 2004. One of the incidents that occurred in 2003 was delayed at the insistence of the police until the judicial process was completed, and due to the subsequent illness and maternity leave of the person's consultant psychiatrist. The reason we included them in the review was due to the length of time it took for the report to be presented to the trust's board. The report of the incident that occurred in October 2003 took 23 months to complete and was not submitted to the trust's board until March 2006. The reports of three of the four incidents that occurred in 2004 were not submitted until 2006 and one was submitted in May 2005.

The incidents included suicide, attempted suicide, serious self-harm and homicide, and had occurred in community and inpatient services across the trust.

A further in-depth review was carried out by two of our expert advisors. They reviewed 12 reports, 11 of which were a subset of the 37 reports referred to

above. The other was a critical incident review into an attempted suicide that occurred in early 2008.

### **Term of reference and investigation/review panels**

Of the 37 reports, 34 had terms of reference. Two of the three reports that did not have terms of reference did not identify any problems with either the service or the care provided, although they did include recommendations.

The composition of the investigation/review panels varied and this may have been due to the different information contained in the policies. The patient safety incident reporting and inquiry procedure stated that, for “severe/death patient safety incidents”, the panel should consist of five or more members including “an independent senior clinician”. The serious untoward incidents and resulting inquiries policy stated that, for incidents such as suicide and life threatening activity, the chief executive would determine the composition of the panel and that the panel would consist of three or more members. For the more serious incidents, defined earlier in the policy as “homicide, a cluster of serious untoward incidents in a clinical area, allegations of abuse of patients”, the panel would be agreed with the SHA and have an external chairman.

Six investigations/reviews had less than the required number of panel members. Five of these were from Hounslow; the other was from the service for older people at Hammersmith and Fulham.

Three of the critical incident reviews, conducted following incidents in Hounslow, had only one person investigating the incident. When asked about this, the clinical director said that it was for the sake of expediency.

Serious untoward incident investigations should have been chaired by a non-executive director. Five of these (out of 20) were not chaired by a non-executive director, they were chaired by senior staff such as an associate director or the head of allied health professions. There was also an absence of some staff groups on the panels. Occupational therapists, social workers and senior pharmacists were not routinely asked to be members of panels for investigations or reviews. We were told that decisions

about the membership of panels were made by executive directors.

### **Investigation/review method**

In 23 of the 37 reports, root cause analysis was used as the method for investigation and each of these followed a similar format.

Training for staff to undertake investigations had been provided by the trust for some staff. However, not all of the panels included a member of staff who had received training.

### **Timescales for investigations/reviews**

Table 2 sets out the timescales for when serious untoward incident investigations and critical incident reviews were completed. Both the serious untoward incidents and resulting inquiries policy and the patient safety incident reporting and inquiry procedure contained flowcharts outlining the different types of enquiries and timescales for completion. Different wording is used in each policy to describe the type of review or investigation required. For example, one refers to a limited inquiry; in the other this is described as a limited incident review. Reviews are described as critical incident/peer review or divisional limited incident review. From the information in the policies, it would seem that serious untoward incident investigations should have been completed in six weeks and reviews in four weeks. Limited inquiries and limited incident reviews should also be completed in six weeks.

Of the 37 reports we reviewed, 22 (15 serious untoward incident investigations and seven critical incident reviews) did not include the date when the review was completed and so it was not possible to determine the length of time between the incident and the date when the investigation or review was completed. Of the remaining 15 reports, the average length of time from incident to completion of investigation or review was nine months: the longest was 23 months and the shortest was two months.

Fourteen of the 15 reports of serious untoward incident investigations that did not include a date of completion, did include a date when they were submitted to the trust’s board. The longest period of time from the date of the incident to the date when the report was presented to the trust’s board was 22 months and the shortest was four months. The average length of time was eight months.

**Table 2: Timescales for completing investigations and reviews, 2005-2007**

| Type of review  | Total number of reports | Time from date of incident to date of review indicated on report (months) |
|---|-------------------------|---|
| Critical incident review (one month following incident)                       | 1                       | 23  |
|   | 1                       | 13  |
|   | 1                       | 10  |
|   | 1                       | 8   |
|   | 1                       | 7   |
|   | 1                       | 6   |
|   | 4                       | 5   |
|   | 1                       | 2   |
|   | 7                       | No date on report   |
| <b>Critical incident review total</b>   | <b>18</b>               |   |
| Serious untoward incident investigation (normally 6 weeks following incident) | 1                       | 23  |
|   | 1                       | 10  |
|   | 1                       | 7   |
|   | 1                       | 6   |
|   | 15                      | No date on report   |
| <b>Serious untoward incident investigation total</b>                          | <b>19</b>               |   |
| <b>Total</b>  | <b>37</b>               |   |

None of the reports included information about why it had taken so long to complete the investigation or review. During interviews, we were told that there were difficulties with the availability of staff who were panel members, and of a recent occasion in 2008 where a non-executive director had been asked to chair a panel two months after the incident occurred.

On occasion, PCTs and local authorities had to agree the terms of reference and this impacted on the timescales. At the risk management committee on 31 October 2007, it was noted that the terms of reference had been approved by the PCT and local authority for an incident that had occurred in April 2007. Other reasons given were the involvement of other agencies, including the police, which meant that the trust sometimes had to wait for other investigations to be completed before the trust could begin its own investigation or review.

The length of time it took to complete investigations and reviews was an ongoing issue and was discussed regularly at a number of meetings. In June 2006, the minutes of the risk management committee record a discussion about the length of time it was taking for investigations to be completed, and that the date of the incident recorded in an investigation report was different to the original date given for the incident.

In an attempt to improve the process for investigating incidents, in October 2006 the forensic division established the incident monitoring and review group at Broadmoor Hospital and in the forensic services at Ealing. The purpose of the group was to ensure that incidents were properly investigated, action plans were completed and information about incidents was disseminated. The minutes from meetings of the Broadmoor Hospital group were not circulated to other forums or committees. It was the responsibility of members of the group to disseminate information to other members of staff.

At the meeting of the Broadmoor Hospital group in October 2006, it was noted that most members had not seen more than two or three of the 21 outstanding critical incident reviews, nor any of the completed reviews. It was a similar picture for serious untoward incident investigations. In the case of the outstanding reviews, in some cases these had taken place but not all of the actions had been implemented. Concern was raised about the number of outstanding critical incident reviews and the associate director asked service directors to review their current list of reviews to see how many were outstanding.

The group discussed the progress of investigations/reviews following serious incidents, recommendations and action plans.

We were told that it was not until 2008 that an incident monitoring and review group was established in the local services division. There is a reference to reports being submitted to the group in May 2008.

In November 2006, it was noted at the trust research and clinical governance committee that quarterly incident reports should include information about reasons for delays. At the meeting of the risk management committee in February 2007, the director of nursing was asked to ensure that, where there was a delay, the reason was documented in the quarterly incident reports. The issue was raised again in April 2007, along with the decision that the executive directors for forensic and local services should investigate the reasons for the delays. The assistant director of patient safety commented that sometimes there were “no reasons for a delayed report”. Some staff told us that they felt the timescales for completing investigations and reviews were unrealistic and needed to be extended.

We are aware that the trust created a central network to monitor progress on investigations into serious incidents and critical incident reviews, but this achieved limited success. We were told by staff at Broadmoor Hospital that, although there was a discussion about setting up the network, some key staff were not involved in the discussions. The information, on the network, was meant to be updated on a weekly basis but we were told this did not happen. There was some concern that the central network used a different numbering system for identifying investigations and reviews to that used by Broadmoor Hospital.

Local services did not use the central network. Instead, a database of all incidents occurring in local services was held by the director of local services. The trust provided copies of the database.

### Findings of fact

- The composition of the investigating and review panels did not always comply with trust policies.
- The policies were unclear about the composition of the panels.
- On many occasions, the investigations and reviews were not completed within the timescales in the trust’s policies.
- Some investigations had significant delays.
- The trust was aware there were delays in completing the investigations.
- Reasons for the delay were not documented in the reports.
- Many reports were undated.
- Some action was taken in the forensic services to improve the monitoring of serious untoward incident investigations and critical incident reviews.
- The information on the central network was not updated on a regular basis.

### Recommendations arising from investigations

Of the 37 reports that we looked at, seven did not have an action plan. Four of these did not have any recommendations, and we were not provided with action plans for the other three.

An analysis of the recommendations made in different reports over time found that many of the recommendations had already been made in previous investigations (see table 3). In some instances, these related to incidents in the same service.

Risk management featured most frequently: 56 recommendations in 24 investigation reports

were about the management of risk. Nine recommendations were related to the trust's approach to the management of risk, including that assessments should focus on the risk of self-harm as well as harm to others. Five reports identified the need for a procedure for how to manage a major change, such as a new treatment. Other recommendations included the need to reflect, in the care programme approach, the historical risk of suicide or deliberate self-harm.

Seven recommendations about care programme approach featured in seven reports.

Improvement in observation was recommended in seven reports into incidents in different services: once at Hounslow in 2005, five at Broadmoor Hospital in 2005-2007 and once, in 2007, in the service for older people at Hammersmith and Fulham. This included the need for observations to be carried out in line with the trust's policies, training and assessment of staff undertaking observations, and regular checking of people who were on enhanced observations.

The need for improved training and education

featured frequently, with 18 recommendations in 15 reports. The recommendations covered mandatory training, and provision and access to training.

The environment was addressed in six investigation reports: the need for investment to address some of the problems and progress on reviews of ligature points. In one case, the critical incident report noted that "the presence of a potential ligature point on some of the rooms ... raised concerns" and that there had been a delay in removing them.

The prevention of suicide featured in four reports, particularly the need for improved planning and prevention work. One investigation had identified a disconnection between the risk assessment and the care plan; the day to day management of risk did not marry up with the assessment. Other recommendations in relation to suicide included the need for improved management of emergencies: six reports with fourteen recommendations, covering training in cardiopulmonary resuscitation, the provision and location of life saving equipment, involvement of doctors and emergency protocols.

**Table 3: Types of recommendations in investigations and reviews, 2005-2007**

| Area of recommendation                      | Total number of reports each area of recommendation appears in |
|---|--|
| Risk management                             | 24   |
| Record keeping                              | 16   |
| Training and education                      | 15   |
| Pre-admission transfers                     | 11   |
| Policies                                    | 10   |
| Post-incident management                    | 9  |
| Care programme approach                     | 7  |
| Observation                                 | 7  |
| Supervision, leadership and line management | 7  |
| Emergencies                                 | 6  |
| Environment                                 | 6  |
| Suicide prevention                          | 4  |
| Diversity and transcultural issues          | 3  |
| Medication                                  | 3  |
| SUI policy and strategy                     | 2  |
| Communication with families/carers          | 2  |

Although communication with families and carers following an incident only featured twice in two of the 37 reports reviewed, good communication with families following the suicide or attempted suicide of a person using services is crucial. Suicide is devastating for families and carers to cope with, leaving them not only to deal with a range of emotions, but with many questions. This issue was relevant to all services. It was identified in an investigation into an incident in local services in 2005, and identified again in 2008 in the thematic review of incidents at Broadmoor Hospital.

Where appropriate, examples of good practice in the care of people during and after an incident were highlighted in the reports.

When asked about recommendations, staff told us that some of the recommendations were inappropriate, such as ones that said the trust must review all its policies. Others were “badly worded”, or they were “not as robust” as they should have been, or they were undeliverable.

The recurring problems and recommendations were noted at the local service clinical governance executive meetings in 2005.

### Findings of fact

- Recommendations were repeated, sometimes in reports into incidents in the same service.
- Where appropriate, some reports included examples of good practice.
- The management of risk and care planning were the most frequently recurring themes in recommendations.

## In-depth review of investigation reports

Two consultant psychiatrists who provided advice to our investigation carried out a more in-depth review of 12 reports into serious untoward incidents and critical incidents. Eleven of these were a subset of the 37 reports previously discussed, and covered incidents that occurred in local and forensic services. The consultant psychiatrists also reviewed a range of

trust policies and national guidance in place at the time of the incidents.

The in-depth review found an inconsistent approach to the investigation of incidents. The constitution of the panels was variable, in particular the use of external experts. In one critical incident review, the medical member of the panel was only involved from the draft report stage. Much of the report was concerned with nursing practice and a nurse was not included on the panel.

Many of the reports were undated and, as previously mentioned, timescales for completing investigations and reviews were unclear. In one case, the report of the critical incident review was not reported to the trust’s board until over a year after the incident, despite complaints from the family.

Some of the recommendations in the reports of the critical incident reviews confirmed that the panel considered that a serious untoward incident investigation would have been more appropriate.

The terms of reference were addressed in the findings of each report, but the format of the reports varied greatly. There was a lack of consistency in the methodology applied in undertaking the reviews. This could not be accounted for by the different requirements for serious untoward incident investigations and critical incident reviews. It appeared that different approaches had been taken by the panels in each case.

Although, in the majority of the reports, the recommendations reflected the findings of each panel, of concern was the absence in two reports of recommendations about ligature points where death occurred by hanging. Another investigation failed to examine in detail staffing levels on what was a very busy ward when the incident occurred, while one left a number of areas unaddressed.

While many of the reports were of a reasonable standard, mainly the earlier reports, some were of poor quality and it was concerning that they were accepted by the governance committees without comment.

In one of the most recent reports, there were a number of omissions. The physical condition of the person had deteriorated significantly and the person had written a suicide note. Despite this, the

possibility of self-harm or suicide did not seem to have been considered. The report notes the lack of appropriate reference to the suicide note. It is not clear from the report if the panel established whether the medical staff who attended the incident were aware of a suicide note, which was absolutely critical.

Along with recommendations, many of the reports included examples of good practice, such as evidence of comprehensive notes and good communication between the mental health services and a person's GP.

### Findings of fact

- There was inconsistent practice in the way the trust investigated incidents and some reports lacked a clear structure.
- There were considerable delays in completing reports.
- Some of the reports were of very poor quality and there was no evidence that this had been commented on at the various committees reports had gone to.
- The review found some examples of reasonable practice in investigating incidents.
- There were serious omissions in some reports.

## Implementation of action plans

There were a number of problems with the implementation of action plans. During interviews with staff, we were given conflicting responses about who was responsible for implementing action plans. Some staff told us they did not know, while others said it was up to service directors and lead clinicians to identify who was responsible for taking forward actions. Some said it was the responsibility of the chair of the investigation/review. A non-executive director, who chaired investigation panels, was clear that it was not the chair's responsibility to ensure action plans were implemented; instead it was the responsibility of the directorate/service in which the incident occurred to implement the actions.

The patient safety incident reporting and inquiry procedure states that the initial findings and key

problems from reviews/investigations will be shared with the relevant clinical team to "generate solutions and recommendations". However, staff that we interviewed were concerned that reports and action plans were submitted to the trust's board before they were shared with senior medical and nursing staff of the service where the incident occurred, or with groups such as the incident monitoring and review group. This sometimes resulted in impractical and unrealistic action plans being approved by the board.

The procedure also stated that action plans would be developed by the relevant divisional director and approved by either the trust's board or executive directors, and that they would include nominated staff for ensuring the recommendations were implemented.

We were told that, in 2005, following suicides at Broadmoor Hospital, an analysis of action plans, resulting from investigations into suicides, found that some had not been put through the approval system and therefore were not being implemented.

In 2006 in the forensic division, it was noted that the responsibilities of senior and middle managers for completing action plans needed to be highlighted.

During interviews, we were told that, at Hounslow, it was intended that the local service executive would sign off action plans, but the process for this to happen was not agreed. The action plans were considered not unreasonable, but were not presented in a way that could be deliverable. For example, one incident resulted in actions about communication with families. Although they had addressed this, there was some uncertainty about whether there was a process in place to ensure best practice in terms of communicating with families. It can be difficult to know who it is best to speak to in terms of family members and some senior staff were disappointed that the new policy did not include information about something as simple as a letter of condolence to the family.

We were told that, where appropriate, changes were made immediately after an incident to ensure the safety of users of services. The in-depth review of investigations found that not all of the action plans included the names of staff responsible for ensuring the recommendations were implemented.

We found that 22 action plans contained information about progress and eight that did not include any information about progress. The remainder did not have actions plans, although some of them had recommendations.

One concern expressed, as far back as 2005, was that the amount of energy dedicated to conducting investigations was disproportionately high to the energy exerted in bring about the necessary changes identified in the reports and that the reporting of incidents could be “cumbersome”.

The information provided by the trust about the database used in local services indicates that 17 incidents that occurred in 2005/06 and 13 that occurred in 2006/07 still had outstanding actions. It is not clear from the information why the actions have not been completed.

During interview, the chief executive acknowledged that the mechanisms for ensuring actions were implemented were previously unclear and said that the trust had recently introduced a new system.

### Findings of fact

- There was some confusion about responsibility for implementation of action plans.
- Some action plans had not been implemented because they had not been through the approval system.
- Action plans were not always realistic or practical.
- Action plans were not always shared with key staff prior to submission to the trust’s board.
- The trust did not have clear mechanisms to monitor implementation of action plans.

## Dissemination of learning from investigation/reviews

The policy for serious untoward incidents and resulting enquiries states that results and recommendations for actions would be communicated to all staff involved in the investigation of a serious untoward incident. It did not clarify who would be responsible for this work.

From the information provided, there was evidence of some discussion about incidents, at meetings of senior staff at the clinical and research governance executive group, the trust clinical and research governance executive and local clinical governance meetings. The incident and the findings from the investigation were discussed, but it was unclear how or whether the information was disseminated to other staff involved in delivering care and how, where appropriate, it was used to inform changes in practice or service delivery across the trust. There was also discussion of national reports such as the National Audit of Violence and other independent inquiries.

Many staff also told us that they would not necessarily learn about incidents in other services or sites. Some staff said that they would receive feedback from incidents on their own sites or service and this would happen at local clinical governance meetings.

It was noted that communication across the divisions was limited and professionals in other parts of the service were unaware of incidents outside their division.

### Findings of fact

- Staff were not always informed about recommendations from investigations into incidents.
- The trust did not have a robust system to share learning and implement changes from incidents across services and sites.

## The trust's thematic review

Following four serious untoward incidents involving the death and three apparent suicides of people at Broadmoor Hospital between July and November 2007, the trust commissioned a thematic review of the incidents. The review panel consisted of staff who had been part of the trust's original investigations into the incidents, and external experts from other mental health trusts, including those providing high secure services. The purpose of the review was to build on the learning already identified in the trust's investigations into the deaths.

The review reported in September 2008 and noted that, since the incorporation of the three high secure hospitals (Broadmoor, Ashworth and Rampton) into NHS trusts in 2001/02, there had been no suicides at Ashworth and one at Rampton. In contrast, there had been eight suicides, five by hanging, at Broadmoor. Following the commissioning of the review, another apparent suicide occurred at the hospital.

The review identified a number of themes from the four incidents and made a number of findings in relation to the trust's process for investigating the incidents: there were delays in completing investigations due to the availability of panel members, it was not always clear how conclusions and recommendations were reached, and there were problems in communicating with the families of the users of services. Although initial contact with the families was good, it was recognised that the trust needed to identify a senior member of staff to act as the main contact for the family from the outset and for the duration of any investigation.

The environment was described as the "single most important theme to be addressed" and the wards were described as "not fit for purpose". The size of the wards and location of the bedrooms in the older buildings provided staff with a large area to observe. This meant they often spent time "patrolling" the ward, rather than engaging with people. It also made carrying out observations at night time difficult, since there were less staff on duty. Two of the four incidents were apparent suicides by hanging from previously identified ligature points. The trust has tried to reduce the number of ligature points, but because of the age of the building it was unable to

remove all of them. Staff interviewed as part of the trust's investigations into the deaths had not referred to the environment as being problematic.

The impact of change on users of services, such as a new therapist or a new programme of treatment, was not always recognised. Changes, even those considered positive, such as starting a new rehabilitation programme, can result in increased anxiety for people in high secure hospitals and can increase the risk of self-harm for people who are already vulnerable.

The review noted the difficulty of accurately identifying people who might be at risk of self-harm. Although people in high secure services are known to be at high risk of committing suicide, the nature of their offences is such that much of the focus is on reducing the risk of violence to others rather than the risk of self-harm.

The review concluded there were no serious deficiencies in the investigations carried out by the trust and the panel made 21 recommendations. They included work to improve the environment, increasing the staff to patient ratio, improving attention to physical healthcare needs, and improving team working. The panel also made recommendations about the investigation process: improving the timescales for completing investigations, improving the report structure (conclusions and recommendations should be linked to evidence in the report), and learning from incidents.

### Findings of fact

- The review recognised serious problems with the environment at Broadmoor Hospital.
- The review did not find any serious deficiencies in the four investigations it considered.

## Reporting incidents and near misses

In the national survey of NHS staff for 2007, the trust was below average when compared with other trusts for the percentage of staff reporting errors, near misses or incidents. This was a slight improvement

when compared with the results for 2005 and 2006, when the trust was in the worst 20% of trusts for reporting incidents.

Many staff that we interviewed showed an awareness of the procedure for reporting incidents, but some were unsure about what happened after they had reported an incident. Only a few staff told us that they were unsure about how to report an incident, but they said they would know who to ask. In terms of feedback from incidents, some staff said they received feedback about serious incidents from their ward manager. For other incidents, it was variable. Some staff said they did not receive any feedback. Many staff told us that they did not learn about incidents on other wards or other areas of the trust.

### Findings of fact

- Staff were aware of the process for reporting incidents.
- Staff did not always receive feedback about incidents they had reported.

The analysis of near misses helps organisations to reduce risk by highlighting areas that may need intervention.

The incident reporting policy and the patient safety incident reporting and inquiry procedure contained different definitions of “near misses”. This was because the latter policy included the definition used by the National Patient Safety Agency. The trust also provided another definition of a “near miss”, which was “any incident that has the potential to cause harm to an individual or the organisation”.

From 2005 until the early part of 2007, the trust used a paper system for reporting incidents. It was difficult for the trust to provide any robust information about the reporting of near misses prior to 2008. For near misses, staff had to answer two questions: was any individual affected by the incident and did the person suffer physical injury or ill health? As this was a paper system, the trust said that it was difficult to assess the number of incidents by severity. The trust appears to have done little work to identify themes from near misses.

In early 2007, the trust introduced an electronic system for reporting incidents and near misses. This enabled the trust to separate “no harm” from “low harm” incidents.

We were told by senior staff that there was under-reporting of near misses and that the definition was not well understood by staff, it was “subjective” and considered a “matter of judgement”. Some staff at Broadmoor Hospital were unsure about the classification for some incidents and some staff reported self-harm incidents as near misses. For example, when a person slashed their wrists, this was reported as a near miss and not as a self-harm incident. We are aware that the definition of near misses is problematic in mental health services and the problem is not unique to the trust.

In 2008, the list of reported incidents categorised as low harm or no harm included barricade and loss of data, along with attempted suicide. Thirteen of these incidents were categorised as no harm and 38 were categorised as low harm.

The trust provided annual incident reports for 2005 to 2007. The trust was unable to compare year-on-year data for all categories of incidents, due to changes in the classification of incidents and reporting systems. Some of the categories were quite broad. For example, “death” included all deaths whether by suicide, accident, homicide or natural causes. For a number of categories – loss of data, damage to property, attempted suicide and non-physical assault to staff and patients – no incidents were recorded for 2005 and 2006 across the trust. One area of note was in services for older people. Between 2005 and 2008, the number of incidents reported dropped from 399 to 192.

All of the other directorates reported similar number of incidents year-on-year, except for a slight increase in 2005/06 which could be due to different reporting systems.

Quarterly and annual incident reports were discussed at the clinical and research governance committee on several occasions. There was little evidence of discussion at divisional clinical governance meetings or the clinical and research governance executive group.

## Findings of fact

- Different definitions of a near miss were in place from August 2006 to April 2008.
- Near misses were not always reported.
- The trust did not distinguish between the different types of deaths.
- It is unclear why some categories of incidents were not reported for a year.
- The trust changed the classifications for the reporting of incidents, making it difficult to compare year-on-year reporting.

## Systems to investigate and learn from complaints

### Sources of evidence

- Trust complaints reports
- Interviews with trust staff
- Interviews with people who used the trust's services
- Minutes of various trust meetings

At a national level, the trust was 40th out of more than 700 healthcare providers for the number of complaints that had progressed to the second stage of the NHS complaints procedure since April 2004. Out of 200 second-stage complaints about the trust received by the Healthcare Commission's complaint function, 21 were about Broadmoor Hospital. In total, 46 of the complaints were upheld.

The ethnicity of complainants for 2006/07 showed a slightly higher proportion of users of services from a white background made complaints than did the population as a whole. There was no significant difference between the number and nature of complaints across forensic and local services.

The primary cause for complaints from 2005 to 2008 was the attitude of staff and general care and treatment. Other recurring themes in complaints received from 2005 to 2007 were:

- Monitoring of physical healthcare.
- Property matters (mainly in high secure services).
- The need to reinforce the trust policy on racial abuse and harassment.
- Users of services unable to go outside due to shortages of staff.

In response to the problems about property (delays in people receiving their property when they are admitted or transferred), Broadmoor Hospital has established a group to look to resolve the problems.

The record for formal written complaints showed very few complaints relating to discrimination (four in 2005/06 and five in 2006/07), with none being substantiated.

Although the trust had a clear process for responding to complaints, the trust's performance had slipped. At the end of 2006/07, the number of outstanding complaints was 10 and for 2007/08 it was 23. Some of the reasons put forward about why this was happening were: staff were unable to provide responses as they were on long-term sick leave; some of the reports were not very good; and training sessions on managing complaints had not been taking place for three to four months because the complaints team were under-resourced.

The trust used to have a group to analyse complaints but, in July 2006, the group was dissolved and the work was transferred to the patient and public involvement forum. The trust's board received quarterly and annual reports on the number and type of complaints for each area, by division and service. In July 2005, the chief executive asked for the next annual report to focus on learning from complaints. The following year, the report included some information about learning from complaints.

Although much of the discussion at the trust's board was around response times, questions were asked about how the trust was reassured that actions had been implemented. The director of nursing told the trust's board that this was monitored by the head of complaints and managed by the local clinical improvement groups.

From December 2005, the trust's complaints reports were presented by the assistant director of clinical governance at the trust clinical governance and research governance executive.

The complaints manager attended the board level complaints reviews meetings, but did not attend clinical governance forums on a regular basis. There was evidence of attendance on a few occasions at divisional clinical governance meetings. At one such meeting, of the trust research and clinical governance executive group in December 2006, it was noted by a few attendees that they had never seen a complaints report discussed "in any venue" and that they had never seen a list of "substantiated complaints".

There was evidence of some discussion of complaints at governance meetings in the forensic and local services division. Some of the discussion was around response times, but questions about other aspects were raised, including how the trust captured repeated complaints made against individual staff. It was also expressed, in January 2007 at the clinical and research governance executive group, that the trust needed to focus on learning from complaints as well as complying with the response times. There was some concern in local services that, on occasion, the complaints staff were "paring back the response to the point where it was meaningless".

If a complaint was received that subsequently needed to be reported as a clinical incident, the response to the complaint was held in abeyance until the serious untoward incident investigation or critical incident review had been completed. At the time of the investigation, there were five that had "been on the system for a long time".

A few users of services and carers that we interviewed during our investigation raised concerns about delays in responses to complaints. One person described the process as "very difficult". Another person and carer had lodged a complaint about the care received as an inpatient. They sent the letter of complaint in the summer of 2007 and received a letter of acknowledgement. They then received another letter telling them the complaint was being reviewed as a critical incident and they would receive a response once the review was completed. In June 2008, they

still had not received a response, despite contacting the trust. It was not included on the list of reviews into critical incidents provided by the trust.

In another instance, a carer who had raised concerns was not informed about the NHS complaints procedure.

The Mental Health Act Commission can act as advocates for people and has sent letters of complaint on behalf of users of services.

Technically, the trust did not have a distinct patient advice and liaison service (PALS). Following the departure of staff in 2007, the service was being provided by the complaints team. The majority of contacts with the PALS were to request information or raise concerns about the attitude of staff. A frequent issue raised by inpatients of Broadmoor Hospital was around property.

### Findings of fact

- Resources to manage complaints and provide a patient advice and liaison service had been reduced.
- Some information about learning from complaints was included in the complaints reports.
- The same staff who managed complaints also provided the patient advice and liaison service.
- The trust generally met the timescales for responding to complaints.

## Environment

### Sources of evidence

- Observations of inpatient area
- Trust documentation
- MHAC reports
- Interviews with staff

Unsafe environments were highlighted in the National Audit of Violence (2003–2005), which recommended that greater effort should be made to improve

wards to optimise safety. *The National confidential enquiry into suicide and homicide by people with mental illness* (December 2006) recommended the prevention of suicide by mental health services taking steps to “further improve the physical environment on wards”.

The quality and age of the inpatient environment across the trust was variable.

### **Broadmoor Hospital**

Broadmoor Hospital was opened in 1863 and is a mix of the original buildings, and new wards built in the latter part of the last century, along with the refurbishment of some of the older wards.

In 2003, the majority of the inpatient wards were described as “totally unfit for purpose” and lacking in “basic standards of dignity and privacy” (CHI, Clinical governance review, November 2003). Following the review, the trust developed a strategic outline case for the redevelopment of the hospital. This was completed in August 2004 and approved in October 2005. The outline business case was initially presented to the trust’s board in June 2008. Between October 2005 and June 2008, much time was spent in discussions about the affordability of the potential options, with a substantial amount of the time taken up with the impact of the planning implications of the listed buildings on site.

During interviews, we were given a range of dates for completion of the new building: the dates ranged from 2016 to 2023. Senior staff told us that the trust had not experienced any unacceptable obstacles in taking the redevelopment forward. However, the trust recently provided additional information stating that the process for developing the outline business case was “faced with a number of external challenges and delays” caused by “planning difficulties and the process of gaining agreement from commissioners and other stakeholders to a preferred solution”. The proposed date for completion of the redevelopment is August 2016.

The problem of ligature points was highlighted by some staff at Broadmoor Hospital, but the problem was not confined to this site. Between 2005 and 2006, the trust carried out a review of ligature points on 56 wards across the trust. Following the review,

suicides occurred on four of the wards included in the review. In April 2007, the risk management committee agreed to identify the top four or five significant ligature risks that were capable of being removed or replaced, and to develop a programme for their removal or replacement. However, the trust does not have an ongoing programme to remove or reduce the number of ligature points. Instead, they are addressed as part of the yearly capital works programme.

Although the trust has carried out refurbishment on some wards, they told us that they have been unable to do all the necessary work to minimise risks to users of services because some of the older buildings are listed. For example, on some wards they have been unable to eradicate some obvious ligature points such as bars on windows.

The risk register for the London directorate assesses ligature points as “red” (extreme). A review of ligature points outside ward areas was not completed and there were outstanding remedial actions on wards.

The layout of the original wards has made it difficult for staff to observe people at all points of the ward. This, along with shortages of staff, has at times resulted in staff locking off parts of the ward at night. Locking off an area of the ward enabled staff to better observe the movement of inpatients, but it restricted the areas that the inpatients could access. Staff were positioned at “lock off” points. For example, if the area “locked off” was the corridor where the bedrooms were located, staff were located outside the locked corridor. A serious investigation into the suicide of an inpatient in 2007 found that the layout of the wards “inhibited the naturally occurring engagement and observation points”.

People who used the trust’s services raised the issue during interviews with us, and senior medical staff acknowledged that the practice had been going on for “many” years. The executive director of forensic services was aware of the practice but it was not documented in the minutes of any management or clinical governance meeting until May 2008. We were told that the trust was in the process of developing guidance advising that only areas not intended for users of services, such as the kitchen, should be locked off. The chief executive agreed that it was

not good practice and they were trying to stop the practice by recruiting more staff.

The bedrooms in the older part of the hospital are small with dilapidated fittings. There are rusting bars on windows creating a “prison feel” to the ward. The communal areas are quite large.

On a visit to an assertive rehabilitation ward, we observed a stereo system and television with satellite stations in the day room. People had a key to their bedroom and the beds were bolted down in the bedrooms. The ward was scheduled to undergo a refurbishment. The ward received two to three newspapers a day; certain articles were censored, but we were told this was a rare occurrence. The meeting/resource room was locked when not in use and it was also used as the prayer room. Activities were stopped at 8pm to allow for security checks to take place.

The windows in the newer buildings look “smeared” but were in fact coated with a special film to protect them, which had degraded.

The visit centre was clean and spacious, with a separate area for children who may visit. The timings for visits from children are different to those for adult visitors. There were toys and games and a small kitchen in the children’s visiting area.

The main visiting room consisted of small tables surrounded by four chairs, which were secured to the floor. The area is observed by security staff. Security staff demonstrated an awareness of the importance of being sensitive to families and people who use services during visits, particularly during the first visit when they can become distressed. They try to manage any concerns during a visit in a discreet manner. There are individual rooms where people can meet with their spiritual advisor and there is one room with a partition. Users of services can see their visitors through a glass partition and talk to them using a phone.

## Ealing

While much attention has been paid to the buildings at Broadmoor Hospital, some of the buildings at St Bernard’s Hospital in Ealing are older, dating back to 1830, and also in urgent need of upgrading.

In 2005, the MHAC noted problems with vermin in both the forensic and local services at St Bernard’s

Hospital in Ealing. The report commented that it was “unacceptable, irrespective of the age of a building used to accommodate patients, for there to be mice and cockroaches evident in such premises”.

In 2006, the MHAC report again identified problems on the site: the presence of mice in the bedrooms and the kitchen. The trust intended to address the problem, but advised the MHAC that it was difficult to control outbreaks in buildings that were over 170 years old, and that it would not be possible to completely eradicate the vermin.

In 2007, there was an outbreak of legionnaires disease on the site which affected one person, who subsequently recovered.

Ealing PCT was aware of the problems and commented on the poor quality of some of the community mental health facilities.

A independent report on the estate, submitted to the trust’s board in June 2007, described the wards as “old, in the main – listed and not fit for the purpose of providing modern mental health services”, with ongoing problem with mice and cockroaches in both the new and older buildings. The report confirmed that many of the wards had poor ventilation and limited therapeutic space, and raised concerns about ligature points.

A programme board for the redevelopment of the site has been established and, at the end of 2008, the trust had agreed the priorities for the redevelopment.

## Hounslow

Lakeside mental health unit is a modern building. It has recently undergone a programme of refurbishment and many of the wards are single sex wards, except for the ward for older people.

During a visit to the unit, we visited some of the wards. On Kestrel ward, a 19-bed adult ward, daily activities were advertised on the locked notice board, along with the minutes of the ward meetings (but only the first page was visible). The day room had three sets of Scrabble and a jigsaw puzzle. The dining room had seating for 10 people plus two seats for staff. The ward was ‘L’ shaped, which could make observation of the users of services difficult.

On Finch ward, a 16-bed adult ward, ward rounds were taking place in the games room. Therefore, the room was out of use for users of services for the duration of the meeting.

### Hammersmith and Fulham

In August 2008, we carried out an unannounced visit to the inpatient wards at Hammersmith and Fulham. It is a modern building with mixed sexed wards that have separate areas for sleeping and washing. On area 3, each bedroom had a bed, a wardrobe (without rails), a desk and a sink with anti-ligature taps. The ward had a “flexi corridor”. This enables the ward to adjust the number of bedrooms for men and women. If there are more male patients, the corridor can be shifted to accommodate this, while keeping the female area separate (and vice versa).

There are female only lounges, which on some wards doubled as the staff meeting room. Communal lounges, although small, were light and airy. Users of services had access to small courtyards that were enclosed by steel mesh. During the visit on one ward, we observed a leak under the floor which caused water to travel up the walls, damaging the paintwork and causing a musty smell. Another ward showed no visible signs of disrepair. However, we were informed of recurrent problems with blocked toilets which the trust was trying to resolve with the introduction of new toilet paper dispensers.

The courtyard for the older people ward had open metal staircases leading onto it. This was a potential risk as older people could attempt to climb the staircase and a member of staff had to be present in the courtyard when users of services were there.

There was one seclusion room on the site, located next to the PICU. It did not have bathroom facilities. A bathroom was located next to the room and when a person needed to use the bathroom, additional staff from the PICU assist with transferring the person.

### Findings of fact

- Previous independent reviews have deemed much of the trust’s estate as old and “not fit for purpose”.
- Many people were receiving care in environments that had been assessed as sub-standard.
- Although staff gave different dates for the completion of the redevelopment at Broadmoor Hospital, the trust has stated that the proposed date for completion is 2016.
- The environment at Broadmoor Hospital makes it difficult for staff to observe people.
- There were recurring infestations of vermin in some of the trust’s buildings.

### Bed occupancy

#### Sources of evidence

- Interviews with trust and PCT staff
- Trust information about bed occupancy
- Minutes of meetings, including the executive committee
- Mental Health Act Commission reports

#### Background

Overcrowding on wards increases the potential of incidents occurring. The National Audit of Violence (2003–2005) identified overcrowding as a factor that may increase the likelihood of violence occurring. The Royal College of Psychiatrists has suggested that bed occupancy rates should not be higher than 85% if a safe environment is to be provided.

The Healthcare Commission’s review of NHS acute inpatient mental health services (published in July 2008) found that the average bed occupancy rate (excluding leave) for trusts in England was 87%. One in 10 trusts had rates in excess of 100%. London Strategic Health Authority had the highest number of trusts with bed occupancy rates above the recommended level: three-quarters of London trusts reported bed occupancy of 90% or more.

The CHI review of the trust's clinical governance arrangements (Clinical governance review, November 2003) found that people were staying on wards for long lengths of time after the ward no longer met their needs. Some had been on the PICU for over a year. The review recommended the trust to take "urgent action in conjunction with relevant health and social care partners to review bed capacity in the local adult services" including "addressing the sleeping out arrangements".

After the investigation was approved in March 2008, we noted in the minutes of the meeting of the trust's board in June 2008 that there were problems with bed occupancy at the Hammersmith and Fulham site. The minutes stated there were extra users of services on the wards during the day, and they were choosing to sleep on sofas rather than be transferred to the independent healthcare sector.

Although bed occupancy was not one of the initial concerns raised with the Healthcare Commission, we were concerned that people were having to sleep on sofas and decided it was important that we established the scope of the problem and the action that the trust had taken to resolve the situation.

### **History of problems at Hammersmith and Fulham**

The history of the problems at Hammersmith and Fulham goes back to 2005. The inpatient unit had 72 beds, plus 12 for psychiatric intensive care. In July 2005, the crisis resolution team was extended (without additional funding), which led to significant capacity in the mental health unit. The trust has commented that Hammersmith and Fulham PCT specifically supported the closure of the beds to support the transfer of funding to the new crisis resolution home treatment teams.

Vacant beds were present from August 2005 to December 2005, when at one particular time there were approximately 30 vacant beds. In January 2006, the trust closed 16 beds on a temporary basis.

In October 2005, the MHAC report noted that bed occupancy levels were over 105% at Hammersmith and Fulham and Ealing, and recommended that the trust assess its bed management policy. The trust's response acknowledged the problem of managing

emergency admissions when beds were not always available: staff were sometimes faced with the difficult choice of transferring people in the early hours of the morning, which may be very disruptive for them, or making temporary sleeping arrangements for them.

In May 2006, the trust reconfigured the number of beds at Hammersmith and Fulham, resulting in the closure of one ward (A2). The funding released from the closures was used to fund the extension of the crisis resolution team. This was done in agreement with the Hammersmith and Fulham PCT commissioners. This left three wards, two with 16 beds and one with 22 beds, plus the 12-bed psychiatric intensive care unit (PICU). In June 2006, inpatient care for older people was transferred in from Charring Cross Hospital. Twelve of the 18 beds on the closed A2 ward became a ward for older people.

From June 2006, there was consistent high demand for beds on the three adult wards, and the trust received complaints from users of services about having to sleep over on other wards, and not being able to have their escorted leave per their care plan. This was accompanied by increased levels of staff sickness.

Shortly after the transfer of the ward for older people, there were complaints from relatives and advocates about the ward. Some staff were suspended, and a review was undertaken. The review concluded there was an absence of any real ward management, a lack of experienced staff and a lack of supervision for staff, all of which resulted in people receiving poor care.

At the same time, there were changes in the PICU. Increased demand from the prison service meant that six of the 12 beds were taken up with admissions from prisons. Two beds were allocated for long-stay users of services, leaving four beds for services users requiring intensive care. The reduced access put resulting pressure on the wards and each of these user groups required a different care environment and philosophy of care.

In September 2006, the trust decided to open and staff six unused beds on the older people's ward. The beds were not funded by the PCT and were used for adults. Although the trust said they were separate to those for older people, it was difficult, given the

structure of the ward, to see how the users of services were kept separate. At times, some of the 12 beds for older people were vacant and were used for adults.

To cope with the increased admissions, the trust transferred some adult users of services to services at Ealing and Lakeside mental health unit in Hounslow.

In March 2007, it was proposed that the older people ward and the six beds for adults should combine to form one ward of 18 beds. People over the age of 50 would be admitted to the ward. It was felt the proposal would support the notion, in the National Service Framework for Older People, that 50 is the starting point for the older age group. It also gave the service more flexibility in terms of the availability of beds.

Older people with organic and functional illness were cared for on the ward. During interviews, executive directors at the trust said it wasn't unusual to have people with functional and organic illness on the same ward. They were happy with the arrangement as long as the proper risk assessments were carried out. There was general agreement that this was an appropriate model of care for older people. However, placing functionally ill (for example those suffering with depression) people in the same environment as people suffering with dementia can be distressing to people who are already depressed. The exception to this may be a person who is depressed and is also physically frail and weak, whose needs might be best served in a ward where staff are familiar with physical healthcare needs.

The MHAC report for 2007 commented on bed occupancy in area 1. Staff had told them that over occupancy was usual and that users of services were moved about to manage beds, including being sent on leave earlier than they might be if beds were available.

### **Excess bed occupancy**

We requested information from the trust about the number of beds occupied between January 2007 and September 2008. For nine of the 21 months, the bed occupancy was 110% or higher (in April 2008 it reached 116%). Between January 2008 and September 2008, 43 people (22 from Hammersmith and Fulham) had been admitted to wards across the trust and then transferred to the independent healthcare sector.

Between January 2008 and September 2008, 44 people at Hammersmith and Fulham had on 76 occasions slept on sofas, rather than in a bed on a ward. This happened most frequently in May and August, on 15 occasions each month.

In August 2008, we carried out an unannounced visit to the site. We asked staff how they managed when they did not have sufficient beds for the number of people. They acknowledged this happened and that sometimes people had to sleep on sofas in communal lounges. Personal belongings were stored in cupboards or carried around. Staff commented that it was difficult having to tell people they may not have a bed on the ward as sometimes they became upset, and at times angry. Although the ward had 16 beds, at times they had to accommodate up to 19 people. On another ward, with 16 beds, we were told that they had recently had to accommodate 18 patients on three successive nights. When asked if they ever reported these occasions as "near misses" or incidents, they said no.

During the visit we observed a handover on one ward and noted there were a number of delayed discharges. We were told this was because of insufficient houses, housing being upgraded or people waiting for financial support to be arranged in order to buy food and other essentials on discharge.

We carried out a further unannounced visit in September 2008. We did not find any people sleeping on sofas, but there were four people in the PICU who were awaiting transfer to the ward. Staff told us there were no plans to transfer them back to a ward. Staff told us they are not always given priority when beds become available on wards. It wasn't unusual for people to stay on the PICU for the duration of their admission. The trust commented that people who no longer required intensive care were transferred to the first available bed in the unit. If a bed is not available, then a care plan is devised to ensure the person attends activities and receives unescorted leave as appropriate.

Following the visit, we wrote to the trust expressing concern about people having to sleep on sofas and recommended that the trust take all necessary action to address the capacity issues to ensure that people did not have to sleep on sofas and that, where possible, they had a bed on the ward they were admitted to.

Senior managers, executive and non-executive directors explained during interviews that they closed beds in response to a reduction in admissions. However, the reduction was a “blip” rather than a permanent decrease in demand. The trust negotiated with the PCT for additional funding to open more beds, and an independent review of the use of beds had been commissioned.

The trust acknowledged it was not a new problem and that it was not acceptable. Senior staff said they were “uncomfortable about it”, while some of the non-executive directors felt it was better “to have someone safe on a sofa than in a street”, and that “one night on a sofa is better than nothing”. However, it was often more than one night, and there was little acknowledgement, during interviews, of the potential problems, such as access to sufficient bathrooms, increased risk of incidents, increased noise and less opportunity of leave for people, which may result. We were told that feedback from users of services to the trust was that they did not want to move to another ward or the independent healthcare sector and would rather sleep on a sofa.

### **Sleeping over arrangements**

We also became aware of people who were cared for on a ward during the day, but due to a lack of beds had to sleep over on the PICU. Between January and September 2008, 27 people slept over on the PICU on 64 nights. All of them, except one, spent five nights or less on the PICU. One person spent a total of 10 nights on the PICU on three separate occasions. We were told that people did not bring any of their belongings to the PICU. In the morning they returned to the ward to shower and have breakfast.

During the same period, people who were assessed as well enough for discharge from the PICU were unable to be transferred to the wards due to a lack of available beds. This happened on 1,164 occasions, affecting approximately 30 people (it was difficult to tell from the information provided whether the same initials are the same person).

Eleven people spent an additional period of at least 30 days on the PICU, and one person spent an additional 133 days on the PICU. During the unannounced visit, in September 2008, there were four people on the PICU awaiting beds on the wards.

When asked, senior managers and executive directors agreed it was an unacceptable practice. Some felt that the problem needed further exploration as there was “no absolute threshold for who should be in PICU and it varies depending on which part of the country you are in”. The view of the director of nursing was that people should not be placed in areas with greater security than they need, but the priority was to ensure people received safe care. He felt it could be argued that people were more at risk, but it could also be argued that PICUs have more staff so safety is improved. There was a general feeling that it was acceptable practice for a short period of time.

The view of the trust was that they needed six beds for intensive care and the rest were used for people for when beds were not available on the wards.

### **Older people’s ward in Hounslow**

The problems with bed occupancy were not confined to Hammersmith and Fulham. At Lakeside mental health unit, there was one ward with 16 beds for older people. Older people with organic and functional illness were cared for on the ward and there were also five beds for people who required respite care. Between November 2007 and September 2008, except for March 2008, the bed occupancy rate was 104% or greater.

We were told by the trust that the decision to have one ward for older people was financially driven by the PCT. The clinical director acknowledged that it was not easy to manage and was looking at how it worked in practice to see how it could be improved.

### **Meetings and local discussions**

During this period, the trust was underachieving on its targets for the number of people who should be cared for by the crisis resolution team. The view of the trust was that the targets were unrealistic and they would never be able to achieve them. There were ongoing discussions with the PCTs about the targets, and how or if the trust could achieve them.

Throughout this time, there was evidence of discussion about the problems at meetings in the local services division, at performance management meetings and at meetings with the PCTs. It was discussed once at the trust’s board in September 2007. Concern was also raised, at the local services

clinical governance meeting in September 2006, about the reduced number of beds resulting in a higher number of people who were acutely unwell, and the implications for staff in terms of incidents and sickness and the ability to provide a therapeutic environment. It was agreed there were no immediate solutions and to continue to monitor the situation. The trust has commented that it had been concerned about the problem long before the investigation and had repeatedly asked the PCT to fund a more realistic bed base in Hammersmith and Fulham. During the course of this investigation the PCT agreed to fund the six additional beds and commission a review to identify the future demand for beds.

To alleviate the pressure, we were told there were regular meetings to discuss delayed discharges, and various protocols for managing the situation were developed including for transferring people to other sites.

There were also discussions about changing the model of care to one where there were separate medical teams for inpatient and community services. Whereas a consultant would in the past have a catchment area and provide medical input for users of services in hospital and in the community, it has become acceptable practice to have a split whereby there is a separate consultant psychiatrist covering community services and a separate consultant psychiatrist covering inpatient services. If the consultant psychiatrist for inpatient services also manages the interface with the crisis resolution team, it can result in more effective management and where possible people are kept out of hospital in line with their wishes. It can also reduce the number of ward rounds, which frees staff up to provide more hands-on care.

The problems with bed occupancy were not raised by users of services during interviews with us.

### Findings of fact

- Problems about bed occupancy had been identified in the CHI clinical governance review in 2003
- The trust has had ongoing problems with bed occupancy on some sites.
- On many occasions, people had to sleep on sofas.
- Older people with functional and organic illness were cared for on the same ward.
- The PICU has been used to help alleviate the problems with bed occupancy.
- On many occasions people have had to sleep over on the PICU, rather than on the ward to which they were admitted and to which they were more clinically suited.
- Staff did not recognise or report the potential risks of having additional people sleeping on sofas.
- The problems began in late 2005 and, although the trust had taken some action, people were still sleeping on sofas in 2008.

## Summary of findings in this chapter

- The trust had a number of different policies in place for the reporting and investigating of incidents. This led to confusion among staff, and hindered rather than helped them.
- The trust was aware of this confusion and began to introduce a new overarching policy to resolve it. However, it was 18 months before the policy was approved. Rather than allow the confusion to be prolonged for a year and a half, the trust should have taken some interim action.
- The time to complete investigation reports ranged from two months to 23 months. The trust was aware of the delays but, until recently, took little action to improve the process.
- The quality of the reports was variable. Sometimes, findings did not match the evidence and important lines of enquiry were not pursued.
- Recommendations were often repeated, which implied that lessons from previous incidents had not been learned or put into action. Problems with risk management featured most frequently in the investigation reports.
- Action plans were developed without involving key staff, and staff were unclear about who was responsible for implementing them. Considering that action plans were key documents to bring about change, they should have been given more attention.
- At board level, members of the risk management committee were aware of some of the problems, but they were slow to push for action. The non-executive directors should have been more challenging about the delays and why the reasons for delays were not documented as requested.
- Overall, the trust's arrangements for investigating and learning from incidents and near misses were seriously flawed.
- Many of the trust's buildings are old and considered "not fit for purpose". The redevelopment plans for Broadmoor Hospital have been in progress since 2003.
- Some of the buildings at St Bernard's Hospital in Ealing date back to 1830 and are in urgent need of upgrading. There have been infestations of mice and cockroaches in the inpatient areas.
- Between 2005 and 2006, the trust carried out a review of ligature points on 56 wards across the trust. Following this, suicides occurred on four of the wards included in the review. The trust does not have an ongoing programme to remove or reduce the number of ligature points – instead, it is part of the yearly capital works programme.
- There have been problems with bed occupancy, particularly at the Hammersmith and Fulham site. Insufficient beds resulted in inpatients sleeping on sofas rather than in a bed on a ward. Staff did not recognise or report the potential risks of having some inpatients sleeping on sofas.

# Enabling good outcomes for people through high quality care

Providers of services should enable good outcomes for people with mental health needs by ensuring that they receive high quality assessments, care and interventions.

In this chapter, we report on some of the wider quality of care provided by the trust, which we considered to see whether the issues set out in the previous chapter were isolated or part of a bigger problem. They included the environment in which care is delivered, staffing levels and training, access to therapeutic activities and medicines management. These areas have been identified in national reports such as *The national confidential enquiry into suicide and homicide by people with mental illness* (December 2006) and the National Audit of Violence as factors that will increase the likelihood of incidents occurring.

## Staffing and training

### Sources of evidence

- Workforce reports
- Interviews with governance staff, clinical directors, service managers and executive directors
- The minutes of meetings of internal trust committees, including the trust's board and committees relating to risk and governance
- Interviews with users of services
- Training reports

In 2003, the Commission for Health Improvement found serious problems nationally with the recruitment and retention of staff in mental health trusts. It found significant shortages of consultant psychiatrists and inpatient nurses. New community-based services were an opportunity for inpatient nursing staff to transfer from challenging environments (*What CHI has found in mental health trusts*, 2003).

The National Audit of Violence (from 2003 to 2005) identified inadequate staffing as a common factor in causing violence, and found that many services were operating with high levels of vacancies and experiencing difficulty in recruiting staff. Inpatient services were "reliant upon inexperienced leaders".

We reviewed information about staffing levels at the trust at Hounslow, Ealing, Hammersmith and Fulham, and Broadmoor Hospital. Figures quoted below are the percentage of vacancies on a given ward on 31 March for each year. The figures have been drawn from the "snapshot" data provided by the trust.

### Staffing levels in forensic services

Shortages of ward staff, both qualified and unqualified nurses, at Broadmoor Hospital have been a persistent problem over the last three years.

For example, Folkestone ward, in the London directorate had a vacancy factor of 22.6% in March 2007. In March 2006, Banbury ward had the lowest vacancy factor at 8.6%. In the south of England directorate, vacancies were higher – in March 2006, Churchill ward had a vacancy factor of 26.9%.

During interviews, many staff commented on the number of vacancies on their ward and in the trust generally, and the effect it had on morale. To ease the problem, staff were moved from ward to ward to fill vacancies on shifts and areas on wards were "locked off" to users of services, in an effort to minimise the number of areas staff had to observe. At times, this meant that users of services were separated from staff by locked doors. The trust was trying to stop this practice, as it was putting users of services and staff at risk. Staff also worked extra shifts and a few staff told us that, on occasion, they were worked long days, that is double shifts, 15 hours a day.

Users of services commented on the shortage of staff at the hospital, saying there was a "general shortage of staff on the wards" and "short staffing at night and they have to padlock the doors" and there were

“not enough staff to facilitate activities and poor staffing generally”. One person commented that a number of staff were on long-term sickness and that “staff were changing over too often” which was “screwing up the ward”. Another user of services was concerned that too many staff changes was making it difficult for people to “form bonds” and a shortage of staff meant that staff were unable to carry out “regular observations”.

Recruitment was discussed at the Broadmoor operational meeting on a regular basis. There were concerns about delays from recruitment to appointment due to the length of time Criminal Records Bureau checks were taking, and that some of the difficulty was due to the high cost of housing in the area.

### **Staffing levels in local services**

In Hounslow, we found high rates of vacancies at Lakeside mental health unit on the adult and older people wards. Three of the four adult inpatient wards had an average vacancy factor above 24% between March 2005 and March 2008. On the older people ward, the average vacancy factor was higher at 35.8% for the same period.

There were similar problems in community services: vacancies were high in all of the teams except the assertive outreach team, which had more staff in post than the agreed establishment.

Vacancies on inpatient wards at Hammersmith and Fulham were high in both inpatient and community services, regularly exceeding 10% in community services.

On some wards at Ealing, we found high levels of vacancies with high levels of sickness absence.

To help ease the staffing problems, the trust has a “nursing bank”, made up of permanent staff, in place. Staff were allowed to work up to 40 hours in addition to their contracted hours per month.

### **Absences due to sickness**

The trust’s rate of absence due to sickness fluctuated over the period covered by the investigation

At the trust’s board in October 2006, it was noted that the sickness absence rate was 5.6% compared with the national average in 2006 of 4.5% for trusts providing

mental health services. This was an improvement from 2005, when at one period it was 6.5%.

Many staff, both clinical and managerial, reported the levels of sickness absence as a problem. Some managers believed that sickness absence was inevitable due to the challenging group of people they provided care for.

The director of human resources told us that some of the sickness was “almost cultural” and that 50% of the long-term sickness was related to stress. The trust was trying to ensure that the recording of sickness absence was accurate and had introduced a new system for calculating levels of sickness. The trust had also invested in support for staff, such as occupational health services and mechanisms to reduce the levels of stress that staff are subjected to as part of working in mental health services.

The rates of sickness absence on wards in Broadmoor Hospital were concerning. The information provided by the trust includes both qualified and unqualified ward staff. In the London directorate, for the period of the investigation, the average sickness rate was greater than 10% on over half the wards. The south of England directorate also had high levels of sickness; on Windsor ward the average sickness rate, for the period covered by the investigation, was 11.8%.

The forensic services for men at Ealing were slightly better, averaging less than 10% sickness absence on all but one of the 15 wards.

On the older people ward at Lakeside mental health unit, the sickness rate reached 12.4% in March 2006.

### **Availability of therapists**

The availability of occupational therapists and psychotherapists was variable across the trust. The inpatient wards at Lakeside mental health unit had access to occupational therapists, but the assertive outreach team did not have its own dedicated occupational therapist or psychologist; the latter was provided through the parent crisis management home treatment team.

At Broadmoor Hospital, some of the wards did not have access to an occupational therapist, and staff at Ealing Forensic services reported that some psychotherapy groups had been cancelled due to a shortage of staff.

The Mental Health Act Commission report for 2007 commented on the shortage of staff, particularly nursing staff, and that it was a recurring theme. The report referred to the difficulties the trust experienced in recruiting and retaining occupational therapists.

In response to the report, the trust explained that a number of occupational therapists had left the trust in 2007 for either family or career development reasons. However, we were advised that some of the retention problems were due to the rebanding of occupational therapists, which meant they were on a lower grade compared to their peers in other trusts. The trust was looking to retain staff through improved development training and development opportunities. For the period 1 January to 31 March 2007, the vacancy factor for allied health professionals was 16.6%.

### Culture

In the national staff surveys for 2005 to 2007, the trust was rated in the worst 20% of trusts for the number of staff experiencing bullying and harassment from other staff. Other areas of concern highlighted in the national staff survey were appraisal and flexible working. These three areas were consistent with the complaints received by staff side. The trust felt that some of the problems were at team and clinical nurse manager level, and some of the contributory factors were work load and the size of the teams. Work on clinical supervision and a leadership programme for frontline staff had been introduced.

A more recent survey, carried out by the post graduate medical education training board for trainees, highlighted some problems with bullying, particularly in psychotherapy. The associate medical director for medical education had arranged meetings with staff and HR to discuss the problems.

Equal numbers of staff interviewed were positive and negative about the culture of the trust. Some staff felt that morale was good, while others referred to problems and tensions among staff groups. Staff at Lakeside mental health unit said it was friendly and caring, others said it was quite "demoralised". At Broadmoor Hospital, there was a sense that it was moving to a more inclusive culture; staff were becoming more user focused, although some of the

"old school staff" still existed, who were not open to new approaches to care and did not want to "increase patient movement". There was also reference to "Broadmoor time", meaning that change happened slowly and staff felt they were under a "lot of pressure".

During interviews, senior staff referred to difficulties in terms of communication due to the size of the trust and the geographical location of services across west London and Berkshire. We found that some staff identified with the borough or directorate in which they worked, rather than seeing themselves as part of West London Mental Health NHS Trust.

### Recruitment issues

We were also told by many staff that recruitment was hampered by the length of time it took to complete the security checks prior to employment. The trust had tried to overcome this by sometimes employing lower risk staff, for example those not in contact with users of services, to begin work prior to the checks being completed. The process for this was outlined in the criminal records bureau policy (2006). Despite this, members of the executive team said that recruitment could take up to six months from the time of interview to the post-holder starting work.

Although the trust had taken some action to recruit and retain staff, establishing the recruitment and retention forum and introducing the quality awards, vacancy levels of nursing staff remained high.

### Findings of fact

- The trust had significant ongoing problems with staffing levels and recruitment on many inpatient wards and in some community teams.
- In many areas, the rate of sickness absence was generally higher than the national average.
- The trust had difficulty recruiting and retaining occupational therapists.
- Access to occupational therapists and psychologists across the trust was variable.

*(continued overleaf)*

## Findings of fact

*(continued from previous page)*

- Users of services were aware of the staffing shortages and the impact it was having on their care and treatment.
- In some areas, the actions taken by staff to manage the low staffing levels put themselves and people who used services at risk.
- Various surveys continued to highlight problems with bullying and harassment, although the trust had taken action to address the problem.
- Staff interviewed had mixed views about the culture of the trust.

### Mandatory training

Mandatory training was one of the trust's four "must do's" agreed at the executive "away day" in May 2007. It included training in basic life support, updates on security and awareness of risk management, as well as other subjects for specific areas. Staff were required to attend a full day's training on diversity issues every three years.

Across the trust, the uptake of mandatory training was low. In 2005, it was reported at the trust clinical governance and research governance executive that staff were "reluctantly released to attend mandatory training". From 2006 to July 2008, the uptake of mandatory training by ward staff across the trust did not exceed 32%. For the same period, the overall attendance of ward staff by site was less than 50%. In the 2006/07 national survey of NHS staff, the trust was below average, when compared with other trusts, for the percentage of staff having had health and safety training in the previous 12 months.

For some wards for 2006/07, attendance was particularly low: for example 9% on Kingfisher ward at Lakeside mental health unit and 8% on Grosvenor ward. Similarly at Ealing, local services attendance was 6% on both Champion and Mary Seacole wards for the same period.

Many staff, from a range of staff groups that were interviewed, said they were not up to date with their

training. Managers and staff acknowledged that attendance at mandatory training was poor. We were told that it had been a huge problem both in terms of being able to release staff from clinical areas and that some staff were reluctant to attend training. It was the responsibility of managers to ensure staff attended training.

Examples of poor attendance include three staff attending a prevention and managing violence and aggression course which had places for 24 staff. At Broadmoor Hospital, in January 2008, it was reported that less than 50% of staff had attended the annual update on security issues.

An investigation into a fire at the Hammersmith and Fulham mental health unit in 2005 found that the trust had failed to provide training for staff prior to the opening of the unit. The trust was served with an enforcement notice regarding the effectiveness of staff training and the recommendations from the investigation included training all qualified staff up to the standard of fire marshal. Between January and December 2006, there were 290 fire incidents with a slight decrease between January and December 2007: 221 fire incidents. Attendance at fire training continues to be low: in February 2008, attendance at Broadmoor Hospital was recorded as 20%.

The director of nursing said there were concerns about the reliability of the information about the number of staff who attended training, along with problems collecting the information.

There had been some confusion among staff about what constituted mandatory training and in 2004 the trust undertook a review, with further work in 2007. In July 2008, the trust introduced a "passport" for staff detailing the mandatory training they were required to attend and the frequency.

The chief executive acknowledged that mandatory training was one of the trust's four "must do's". He believed the trust had the most "rigorous induction programme of any mental health trust in the country" that covered many aspects of mandatory training. Therefore, a significant number of people attended mandatory training every year. He felt some of the problem lay with the systems for collecting information about attendance at mandatory training and that, if you looked at the number of

staff who had accessed mandatory training, the amount of training courses staff had attended and the comments in the staff survey about mandatory training, it was not “that bad”.

### Findings of fact

- Mandatory training was one of the trust’s four “must do’s”.
- Attendance at mandatory training was low and was an ongoing problem for the trust.
- Attendance at training in how to respond to fires was poor, despite the frequency of fire incidents.
- The trust had taken action to clarify the mandatory training that each staff group had to attend.
- The chief executive did not regard attendance at mandatory training as a significant problem.

## The physical healthcare of people who use services

### Sources of evidence

- Interviews with trust staff
- Interviews with people who use services
- Minutes of trust meetings
- Mental Health Act Commission reports

The national service framework specifies that people with severe mental health problems should have their physical healthcare needs addressed. *The national confidential inquiry into suicide and homicide by people with mental illness* (December 2006) found that almost half of the 235 people who use services whose deaths were classified as a sudden unexpected death, had a history of cardiovascular disease.

People in high secure services have complex and specific physical healthcare needs. They often have a higher incidence of chronic disease for a variety of reasons, including side effects from their medication, limited exercise and poor diet. The nature of their mental ill-health and security restrictions mean that consultations are more difficult to arrange and manage.

At Broadmoor Hospital, there was a medical centre where staff, including nurses, dieticians and physiotherapists provided a range of services, including the management of chronic diseases and physiotherapy. Until February 2007, users of services also had access to a GP four days a week. People were positive about the service and found it to be of great benefit (Clinical governance review, November 2003).

In February 2007, the GP left and the trust advertised for a replacement. None of the applicants were considered to have sufficient experience to appoint. The trust then commissioned a review of the physical healthcare needs of people who use services, which reported in July 2007.

The review found serious “fundamental and organisational problems” in the way the physical healthcare needs of users of services were being met. There were few guidelines for the management of chronic disease, with little information about any activity that was happening. Many users of services take medicines that require regular monitoring of their blood level to ensure their effectiveness and prevent side effects. Although there was some evidence this was happening, it was poorly coordinated. For example, the pharmacist occasionally intervened if they felt there were problems but believed it was the responsibility of the senior house officer. The senior house officer believed it was the responsibility of the medical centre. An audit of ECG monitoring on people who were taking anti-psychotic medication showed a figure of 10% compliance with guidance. There was no evidence that this poor response had generated any action.

There were insufficient staff, and the information systems in place did not allow sharing of information between the wards, pharmacists and healthcare centre.

The review made a number of recommendations including appointing a full-time clinician. It didn’t necessarily have to be a full-time GP; the work could be shared with an appropriately trained nurse and a GP. We reviewed the minutes from a range of meetings at Broadmoor Hospital and could not find evidence of where this report was discussed.

The trust considered re-advertising for a GP, but instead decided to seek an interim solution – the appointment of a locum GP for one day a week,

with extended provision by specialist consultants. The locum GP was appointed in mid-2008. The trust was in the final stages of the tendering process for a primary care service that is supported by a local PCT.

During interviews, it was acknowledged by executive directors that it had been difficult to recruit a GP but it wasn't that the trust didn't want to replace the GP, but "some things do move more slowly than others".

We were told that, currently, the service provided by the GP operates in isolation from the rest of the hospital. The GP records are held on a separate IT system, which staff are not able to access. When a person is seen by the GP, a paper copy of the consultation notes are sent to the ward. The GP was unsure who read the notes. Initiatives such as immunising people against flu are carried out, but information about which people were immunised was not sent to the GP. It was also unclear if the trust had identified people who may be most at risk from the virus as a priority for being immunised. Some users of services are on medicines that require monitoring of the level in their blood. The tests are carried out, but we were told it was unclear if anyone followed up the results.

The impact of the loss of the GP was identified in a serious investigation report into the death of a service user. This person was known to have serious cardiac problems and, until January 2007 (when the GP left), his contact with the GP had been excellent. After January 2007, there were less frequent references to his physical healthcare. The report recommended that the trust recruit a replacement GP or find an alternative service. This incident was included in the trust's thematic review (referred to in the first chapter). The review recommended that there should have been a specific management plan that incorporated the service user's physical healthcare problems.

Attendance at appointments with the GP and hospital appointments were an ongoing problem. We were told that users of services were sometimes unable to attend appointments at the medical centre because of a lack of staff to escort them. People were sometimes unable to attend appointments at other hospitals because the necessary paper work and security checks had not been completed on time, despite the fact that ward staff were given sufficient notice.

Many staff interviewed said that access to physical healthcare could be better and one senior nurse, at Broadmoor Hospital, commented that the healthcare centre was a "mess" and some expressed their frustration about the continued delay in getting a service up and running. There were some concerns about the overall arrangements for physical healthcare and that clinical directors were anxious about the provision of physical healthcare.

Some of the executive directors acknowledged that having a GP service had been considered "cutting edge" and that, since the departure of the GP in 2007, it had not been so good. Users of services commented that physical healthcare was "poor", there were delays in accessing physical healthcare and they felt their physical problems were not being fully investigated. The trust has since commented that the current GP confirmed in discussions with the associate medical director that his current number of sessions is appropriate, but the Department of Health informed us that the GP told them that his time (one day a week) was neither appropriate nor sufficient.

The dangerous and severe personality disorder unit had its own practice nurse, although she seemed to work in isolation.

The problems about access to GPs were not confined to Broadmoor Hospital. People in the forensic service at Ealing have not had access to a GP for many years. The trust has recently asked for additional funding from commissioners to provide a GP and nurse practitioner service.

When asked, some of the non-executive directors were unaware of the problems about access to primary care services, although they said that it was a priority for the trust's board.

In addition to access to a GP, users of services should have been having annual physical healthcare checks. Throughout 2005 and 2007, across the trust, there was ongoing discussion about annual physical examinations. Audits showed that not all people were having physical examinations. At Broadmoor Hospital in the south of England directorate, only a third of people were having annual physical examinations.

In 2007, the trust introduced the fundamentals of care: a set of standards for physical healthcare,

hygiene and self-care of people. The standards specify that users of services should have a physical examination within 24 hours of admission and that each person should have access to a GP, dentist, hospital specialist and optician.

We were told that physical healthcare nursing leads have been introduced in each area, along with training for staff to carry out physical healthcare checks. To monitor implementation of the standards, the trust developed two physical healthcare groups: one for the London sites and one for Broadmoor Hospital. The number of users of services at Broadmoor Hospital having annual physical health checks had increased to approximately 60% to 70%.

Although the trust had taken some action to address the gaps in the provision of physical healthcare, it was difficult to see how all the different strands were joined up.

### Findings of fact

- People in forensic services had limited access to primary care services.
- The primary care service at Broadmoor Hospital has been much reduced and operated in isolation.
- Although the trust has taken some action to ensure that annual physical health checks are carried out, some people in forensic services were still not having them.
- The approach to the provision of physical healthcare has been slow and fragmented.

## Medicines management

### Sources of evidence

- Interviews with staff
- Trust documents including policies and terms of reference for committees
- Review of clinical incidents

Medicines play a significant part in the care and treatment of people with mental health problems and in this section we look at the trust's arrangements

for the management of medicines. We have not considered the appropriateness of the use of medicines.

The Healthcare Commission's review of the management of medicines in trusts providing mental health services (*Talking about medicines*, 2007) found that pharmaceutical services for inpatient services "looked relatively weak when compared with acute trusts". However, where trusts had invested in pharmacy services, these were comparable with services in acute trusts. Pharmaceutical support for community services was found to be "even weaker". The review included 10 recommendations and trusts were recommended to review their strategy and leadership for medicines management and, where necessary, implement action plans to improve their performance. It considered that leadership for medicines management was required from the chief pharmacist.

### Structure of medicines management at the trust

In interviews in November 2008, we were told a paper outlining plans to bring all the pharmacy service in house was developed "18 months ago". Although it has been approved by the executive team, it had not been approved by the trust's board.

For the period of the investigation, the pharmacy services across the trust were a mix of in-house provision and service level agreements (SLAs) with local acute trusts

The chief pharmacist post was introduced in 2003 to manage the in-house pharmacy team at Broadmoor Hospital and the service level agreements.

In 2006, the pharmacy service for Hounslow was brought in house. Two pharmacists were employed to provide the service and they are managed by the pharmacy team manager at Broadmoor Hospital. Procurement, dispensing and supply for Hounslow is provided by the pharmacy at Broadmoor Hospital. Ealing and Hammersmith and Fulham are still predominantly using SLAs.

Across the trust, the in-house pharmacy team includes principle pharmacists, specialist pharmacists and pharmacy technicians. There are organised pharmacy team meetings, but we were told there

is little contact between the pharmacy staff at Broadmoor Hospital and pharmacists working at other sites.

The trust had a “virtual” medicine management group. This was a sub-group of the trust’s drug and therapeutic committee. The membership of the group seemed fairly open, as the information provided by the trust referred to staff groups rather than individual roles, for example “Clinician – SpRs both divisions, Senior nurses from both divisions”. The chief pharmacist was a member of the group. Information about the group was limited, but there is reference to responsibility for developing education and training programmes for all disciplines and implementation and review of policies.

The chief pharmacist was a member of the medicines management group and the drugs and therapeutics committee.

During interviews with pharmacy staff and other senior staff, there was little evidence of a clear corporate identity for the pharmacy service or involvement of senior pharmacy staff at management level: the chief pharmacist attended the trust-wide clinical and research governance executive and divisional governance meetings. Until recently, the senior pharmacist at Broadmoor Hospital was a member of the operational meeting, but over three years attended only 10 out of 36 meetings.

### **Strategy for medicines management**

The trust did not have a strategy for medicine management. We were told that the chief pharmacist did a yearly report that was described as “looking back”, rather than a plan for looking forward.

Senior staff in the trust acknowledged there had been a lack of strategic direction for medicines management and that “medicines management has not strategically been held together...” although, “there is work ongoing ...”. The director of nursing, who holds the responsibility and accountability for medicines management in the trust, and was also the designated accountable officer for controlled drugs, believed the trust was “going in the right direction” and the pace of change had been reasonable “although things can always be faster”.

Some pharmacy staff were unaware of, or had not read, the document *Talking about medicines*. During interviews with some senior staff, there seemed to be some confusion as to whether the document was relevant to trusts providing mental health services.

### **Provision of services**

The level of service provided by pharmacists was variable across the trust. At Broadmoor Hospital, they have prioritised the ward rounds they will attend, mainly the admission and high dependency wards. The rehabilitation wards have a “link” pharmacist. There was a contradictory response from some pharmacists when asked if they felt there was sufficient investment in the service: some felt there was, but also said they were “stretched” to provide the current service and ideally would like more pharmacists.

In Hounslow, the pharmacists recognised that more investment would mean they could attend more ward rounds in the inpatient services and community services. They explained that they had to do the ordering in the morning, as it had to reach Broadmoor Hospital by mid-day. This meant they were unable to attend many of the ward rounds or multidisciplinary team meetings that were held in the morning. In many other trusts, the ordering is done by pharmacy technicians. They visited community mental health services once a month, but were unable to provide a service for the assertive outreach team. The chief pharmacist agreed that they needed to improve the service for community services.

Across the trust, pharmacists attended less than one in five ward rounds and some community teams only saw a pharmacist four times a year. Where pharmacists attended ward rounds and other multidisciplinary team meetings, their contribution was very much valued by staff, who spoke positively about them.

### **Incidents and interventions**

In the National Patient Safety Agency (NPSA) analysis of patient safety incidents, the trust had a higher percentage of incidents in the classifications “medication error” and “self-harming behaviour” than other similar trusts. Medication errors were

reported on the trust incident reporting form. During the period of the investigation, the number of incidents reported was: 80 in 2005, 187 in 2006 and 281 in 2007. Incidents were most commonly recorded as near misses/no harm, medication missing/unaccounted for, and medication errors. A summary of all medication errors is sent each month to the chief pharmacist, who forwards it to the deputy directors of nursing to follow up.

In addition to reporting incidents, pharmacists report “interventions” (occasions when they have contacted medical staff to ensure safe and effective use of medicines or to prevent an incident). The number of interventions recorded varies greatly across sites. For example, 80 were recorded at Broadmoor Hospital in 2005/06 and 90 in 2006/07. Lakeside mental health unit had the most recorded for any site, from 688 in 2005/06 to 329 in 2006/07.

Although pharmacists are now represented on the incident monitoring and review groups, there have been instances where investigation panels have made recommendations about pharmaceutical issues, without involving the chief pharmacist. One particular recommendation, that all medication charts should be photocopied every day and copies kept in the pharmacy department, was made without any consultation with pharmacy staff. The recommendation had to be removed as it was considered completely unworkable.

### Findings of fact

- The trust did not have a medicines management strategy.
- The level of pharmacy advice across the trust was variable.
- Community services received little or no service from pharmacists.
- There has been a lack of strategic direction and drive for medicine management.

## Clinical supervision

### Sources of evidence

- Trust policy
- Interviews with staff

Clinical supervision is defined “as a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations” (*A Vision for the Future*, 1993).

In 2003, the Commission for Health Improvement found “considerable evidence of clinical supervision across all staff groups in local services. In Forensic services there was a lack of understanding among staff of its purpose. Although it was taking place it was not consistently available” (Clinical governance review, November 2003).

Many staff at Broadmoor Hospital and Hounslow told us they had access to clinical supervision and it took place every four to six weeks. A few staff at Hounslow reported that it was not available to night staff, but staff from the early intervention and assertive outreach teams said that they had good supervision arrangements in place and felt they were supported. Some staff from both sites felt that it was variable in terms of frequency, while staff from two wards at Lakeside mental health unit said it was not taking place.

During the unannounced visit to Ealing, four of the seven staff we interviewed told us they had access to clinical supervision.

We were told that psychologists played an active role, at Broadmoor Hospital and Hounslow, in both undertaking and facilitating clinical supervision and reflective practice.

We also found evidence of reflective practice happening, but not across all areas.

Although staff told us they had access to clinical supervision, concern was raised about the robustness of the supervision, particularly at Broadmoor Hospital. It was suggested that some nursing staff did

not have sufficient experience to act as supervisors. They also felt that learning from incidents should be discussed during supervision.

### Findings of fact

- Some staff told us they had access to clinical supervision.
- There was some concern about the robustness of the clinical supervision.

## Involvement of people who use services and carers

### Sources of evidence

- Interviews with people who used services/carers
- Interviews with staff
- Healthcare Commission national patient surveys 2005-2007
- Trust documents

The involvement of people in planning their own care is important, because there is widespread recognition that they are experts and have in-depth knowledge of living with a mental health problem. Their experiences are an important resource and can be used to inform their package of care (Lester and Glasby, 2006).

In the Healthcare Commission's review of hospital services for people with acute mental health problems, published in July 2008, the trust was assessed as "weak" for involving people who used services and carers in decisions about care and treatment. In national patient surveys carried out between 2005 and 2007, the trust was in the intermediate or worst categories for this measure, when compared to other trusts providing mental health services.

### People who used services

We were told by the trust that the involvement of people who used services was a key priority. The trust had a strategy for user involvement and a trust-wide user group forum that met in a bi-monthly forum.

The group was jointly chaired by the chief executive and a user of services. People from all services, including Broadmoor Hospital, were represented on the group, along with executive directors and other senior members of staff. It was suggested that this meeting could be improved in a number of ways, one of which was that it started on time, as many trust staff frequently arrived late for the meeting.

Each service had developed its own systems for involving people and training was available for people who used services. Broadmoor Hospital has a user forum, weekly community meetings, and a user of services consultation group for the Broadmoor redevelopment project. Users of services are invited to attend ward clinical improvement groups and clinical audit meetings.

In Hounslow, a user involvement project has been established jointly with the local branch of MIND. Community meetings have been established on the wards and for people who use services in the community. They continue to seek user of services and carer involvement on ward clinical improvement groups

Involvement of people who use services has been challenging and the trust had varying degrees of success. Some services have contracted independent organisations to help improve this. In Ealing, an independent organisation has been contracted to obtain the views of people who use services and help support them to engage in forums.

As part of our investigation, we reviewed copies of minutes from some user forums across the trust. Some of the issues raised at meetings include care plans not being shared with people who use services, the cleanliness of communal areas and access to property (an issue for people transferred from prison to Broadmoor Hospital – sometimes their property can take up to eight weeks to arrive). There were positive comments about catering, good experiences with particular members of staff, and user forums and what they achieve.

The Mental Health Act Commission has commented that user involvement meetings are well used and valued by people who use services. People generally reported being heard and valued, and that changes, where possible, were made.

There is a trust employment steering group and the trust has provided support to help people to gain employment. This has been done through the individual placement and support training programme and “work rehab”, which provides support to people who use services in getting back to work and education looking at financial benefits in relation to permitted earning. The work has been mainly aimed at people with less severe and enduring mental health problems. Out of 160 people who have attended “work rehab” in the last 18 months, seven have returned to full-time employment or education, with more returning to part-time work or education. During interviews with people who use services, we were told about people receiving support with achieving national vocational qualifications and doing administrative work in a rehabilitation centre.

As part of the investigation, we interviewed people receiving care in inpatient units and in the community. There were mixed views about the care they received. Issues of concern included the availability of activities, a lack of awareness about protected time, the impact of low staffing levels on activities, and staff not treating people with respect or being friendly towards them. This was particularly commented on at Hammersmith and Fulham. There were positive comments about the food (it was “edible and hot”), individual doctors and nurses. Many users of services commented about the ward community meetings and clinical improvement groups they attended. At Broadmoor Hospital, the user involvement group was active and arranged learning sessions for users of services to learn about user involvement skills and how to articulate concerns. Some of the concerns were also raised by the patient and public involvement forum.

### Carers

Carers have an integral role in the care of people with mental health problems. Much of the care provided is by carers: family members, friends and neighbours all provide support to people with mental health problems. Carers have a legal right to an assessment of their needs. It is an opportunity to discuss what help they need with caring.

The trust has a carers’ strategy and quarterly meetings are held with staff and carers to review the action points.

Services across the trust have employed a number of strategies to engage carers with varying degrees of success. At the carers’ strategy meeting in Ealing (February 2007), there were concerns about the way the Ealing carers’ centre operated. It was considered not to be as “welcoming as other centres”. “Drop ins” commenced in June 2007 and the trust “resolved to encourage attendance”.

In Hounslow, in 2007 a carers’ strategy was developed. It was noted that carers’ assessments were not taking place in inpatient services and the uptake was low in the assertive outreach team. We were told that part of the problem in the assertive outreach team was that carers did not want the service. To improve this, it was agreed that the service would be promoted, and activity for carers’ assessments would be audited. During interviews, we were told the number of assessments was reviewed on a weekly basis. They have also introduced carer clinics, but have still to identify a lead to drive forward carer matters.

At Broadmoor Hospital, a monthly carers’ forum has been established. It is an opportunity to update carers about changes and plans for the service. Carers have the opportunity to ask questions and some of the recurring issues raised are access to physical healthcare and the ward and hospital environment. They also have an admission carers group that provides information to carers when a person is first admitted to the hospital.

### Findings of fact

- The trust was trying to engage people who use services at a range of levels and across the service.
- Involvement of people who use services was met with varying degrees of success
- Assessments for carers were not taking place consistently across the trust

## Application of the care programme approach

### Sources of evidence

- Trust policies
- Minutes from trust meetings
- Reports of trust audits
- National patient surveys carried out by the Healthcare Commission
- Interviews with trust staff
- National review of hospital services for people with acute mental health problems carried out by the Healthcare Commission

The care programme approach (CPA) describes the process of how mental health services meet the needs of people, plan ways to meet those needs and check that they are being met. The involvement of people who use services is a key principle of the CPA.

During the period covered by the investigation, people who use services were placed on standard or enhanced CPA. The trust had a range of policies in place for the management of CPA, including a separate policy for forensic services, and guidance about the role of the care coordinator. There were a number of forums with responsibility for some aspect of CPA. They included the CPA audit and performance group, the CPA steering group and the clinical transformation group (concerned with the transfer of CPA from a paper to an electronic system).

An audit of CPA carried out between January 2005 and May 2006 found that CPA “continued to be a fragmented process with pockets of good practice” across the trust. The recommendations from the audit included the development of CPA standards and a CPA checklist.

In 2007, the trust identified CPA as a key priority and one of the trust’s “four must do’s”.

According to the information submitted to the trust board, for 2007/08, the number of people in local services who were on enhanced CPA and who had not had a review in six months ranged, each month, between 854 to 1,149. For forensic services, the number ranged from 114 to 214. Both divisions did

not meet the target of no people waiting longer than six months for a review. The trust has commented that these figures are not accurate and appear high due to data quality issues.

During interviews with staff in Hounslow, we were told that users of services and carers were invited to CPA meetings, along with members of the community mental health team. We were told that some members of the multi-disciplinary team, such as psychologists and occupational therapists, did not always attend CPA meetings.

At Broadmoor Hospital, the general view was that CPA continued to be problematic, with variable practice, although there had been some improvement recently. We were told that CPA meetings included all members of the multi-disciplinary team, including members of the security staff. We were told that, although there were lots of productive discussions, they were not always captured and translated onto the CPA. A senior nurse said that the problem was to do with documentation rather than the meetings not taking place. The paperwork was described as “cumbersome and too long”.

The view of some executive directors was that, although the process had improved, there was still much work to do.

Risk assessment is an integral part of the CPA. During 2008, the trust was in the process of introducing a new risk assessment tool to improve the quality of risk assessments carried out by staff. Training for staff was discussed regularly at Broadmoor Hospital. There was concern about the time required to train staff to use the new tool and it was recognised that there was a need to establish a culture of ongoing risk assessments.

In local services, there was concern about the adequacy of the risk assessments of users of services. In October 2005, at the local services clinical governance executive, it was noted that six critical incident reviews, carried out following the suicides of users of services in the community, found problems with the robustness of the risk assessments and the adequacy of the CPA. One of the reviews found that the initial risk assessment was incomplete. Information about previous suicide attempts had not been recorded. There was also a failure to highlight known triggers that may have caused a

relapse. Two critical incident reviews in 2006 found similar problems: there was an “apparent absence or failure to prepare a care plan risk assessment and appropriate recording of observations”. Although it was felt that in one instance “improved assessment would probably not have had any impact on the outcome”.

During interviews with staff at Lakeside mental health unit, we were told that risk assessments were carried out when people were admitted and at six-monthly intervals in line with reviews of CPA, but that it was also done on an ongoing basis. Staff were informed at the handover at the start of each shift of people with particular risks. One service manager was developing a guide for nurses to assess risk: “a proactive risk assessment rather than a reactive assessment which they have found in the past”. While staff told us they were aware of the importance of carrying out risk assessments and staff working in community teams, in Hounslow, seemed particularly aware of the importance of managing risk, some staff reported concerns about the lack of detail in clinical notes about users of services. Much of the documentation of risk assessment and plans to manage risk was done by nursing staff.

At Broadmoor Hospital, when asked about risk assessments, staff told us they were aware of the importance of assessing risk if people were going to be using tools or allowed leave from wards. Assessments were carried out at admission and at CPA reviews. Concerns about individual people were discussed at the weekly clinical team meetings and at shift handovers, and noted in the nursing notes.

What seemed to concern staff at Broadmoor was the quality of the risk assessment and that it was not always translated into the care plan. This has been identified in a number of investigations into serious untoward incidents and critical incident reviews. There was less reference during interviews to the importance of assessing risk in relation to the impact of changes on users of services.

The general view of some senior staff at the trust, including nursing and medical staff and executive directors, was that risk assessments were not as robust as they should be. In reviews of incidents, including reviews of suicides, CPA and risk assessment

were frequently highlighted as areas that required improvement. Views about the current tool used for risk assessment included that it “was fine if you were moving a service user from the hospital”, but it was not useful for looking at a person’s life at Broadmoor Hospital, and while there was focus on the ligature points in the buildings, consideration needed to be given to the “ligature point in the patient”. It was also commented by some senior staff that, in terms of risk assessment, the trust was no worse than other trusts providing mental health services.

### Findings of fact

- Some people did not have their CPA reviewed at six-monthly intervals.
- Some staff felt that key information about people was not always documented in the CPA.
- The trust had taken some action to improve the CPA.
- Assessments of risk related to people who used services were carried out.
- There were concerns about the robustness of the assessments.
- Aspects of risk assessment were regularly identified as a problem in serious untoward incident investigations and critical incident reviews.

## Access to therapeutic activities, protected time, and leave for people who use services

### Sources of evidence

- Visits to inpatient wards
- Interviews with staff and with people who used the trust’s services
- Information provided by the trust

### Access to activities

The National Audit of Violence (2003-2005) identified “high levels of boredom” as one of the six main factors contributing to unsafe wards.

Broadmoor Hospital provides a range of activities and vocational training for users of services. Vocational training takes place during the day (Monday to Friday) and includes horticulture, bricklaying engineering and carpentry. Users of services can also do courses on picture framing and leather craft. All people are risk assessed before they are allowed to attend off-ward activities.

On average, between 12 and 16 people were referred each month. There was some concern among vocational training staff that people were not receiving enough encouragement to attend activities.

It was documented in minutes from a service user group meeting (2007) that users of services felt that “vocational services” offered “real therapeutic value other than the discipline’s function e.g. social interaction, team work and stress release by activity off-ward”.

Referrals for people to attend vocational training are made by occupational therapists. Vocational trainers do not routinely attend case conferences, unless particularly relevant, or CPA meetings, although they write reports which are fed into the CPA process. Some roles that were previously undertaken by staff in vocational training have been transferred to the occupational therapy team. This has caused some tension between the two staff groups: vocational trainers feel they are reliant on another staff group to represent their views at meetings and are concerned about the transfer of roles.

There is also an education centre that provides courses in computer skills and art.

During visits to Broadmoor Hospital, people who used the trust’s services told us that at times it was difficult to access activities due to a lack of staff. This was also noted in the minutes of the senior management meeting in May 2006. At the time, as few as 40 people were found to be engaging in off-ward activities at any one time.

Four users of services, at Broadmoor Hospital, told us they felt there had been a reduction in activities. This view was echoed by a few staff.

At Lakeside mental health unit, we observed a list of activities on the wards. People had access to a

gym, which was available at certain times. The times clashed with other popular activities, forcing people to choose between the activities. The other activities included cookery and pottery. We were also told they had recruited users of services to assist with providing activities at the weekend.

The day hospital provided activities for people receiving inpatient care and for those receiving care in the community. During the site visit in September 2008, we visited the day hospital at about 3.30pm and all but one of the people who used the trust’s services had gone home. There was no sign of any activities taking place. We were told that staff shortages in the day hospital had impacted on the range of activities that were available, and that recently, on several occasions, the hospital had been closed due to a lack of staff.

During a visit to Hammersmith and Fulham, we observed lists of activities on the wards. There was a television in the canteen that had details of the times and places that groups met for activities. There appeared to be four to five planned groups/activities each day including pottery, drama and a walking group. During the unannounced visit, in August 2008, we were told that people often requested additional outdoor activities. The wards had recently received additional money for extra staff to facilitate weekend activities.

The issue of activities was raised on a number of occasions at service user meetings for older people’s services. Some of the problem was attributed to staff shortages, particularly occupational therapists.

### **Leave for people who used services**

Access to leave has been problematic. At Lakeside mental health unit, staff told us that although they try to ensure users of services have access to leave, there are occasions when there are not enough staff available to escort them. On days when there are ward rounds, which takes up the time of one member of staff, escorted leave for people who use services is reduced. The issue has been raised by independent advocates with managers, who have been told the problem is due to insufficient staff to facilitate escorted leave.

## Findings of fact

- The trust provided some activities for people who used the trust's services.
- Activities in the evening and at the weekend were limited.
- Users of services were concerned that shortages of staff at times prevented them from attending activities.
- Insufficient staff was having an impact on access to activities and leave.

## Engagement and protected time with people who use services

### Sources of evidence

- Interviews with staff and people who used the trust's services
- Reports of evaluations carried out by the trust
- Minutes of clinical governance meetings

"Protected time" has been introduced by the trust with varying degrees of success. "Protected time" is defined as a designated period of time when the ward is closed to staff, other than staff working on the ward, and visitors. The time should be spent offering one-to-one sessions with users of services reviewing care plans and risk assessments. Staff can also use the time for clinical supervision and education and training. Visiting times are altered to accommodate "protected time", and nursing staff do not answer ward telephones; calls are diverted to an answer phone.

"Protected time" was introduced at Lakeside mental health unit in November 2006. The information provided by the trust indicated that pilots started at Broadmoor Hospital in 2007. The wards were closed to visitors and members of the multi-disciplinary team, usually for two to three hours on two days of the week.

At Lakeside mental health unit, wards were closed on Tuesday and Thursday from 3pm to 5pm. At Broadmoor Hospital, similar arrangements were in place, with some wards opting to close for three hours. In April 2008 at the Hounslow clinical improvement

group, it was reported that not all staff had a clear understanding of the purpose of "protected time" and some members of the multi-disciplinary team reported it as having a negative impact due to them being unable to access the ward. Some stakeholders were also unclear about its purpose. In 2008, Hammersmith and Fulham MIND noted concerns that staff were still not using "protected time" to spend more time with patients. A few staff at Broadmoor Hospital told us that "protected time" was not happening.

Evaluation of the initiative in Hounslow found concern about staffing levels and how this affected the "continuity and consistency" of "protected time". There were also some comments that users of services did not want to participate. Some users of services were positive and said the sessions were "very helpful and good". Suggestions for improvements included informing patients that it was happening and reducing the time to 30 minutes.

The Mental Health Act Commission report for 2007 commented that, during a visit to a ward at Hammersmith and Fulham, they found little engagement with users of services: it had been a busy morning and protected time was due to happen in the afternoon. While on a visit to a ward at Lakeside mental health unit, they found users of services had little awareness of the purpose of protected time. At Broadmoor Hospital, they had observed some positive interaction between people who used the trust's services and staff.

During planned and unannounced visits to inpatient wards, we often observed little interaction between people who used the trust's services and staff. However, during one site visit a member of the investigation team had lunch on one of the wards. Her observations were generally positive. The atmosphere was described as relaxed. Staff were observed talking to users of services in a friendly manner. Staff observed users of services in different areas. There was an outburst by one person and the response by staff was described as appropriate; "there was no over reaction by staff".

One person came back from leave and joined them for lunch. The person said she felt she had been helped very much by the staff. There was good coordination between the inpatient and the community staff who were facilitating her leave.

Another person was brought to the ward by the police. The staff made sure the police did not leave before they had obtained all the information on her current situation. The person was welcomed to the ward by staff she knew.

### Findings of fact

- Some staff and users of services were unsure of the purpose of “protected time”.
- Protected time was not implemented consistently across the trust.
- Engagement between staff and users of services was variable across the sites we visited.

## Summary of findings in this chapter

- The trust has experienced low staffing levels, accompanied by high levels of absence due to sickness. Although it has tried to recruit staff, this has been hampered by long delays. Despite trying to find ways to reduce the delays, the problems persisted. The low staffing levels also resulted in low attendance at mandatory training and reduced access to escorted leave for inpatients.
- Managing the physical healthcare of people who use the trust’s services at Broadmoor Hospital – a basic right for people with mental ill-health – has taken a backwards step. In 2003, the GP service at Broadmoor Hospital was highlighted as an area of good practice. The GP left in early 2007 and since then the service has deteriorated. Although people who use the trust’s services are having annual physical healthcare checks, the arrangements for physical healthcare are fragmented and much reduced.
- Medicines management is another area where the trust was making improvements, with the appointment of a chief pharmacist in 2003, but since then progress has been slow. The role of the chief pharmacist has not been given sufficient authority or opportunity to be involved in decision-making at the trust. Pharmaceutical advice, although valued by staff where it is available, was a scarce resource, with services in the community being the worst affected.

# Governance arrangements for managing risk and scrutinising the quality of care

Historically, clinical governance arrangements (the systems that promote high quality care and continuous improvement) in mental health services have lagged behind the acute sector (Commission for Health Improvement, *What CHI has found in mental health trusts*, 2003).

This chapter looks at whether senior managers at the trust had arrangements in place to reduce risk and protect the safety of people who use services and staff, and the quality of these arrangements. This is considered in general but with particular reference to the management of risk.

The trust's governance structures had been subject to external scrutiny by the NHS Litigation Authority and the Healthcare Commission as part of the annual health check. On each occasion, assurance was given that the structures were adequate.

## Arrangements at local level for clinical governance

### Sources of evidence

- Risk registers
- Interviews with staff
- Minutes of various meetings including the audit committee, clinical and research governance committee, audit and performance committee
- Trust policies

### Arrangements for clinical governance at division level

Across the trust and at all levels, there was a range of sub-groups with responsibility for taking forward clinical governance. In each of the divisions, the division director was responsible for the implementation of effective systems for clinical governance. They were supported by the associate

medical directors and clinical directors who were responsible for driving the clinical governance agenda.

In the local services division, the overarching committee was the clinical governance executive (previously known as the local services clinical and research governance committee) into which all the division sub-groups reported.

For example, in Hounslow, the clinical director chaired the two key clinical governance groups, audit and performance monitoring and the clinical effectiveness group. In addition to this, there were several clinical improvement groups at ward and team level, along with an inpatient clinical improvement group and the community services clinical improvement group.

From a review of the minutes of these groups, we can see that serious untoward incident investigations and critical incident reviews were discussed, along with the prevention of suicide, at many of them. For example, as far back as July 2005, at the meeting of the clinical governance executive, the associate medical director gave an annual summary of serious untoward incident investigations and critical incident reviews. The main concern was whether actions were being implemented and whether "common themes, once identified were acted upon across the divisions". At meetings of other groups, a description of the events and recommendations were discussed.

In terms of staff awareness of clinical governance activity, we found a mixed picture, with equal numbers of staff interviewed demonstrating an awareness or a lack of awareness of activities.

The view of some staff was that communication between the different teams was either generally "OK" or needed to be improved. Senior staff told us they had worked hard to get as much "buy-in" as possible from staff and they were willing to "have a go". We were also told that the clinical director at

Hounslow had worked hard to develop the systems for clinical governance and had achieved much progress.

In the forensic division, the divisional clinical and research and governance committee was the overarching committee for clinical governance. A range of issues, including physical healthcare and complaints, were discussed at the committee. Discussion of complaints focused on the number and response times, rather than the seriousness of them, and on occasion there was reference to the number of outstanding reviews into critical incidents.

In terms of other meetings, Broadmoor Hospital had similar arrangements to Hounslow: directorate and ward clinical improvement groups. Service users were encouraged to attend these meetings. Staff told us that ward clinical improvement meetings were happening on a regular basis, either weekly or monthly, although attendance varied.

In the minutes of the meetings of both the London directorate and the south of England directorate at Broadmoor Hospital, there was some evidence of discussion about critical incident reviews and of wards presenting findings from audits. Issues such as staffing and training were rarely discussed in the London directorate meetings and, between 2005 and March 2006, there was no reference to serious untoward incident investigations.

In 2005/06, one of the priorities for the south of England group, over and above the trust priorities, was to improve the processing of critical incident reviews to ensure they were dealt with promptly and action plans were implemented.

Senior members of both nursing and medical staff told us that it was hard to get staff involved in clinical governance: the ward meetings in the south of England directorate had recently been re-instigated. One member of staff described the meetings as “appalling”, but acknowledged that more recently there had been a feeling of optimism about the meetings, with more staff getting involved.

There was also an overarching committee that brought the forensic and local divisions together. This was the trust clinical and research governance executive group. The chief executive chaired the group, which brought together a large number of staff, including

executive directors, leads of professional groups and heads of services, from across the trust to discuss a range of issues such as clinical audit and training. A total of 15 subgroups reported to the trust clinical and research governance executive group. The minutes were reported at the clinical and research governance committee. Minutes of the meetings indicate that information about serious untoward incident investigations and critical incident reviews, including recommendations, was discussed.

In addition to all of these meetings, there were nurse governance meetings. They were attended by service managers and senior nurses and were a forum for senior nurses to take forward the nursing agenda in the trust.

### Findings of fact

- The arrangements for local clinical governance were complex.
- There were numerous groups in the divisions with responsibility for clinical governance.
- Critical incidents reviews and serious untoward incident investigations, including timescales, were discussed at many different meetings.

### Policies

We reviewed a sample of the trust’s service and practice policies. These included the Lakeside mental health unit inpatient unit operational policy (January 2008), the seclusion policy (July 2007), the violence reduction and management policy and the engagement and observation policy. The policies were considered to be comprehensive and embraced contemporary thinking.

The policy for violence reduction and management was underpinned with service user principles and promoted prevention and sensitive management, with reference to the environment and the importance of leadership.

The engagement and observation policy was innovative and included supporting information for staff, such as knowledge and skills assessment records and questions for staff.

Overall, the policies reviewed were found to be robust, reflecting best practice and focusing on the wellbeing and safety of people who use services and staff.

### Findings of fact

- The trust had a range of policies in place, which were evidence-based and sensitive to the needs of people who use services

## Arrangements at strategic level for clinical governance

During the period of the investigation, responsibility for clinical governance was shared between the director of nursing and the medical director. The medical director was the trust's board lead and was responsible for bringing aspects of clinical governance together, but not necessarily for leading on components; this was shared among other executive directors. The role was described as "driving the strategy", while much of the operational responsibility rested with the director of nursing.

The director of nursing was responsible for the management of risk and the central support team for clinical governance. At executive level, the roles of the medical director and director of nursing were clearly understood, but we were told there were occasions when they were not clearly understood by other staff.

At strategic level, there was the clinical and research governance committee and the risk management committee, both chaired by a non-executive director. There was also the audit committee, which was chaired by a non-executive director. The minutes of the committees went to the trust's board, where they were often noted rather than discussed.

The executive directors met monthly and discussed both operational and clinical governance issues. Some of the issues discussed included the new framework for mandatory training, the process for signing the core standards declaration, the service model for older people's services and aspects of risk management. Minutes of the meetings were reported to the trust's board.

## The management of risk

Systems for the management of risk should allow trusts to identify potential risks and take timely action to minimise harm to people who use services and staff. Members of the trust's board should be aware of significant risks to the safety and wellbeing of service users and staff, and ensure action is taken to manage the risks.

The risk management committee was initially chaired by the chief executive and then by a non-executive director. The committee met quarterly and reported to the audit committee

Although the risk management committee was where much of the discussion about the management of risk took place, aspects of the management of risk were discussed at a range of other groups: the executive directors meeting and the trust clinical and research governance executive group.

Quarterly and annual incident reports were reported at the risk management committee: changes in the classification of incidents were noted and there was some discussion about trends in incidents. In November 2006, there was a discussion about the circulation of quarterly incident reports. The director of local services said they were circulated to wards, and the director of forensic services said it was done through the clinical governance system, but the issue was how the information was used.

The minutes indicate that there was discussion about improving the systems for risk management, such as creating a central network to hold information about investigations into serious incidents and critical incidents. Minutes from other committees, such as the infection control committee, were noted at the meeting.

The timescales for investigating serious and critical incidents were discussed on a number of occasions, with repeated requests (June 2006, February 2007 and April 2007) for reasons for delays to be included reports.

The clinical and research governance committee discussed investigations into serious untoward incidents and critical incidents. Confusion about the difference between the two types of investigation was

raised in June 2007, along with the need for adequate resources for teams undertaking investigations.

Much of the discussion at all of the meetings was about the investigation process, rather than the findings of investigations.

Views on the effectiveness of clinical governance varied: senior staff thought there was a lot of activity but not much on outcomes; another view was that in 2007 there was a “can’t do” feeling at the trust and it was difficult to get a clear answer on issues raised, but that this was improving.

### Findings of fact

- The director of nursing and the medical director both had responsibility for some aspects of clinical governance.
- Concerns about the timescales for investigating serious untoward incidents and critical incidents were noted on a number of occasions at the risk management committee.
- Requests for reasons for delays to be included in reports were not acted upon.
- Executive and non-executive directors were aware there was confusion about the difference between a critical incident review and a serious untoward incident investigation.
- Minutes from the risk management committee were noted at meetings of the trust’s board.

### Risk registers

A risk register is a way for trusts to record and grade risks in terms of their seriousness.

The risk of suicide by service users and failure to learn from serious untoward incident investigations and critical incident reviews were rated as “red”, meaning extreme risk, on the risk registers for Broadmoor Hospital and the local services division respectively. The “risk to self” was not included on risk registers until after August 2007. It was recommended that the focus include the clinical aspects of management and not just the environmental risk, such as ligature points.

The trust’s risk register was made up of risks, identified at service and directorate level, that were rated high and had a trust-wide impact. The register was reviewed quarterly at the risk management committee, but on very few occasions at the trust’s board. In January 2008, the trust risk register contained 56 risks, 15 of which were rated “red”. The risk of systemic failure leading to suicide by service users remained unchanged and was rated as “red”. Actions to minimise the risk included many of the issues highlighted in the first chapter: training on risk assessment and management, learning from incident enquiries, improving the estate and implementing the trust’s suicide prevention strategy.

### Suicide prevention strategy

To implement the trust’s suicide prevention strategy, the trust had tried to establish separate suicide prevention groups for the local and forensic divisions. However, although between 2002 and 2005, a total of 111 suicides had occurred in inpatient and community services, both groups encountered problems with attendance.

From the information provided by the trust, we can see that the group for the local division met in 2005 and established reporting structures. However, we have not been provided with further evidence of meetings and it is unclear if the group ever met again.

In September 2005 and September 2006, it is documented in the minutes of the group for the forensic division, that links between the two groups should be established in order to share information and practice. When representatives from both groups met in May 2007, it was documented that the group in the local division had been having some difficulty with membership and attendance and, as such, had not had a meeting.

For the forensic division, we have been provided with minutes of meetings from May 2005 until January 2006. There is then a gap until September 2006. The meetings continue until November 2007, when there seems to be a further gap until September 2008. During interviews, we were told that the group was suspended as “interest had dropped off”. The minutes provided for September 2008 are about establishing a suicide prevention group for Broadmoor Hospital. Discussion at the meetings held

in 2005 and 2006 include incidents involving self-harm and attempted suicide and training for staff in suicide awareness. In January 2007, concern is expressed about the under-reporting of self-harm incidents: some were being reported as accidents.

Local services, including Hounslow, had also established groups to monitor implementation of the suicide prevention strategy. The groups included representatives from the local authority, the police, the PCT and the local acute trust. Progress against the action plan was reported at meetings of the local implementation teams.

In late 2007, the trust established a trust-wide suicide reduction and serious incident monitoring group.

### Findings of fact

- Problems with undertaking investigations and learning from serious untoward incident investigations and critical incident reviews were rated as high risk on the risk register for Broadmoor Hospital.
- The risk of service users committing suicide was rated as high risk on the trust risk register.
- The trust's risk register was reviewed at the risk management committee
- The divisional suicide prevention groups experienced poor attendance at meetings and there were long gaps between meetings of the groups.

## How the trust's board functioned

The membership of the trust's board had been relatively stable for a number of years. The board met 10 times a year and included a representative from the staff side. Prior to meetings, there was a presentation about service developments or some aspect of clinical governance. The non-executive directors told us that they had never had separate meetings; the chairman would meet with them if there was something specific to share with them, but this was mainly about external issues. They had access to the chairman at any time, but they wanted to be as open as possible with the executive directors, rather than having confidential meetings.

The meetings included standard items such as finance, complaints reports and the chief executive's report. The minutes from many governance and executive meetings were noted at the meetings, but there was little discussion of the content of the minutes.

In September 2006, the minutes noted that the trust's corporate and clinical governance objectives were linked within the assurance framework to the Healthcare Commission's core standards and to the risk register. The assurance framework was presented on a quarterly basis to the trust's board. During 2007, risks that were rated red included staff not completing risk assessments and management plans, and lessons from incidents not being learned and shared across the organisation. Throughout 2007, the trust's board were satisfied that the risks were accurately reflected and that the key risks were being adequately managed.

The results of the national staff survey, along with patient surveys, were discussed at the trust's board.

Staffing issues such as the approval of a new system for managing sickness and the quality awards were discussed regularly. The problems with staffing levels and decisions about recruitment were occasionally discussed. For example, in May 2006, the decision not to recruit to vacancies in Hounslow was questioned by a non-executive director. The response was the decision was made to help the trust achieve its financial target.

In November 2005, the trust applied for foundation trust status. When asked, by a non-executive

director, why the trust was pursuing this option, the chief executive responded that it would strengthen relationships with the local community, and social inclusion, and enable the trust to retain and invest any financial surplus. The trust's application was put on hold while the implications for trusts providing high secure services was considered by the Secretary of State.

The trust's board discussed individual investigations in the confidential part of the meeting. Information about new serious untoward and critical incidents was presented, along with updates on the progress of investigations/reviews and action plans. Some questions were asked about the incidents and the trust has commented that the minutes were only a summary of the discussion and do not reflect the amount of time spent on these issues at the meeting.

On some occasions, there were requests for non-executive directors to chair investigation panels and terms of reference were approved. On one occasion, September 2006, a non-executive director noted there were recurring recommendations but with different resolutions. Reassurance was given by the director of forensic services that the incident monitoring and reporting groups were responsible for ensuring consistency in action plans.

Concern about resources was raised in January 2007: the chair of one investigation panel had spent 80 hours, in addition to her "day job", investigating the incident. Draft action plans were submitted and on occasion progress reports on action plans were submitted.

There were discussions about particular problems, such as the outbreak of legionnaire's disease and the finding of asbestos on two sites. Although concerns about levels of bed occupancy were included in reports from the Mental Health Act Commission, which were submitted to the trust's board, there was an absence of discussion about the problems at Hammersmith and Fulham until September 2007 and then again in June 2008. There was little discussion about trends in incident reporting, although this may have been because it was difficult for the trust to compare year-on-year data. The trust has commented that discussions took place at the board sub-committees and that not all discussion was repeated at the board. While this may be appropriate in some instances, the chairs of the committee should have brought serious matters to the attention of the board.

When some of the issues included in this report were raised with executive and non-executive directors, although many of them seemed to have an awareness, some of the responses we received were it "wasn't within their portfolio" or "the problems were not unique to the trust", or the trust was "no worse" than anywhere else and there were poor environments in every organisation.

Access to physical healthcare for service users, particularly in forensic services was not generally discussed. When some non-executive directors were asked about this issue, their understanding was that temporary arrangements were in place or this was an issue they could not respond on. We were given a similar response from another non-executive director when asked about the bed occupancy problems at Hammersmith and Fulham: although they had some understanding of the issue, they were not familiar with it as it was "not their area".

### **Compliance with core standards**

The Healthcare Commission's annual health check assesses NHS organisations on many aspects of their performance. The assessments are based on a range of data gathered throughout the year, including information about whether trusts are meeting the targets and standards set by the Government. Trusts have to complete a declaration stating whether or not they are compliant with the core standards.

For 2007/08, the trust declared itself compliant with all of the 24 core standards. The director of nursing described the process used by the trust, saying they had worked very hard with the Healthcare Commission to agree an understanding of the terms "reasonable reassurance" and "significant lapse". The trust had three levels of assurance: high, medium and low. If the assurance was assessed as low, action plans were developed to bring about the necessary improvements. The Healthcare Commission had commended the trust's system for assessing compliance against the standards. When asked if the trust was assured that all areas of the trust were compliant with the standards, the director of nursing responded there was reasonable reassurance for the trust in the way it was intended to be measured. A dirty room or a mouse sighting in an old building, although a matter of concern, would not necessarily add up to the trust declaring a "significant lapse".

Executive and non-executive directors were asked on what basis they declared themselves compliant with the standards for the environment, privacy and dignity, and mandatory training. Some of the responses included that there was room for improvement and, because they could see changes were happening, it gave them confidence to say “yes, this isn’t good, but it is a dynamic situation...” and “times when these have been signed off, not on the basis that is 100% but from where they are coming from as a trust”. Other responses were that the environment was only one element of care and that, if the environment is poor, it didn’t mean that the score would have to be poor.

### Findings of fact

- Some aspects of the experience of service users were discussed at meetings of the trust’s board
- Key issues such as bed occupancy and staff vacancies were discussed only occasionally at meetings of the trust’s board
- Serious untoward incident investigations and critical incident reviews were discussed at meetings of the trust’s board.
- The trust’s board was reassured that mechanisms were in place to ensure consistency in action plans
- Concerns about resources for carrying out investigations were raised, but no action was taken
- The trust’s board was assured that key risks related to staff carrying out risk assessments and learning from incidents were being managed.
- The trust had a process for assuring compliance with core standards
- The non-executive directors did not always have an overview of problems across the trust
- Some executive and non-executive directors responded to queries about some aspects of performance to the effect that they were no worse than other mental health trusts

## Engagement with clinical staff

Effective engagement with clinical staff is vital to the improvement of quality in the NHS. From minutes of divisional meetings and clinical governance meetings, and some interviews, we had gained an impression that the trust had structures in place to involve senior medical staff in the decision-making processes of the trust.

Each service had a clinical director and senior manager. The medical director was supported by three associate medical directors: one for each division and for medical education. The director of nursing was supported by two deputy directors of nursing. Allied health professions and pharmacists were not members of the trust’s board or the clinical and research governance committee. However, they were members of the trust’s clinical and research governance executive group.

One of the deputy directors of nursing acknowledged that, although they had some senior nurses in post, there needed to be more accountability at senior level. Nursing needed to be taken “seriously”: they were seen as “foot soldiers”. At Broadmoor Hospital, there were two nurse consultants. They were described as “well established” and rated highly by the executive team.

In terms of allied health professions, the view was that, although they felt supported by the trust, they could be more involved in the “business of the trust” and they needed to be present at meetings of the trust’s board.

Medical staff were involved in a number of committees, both divisional and trust-wide. Across the trust, there were medical advisory committees (MACs), each chaired by a consultant. The committees at Hammersmith and Fulham and at Broadmoor Hospital were described as well attended, but less so at the Ealing and Hounslow MAC, with meetings cancelled due to poor attendance. The associate medical directors attended the medical advisory committees and, on occasion, the chief executive and medical director also attended meetings.

During the investigation, senior medical staff contacted the Healthcare Commission to raise

concerns about the management structure and the arrangements for clinical governance. Although we interviewed medical staff as part of the investigation, a group of consultant psychiatrists requested to meet with us outside of the planned site visits.

The first meeting involved 20 consultant psychiatrists (out of 110 employed by the trust) from across the trust, and a ward manager. One of the consultants had left the trust. Some were reluctant to give their names for fear of "reprisal". The consultants were concerned about the leadership style of the chief executive and the medical director. They felt they were not in "touch" with either staff or patients and that the "voices" of senior clinicians were not heard. When asked if they had raised their concerns with the medical director and chief executive, we were told that some staff were "too scared to come forward", while another was told he could leave if "he believed things would be better elsewhere". The trust commented that it is not aware of any "reprisal" against any staff (consultant or otherwise) as a result of comments to senior management and there was a whistle-blowing policy in place.

Towards the end of 2008, we received a request for a further meeting. The second meeting was attended by 10 consultant psychiatrists, one of whom had left the trust and four who had been at the first meeting. They also brought letters of concern from other consultant psychiatrists who were unable to attend the meeting. The concerns expressed were similar to those expressed at the first meeting. The trust had an "authoritarian and bullying style", the medical director was described as dismissive of those who did not share the same opinion as her. Some managers in the trust were "very good" but others were "extremely aggressive" or "did nothing". Executive directors did not want to hear about problems "as long as the budgets are achieved they turn a blind eye". The chief executive was described as a "decent bloke" and if he left the trust it wouldn't necessarily change anything. They felt they were losing key staff because of the bullying culture.

During interviews with other senior medical staff, the medical director was described as "helpful and supportive" and "challenging and has high expectations". Some said that it had been difficult to engage the medical director and director of nursing at

divisional level, while others said that they found senior colleagues to be approachable and supportive and that consultant psychiatrists were involved in the decision-making process. The chief executive was described as "open and honest" and a "good leader".

In November 2007, the trust commenced a review of the Ealing and Hounslow MAC. The review found that not all consultants were aware of the purpose or the dates of the meetings, differing views about the effectiveness of the meetings, and a general sense that some consultants felt excluded from operational and strategic decision making. They were also concerned about the role and importance of the consultant psychiatrist and wanted it "restated and clarified". It was agreed that the MAC should be "refreshed" and the terms of reference should be reviewed.

While mindful that there is often a certain amount of tension between clinicians and managers, which can be healthy in terms of driving improvement for service users, we were concerned that, in this instance, the level of tension may have adversely affected other staff and service users. In December 2008, we wrote to the chief executive expressing our concerns and suggesting that the trust take action to "facilitate a culture of discussion and engagement between senior medical staff and executive directors".

The trust responded that it was "not convinced" there was a general view that medical staff felt undermined, that it was "the perception of a few, disaffected, staff", and that it was not widespread throughout the trust. There were systems in place for staff to raise concerns, either directly to the chief executive or through the whistle-blowing or bullying and harassment policy. During the period of the investigation more than 16% of all medical staff had management responsibilities and were involved in decision-making in the trust. However, in order to be as inclusive as possible, the chief executive intended to make it a priority to meet with the chairs of the medical advisory committees.

A few consultants have since written to us, telling us that the trust had an excellent reputation among medical staff and a low turnover in senior clinical posts, and that medical staff were extensively represented at management meetings. They said that the trust "had patient care at its heart" and described

the trust as a “nurturing organisation”. They felt the trust had made efforts to engage consultants on a regular basis and that some of the problem may be attributed to the changing clinical environment where consultants no longer have “pre-eminence in clinical matters”.

### Findings of fact

- The trust had put some systems in place to involve senior medical staff in decision-making processes.
- Some senior medical staff felt they were not involved in the decision-making processes.

## The strategic health authority

In 2002, strategic health authorities (SHAs) were created to manage the local NHS on behalf of the Secretary of State. Each SHA is responsible for developing a strategic framework for its local health and social care community and managing the performance of NHS healthcare providers (other than foundation trusts) within its geographic boundaries.

The trust was part of North West London SHA until 2006 when the SHAs were reconfigured and it became part of the London SHA.

### Monitoring of the trust’s performance

The SHA, NHS London, has statutory responsibilities in relation to Broadmoor Hospital. They are outlined in the *Framework for the Performance Management of High secure hospitals* (April 2008). The overarching responsibilities include ‘line of sight’ on behalf of the Secretary of State and the high security hospital. There is a nationally agreed performance framework for high secure hospitals, which include key performance indicators (KPIs) and the reporting of serious untoward incidents.

The SHA provided evidence of regular meetings with senior trust staff and the commissioning organisations to review the KPIs.

A range of issues, such as the redevelopment project and activity reports (admission and transfer of service users), were discussed at the meetings. Issues related to the care of service users were also discussed: physical

healthcare and the number of service users who had a care programme approach. The trust provided updates on serious untoward incidents and activity reports on the advocacy service. The Mental Health Act Commission attended some of the meetings.

In addition, there were regular meetings with the chief executive of the trust. These meetings were quite detailed and included discussion about serious incidents, ligature points and risk assessments, staffing levels and staff attendance at training.

The performance manager carried out visits to the hospital and spent time visiting wards and meeting with staff.

In terms of the rest of the trust, the SHA used the range of measures, as set out in the NHS London Provider Agency Performance Regime, to assign performance ratings for trusts. Performance management was mainly through quarterly reports to the SHA on KPIs. The SHA assessed the trust’s performance and rated them for each category of KPI. For most of 2007, the trust received a good rating for quality and safety and governance, but a lower rating for financial risk. The SHA noted information from national surveys of staff and service users and the trust’s performance in national clinical audits. This information was used to inform the risk rating for the trust.

The trust was not required to inform the SHA about bed occupancy, and the SHA was not initially aware of the severity or duration of the problems in Hammersmith and Fulham. When asked if some of the problems were due to pressures faced by trusts in London, the SHA felt it was more related to the trust’s management of inpatient services and how the PCT was commissioning.

In terms of reporting serious untoward incidents, the SHA acknowledged that it would have more involvement in serious untoward incidents that occurred in Broadmoor Hospital. It approved the terms of reference and would make suggestions for members of the panel. For local services, it would not necessarily have to approve the terms of reference, only in specific cases such as a homicide.

An internal NHS London email, dated January 2008, listed the number of incidents for which it did not

have reports. The incidents dated back to February 2006. The information indicates that some of the investigations were completed, but some from October 2006 were categorised as ongoing.

Other internal SHA emails confirmed some of the problems around access to information before 2006. An email dated 18 July 2008, in response to a request for information from the Healthcare Commission, stated there was some information from before 2006, but there weren't "many files" and they "didn't connect or tell a coherent story". It was the same for performance monitoring reports before 2006. When asked, the SHA said that due to the changes in organisations there wasn't a clear picture before 2006, but some of the information could be accessed from the SHA archive.

Prior to 2006, the trust was under the North West London Strategic Health Authority (NWLSHA). The SHA stated that NWLSHA's policy for reporting serious untoward incidents did not set out clear requirements for the "submission, formal monitoring and closure of SUIs". It believed that the policy did not outline a clear process for investigations, reports and follow-up action. The policy stated that all SUIs should be reported and that a "final report should be provided to the SHA following the initial investigation of the incident". There was also a list of the information that should be included in the report.

In 2006, NHS London amalgamated the policies for the reporting and investigating of serious untoward incidents from the five previous London SHAs. During 2007, it carried out a consultation exercise for a new policy for the reporting of serious untoward incidents. In October 2007, it issued the final guidance, including a 60-day timescale for the completion of investigations into serious untoward incidents. It felt that, in most cases, trusts should be able to complete investigations within 60 days

In January 2009, the SHA provided a list of all the serious untoward incidents reported by the trust for the years 2006, 2007 and 2008. Since 2006, the trust had reported 140 serious untoward incidents, but the data for 2008 was the most accurate, as it was the first full year that comparative data using the same system and policy was available.

For the preceding years, although the trust had reported incidents, the information was not as reliable, due to the merger in 2006 of the five London SHAs. However, the SHA did not believe this was because the trust did not comply with the guidance and policies in place at the time of NWLSHA. It believes the information suggests that the trust was a "good reporter of incidents", but also said that the trust had increased reporting levels of serious untoward incidents over 2006, 2007 and 2008.

The trust is ranked by the national reporting data from the National Patient Safety Agency as 23 out of 66 mental health trusts nationally.

However, whether or not the SHA believes that the NWLSHA's policy was explicit, the information contained in the emails indicates that a number of investigations into serious untoward incidents that had occurred in 2006 had not been completed.

In terms of PCT involvement in serious untoward incidents, the SHA explained that some were more explicitly involved than others; it would depend on the nature of the incident. If a trust provided services for a number of PCTs, the "host" PCT, in this case Ealing PCT, has access to the electronic reporting system, enabling it to see all of the information about serious untoward incidents relating to the trust.

### Findings of fact

- The SHA carried out regular visits to the Broadmoor Hospital and had regular meetings with the chief executive and senior staff in relation to the hospital.
- The SHA had more involvement in serious untoward incidents that occurred at Broadmoor Hospital than those that occurred in other services.
- The SHA was not initially aware of the problems with bed occupancy at Hammersmith and Fulham.
- In 2008, the information held by NHS London indicated that there were a number of outstanding investigations into incidents that had occurred in 2006

## Primary care trusts

Primary care trusts (PCTs) covering all parts of England receive budgets directly from the Department of Health. Since April 2002, PCTs have taken control of commissioning local healthcare while strategic health authorities monitor performance and standards.

High secure services for London and the south of England are provided at Broadmoor Hospital. The lead commissioner for high secure services provided at Broadmoor Hospital is the London Specialised Commissioning Group. They lead on behalf of the hospital catchment specialised commissioning group.

As part of the investigation, we contacted the relevant PCTs in the south of England and interviewed a representative from South East Coast Specialist Commissioning Group (SCG). The SCG had 38 service users in the hospital and spoke positively about the working arrangements with the trust. It is informed when serious untoward incidents involving service users from their area occur and receive copies of the investigation reports. Broadmoor Hospital had established good links with the regional secure units and had involved the PCTs in the redevelopment of the hospital. The SCG has a dedicated manager who attends CPA meetings. It felt the transfer of the women's service to the Orchard unit at West London Forensic was well managed. Although, since the service has transferred, there have been some problems in communication with staff at the site, which the SCG has put down to "teething problems".

In terms of local services, the three commissioning PCTs were Hammersmith and Fulham, Ealing, and Hounslow. Ealing PCT was the lead commissioner.

Over the last few years, Hounslow PCT has been hampered by severe financial problems. Particularly difficult was 2006/07, and although there was no cut in actual funding for mental health services, there was no increase in funding for services. Some of the voluntary services that were considered to be more social care rather than healthcare were decommissioned. Alongside the financial problem, there was a frequent turnover of senior staff. All of this has, at times, made the working relationship difficult. However, both the PCT and senior staff at

Hounslow told the Commission they have worked hard, in the face of these challenges, to maintain an effective working relationship.

One of the key meetings was the mental health joint strategy group and national service framework local implementation team. This group met bi-monthly and included staff from the trust, PCT and local authority. Discussions included taking forward the strategy for the prevention of suicide and user and carer involvement. Progress on achieving activity targets was discussed along with finance. Feedback from service users about the service was provided.

In terms of reporting serious incidents, the PCT received electronic copies of serious incident reports from the director of local services. Information about serious incidents was presented to the PCT's board in 2005 and 2006. On occasion, the PCT was involved in approving the terms of reference for an investigation. The PCT described the trust as the most consistent in providing information about incidents. The PCT did not receive any information regarding complaints about the service.

There were similar meetings with Ealing PCT, and Hammersmith and Fulham PCT. In Ealing, the mental health strategy group is called the mental health partnership board and meets bi-monthly. The NSF local implementation team, however, meets monthly.

The trust was having difficulty meeting the targets for the number of service users that should be seen by the crisis resolution team or home treatment teams. The trust was undertaking some work to see if the targets were realistic.

The PCT was aware that, following the closure of two wards at Ealing, there were some problems with service users having to sleep out. This has now been reduced considerably since the home treatment team was established.

We asked the trust for information about this and there was evidence that the situation had improved. During an unannounced visit to the Ealing site, we also asked staff and were told that it happened on very rare occasions.

As well as receiving performance information about activity, Ealing PCT received details of serious incidents, along with copies of investigation reports.

A protocol for monitoring action plans from serious untoward incidents was in development. In addition, reports on complaints and the priorities for clinical governance were sent to the PCT.

Hammersmith and Fulham PCT were informed of serious untoward incidents when they occurred. Quarterly reports to the mental health partnership board included information about complaints (and the response times) and incidents. The reports were quite detailed and compared year-on-year information.

More recently, in 2008, the three PCTs established quarterly meetings to review the trust's performance. They were developing a scorecard to assess the quality of the services, which would include indicators such as length of stay, serious untoward incidents and response times for complaints.

General comments from the PCTs included that, although things have not been perfect, they feel the trust is moving in the right direction and the chief executive had done a lot of work in taking the trust forward. Another view was that the trust was "very helpful and cooperative" but "culturally not proactive in sharing information with their partners" and "fixated on targets rather than the quality of the service".

## Local authorities

The trust provided integrated community mental health services in partnership with Ealing Local Authority, Hounslow Local Authority and Hammersmith and Fulham Local authority.

Although the trust had formal partnership arrangements in place, they did not use specific section 31 powers.

The local authorities were part of the commissioning groups and local implementation teams in all of the boroughs.

Staff employed by local authorities worked in the community teams, and processes were in place to manage employment issues such as sickness absence and appraisal. Senior managers could be employed by either the trust or the local authority, and reported to both the director of local services and the corresponding manager in social services.

While there was evidence of partnership working and sharing of information at division level, there were no representatives from local authorities on trust-wide committees such as the clinical and research governance committee.

Representatives from the local authorities were interviewed during the investigation. They described themselves as part of the management team and routinely received information about serious incidents, although not all of them received information about complaints. Some mild concern was expressed about the way in which incidents were handled: the responses/reports were described as "spasmodic".

The local authorities were generally positive about the trust and commented on the strong presence of the director for local services.

The three-way partnership working between the PCTs and local authorities was described by one local authority as "the best group of partnerships within mental health services".

### Findings of fact

- PCTs and local authorities received routine activity information from the trust
- PCTs and local authorities were informed when serious untoward incidents occurred
- The trust provided PCTs and local authorities with investigation reports into serious untoward incidents and critical incident reviews
- Partnership working at division level was generally viewed as positive by the trust, PCTs and local authorities

## The Mental Health Act Commission

The Mental Health Act Commission (MHAC) carried out announced and unannounced visits to the trust at regular intervals and interviewed service users who were detained under the Mental Health Act 1983 (amended by the Mental Health Act 2007) and staff. In 2007, the MHAC visited over 50 wards across the trust, and met with over 300 service users. Following each visit, summaries were sent to the trust. If there

were any concerns, the trust was required to respond within 21 days. However, on many occasions, the trust has taken longer to respond.

Annual reports are presented to the trust's board. The reports for 2005 to 2007 highlighted a number of key concerns for the trust, including bed occupancy, staffing levels and the environment. Each annual report was presented to the trust's board. They generated some discussion, but this discussion did not include any of the issues above. Trusts are required to provide a written response to the reports. In 2006 and 2007, the MHAC noted that there had been considerable delay in the trust responding to concerns raised in the ward summaries. The trust agreed to improve the timeliness of its response.

The MHAC described the relationship with the trust as that of a "critical friend". They felt the trust had good intentions, but there was a difficulty in communicating them to staff. However, it felt that it did a lot of good work and dealt with some of its more challenging issues very well.

The MHAC described the trust as prompt in informing them of the death of a service user. They were generally notified on the day of the death in line with their requirement. However, the MHAC was concerned that their recommendations following attendance at inquests were not actioned with similar purposefulness and timeliness.

### Findings of fact

- There had been delays in the trust responding to recommendations in ward summaries.
- The MHAC reported that it had a positive working relationship with the trust.

## Summary of findings in this chapter

- The trust had arrangements at strategic, division and service level for clinical governance and there was much activity, but it took a long time to address some key issues such as bed occupancy and staffing levels.
- Executive and non-executive directors were aware of the problems with investigating serious untoward incidents, but the concerns were not responded to with any urgency and this was not challenged.
- The risk of suicide had the highest risk rating, but attempts to introduce divisional meetings to discuss suicide prevention were met with little success.
- The SHA did not have accurate information about serious incidents for 2006 and 2007, but it has now strengthened the reporting arrangements for serious untoward incidents.
- Generally, the trust had a good working relationship with commissioning PCTs and local authorities and informed them about serious untoward incidents, but there was little discussion about the investigations or the outcomes of the investigations.
- The MHAC was generally positive about the trust, but had some concerns about the timeliness of its response when concerns were raised.

# Conclusions

This section of the report brings together our overall assessment of the areas covered by the investigation. It is based on the evidence and findings in the report and describes what we found.

## Providing a safe environment and protecting people from harm

The trigger for the investigation was concerns about the responsiveness of the trust to serious untoward incidents, including suicides. We found that many aspects of the trust's arrangements for investigating serious untoward incidents were seriously flawed during the period under investigation.

### Trust policies

There were difficulties with the trust's policies for investigating incidents. There were a number in place containing different information, resulting in confusion for staff. The policies contained information about the types of reviews and investigations that could be carried out but, as this information was not consistent, it hindered rather than helped staff. Aware of the confusion caused by having differing policies in circulation, the trust began action to introduce a new policy that would clarify the process for staff. However, implementation of this policy stalled in anticipation of the introduction of national guidance about serious untoward incidents. This meant that the confusion was prolonged for almost 18 months. The trust should have continued with its plans to revise its policies and amend them where necessary.

### Classification of incidents

The trust used different classification systems, which added to the confusion. Some of the problems could be attributed to the number of classification systems used by different organisations. For example, the Mental Health Act Commission categorised serious untoward incidents as A to E (A being the most serious and equivalent to the NHS London

classification of a serious untoward incident), while the National Patient Safety Agency uses the terms "death", "severe", "moderate", "low" and "no harm". The trust exacerbated this confusion by stating that all deaths (except those from natural causes) should be classified as serious untoward incidents and, despite this, carried out different types of investigations and reviews

The policies contained different definitions concerning "near misses", which along with individual interpretation made it difficult for the trust to obtain an accurate picture about the nature and frequency of near misses. This prevented the trust from taking proactive action, as opposed to responding reactively.

However, we are aware that the problem of defining near misses in mental health services is complex and not unique to the trust.

### Timescales for investigations into serious untoward incidents

There were significant delays in completing many investigations. Timescales for completion ranged from two to 23 months. Some of the reports were undated, making it difficult to determine how long the investigation took.

On some occasions, a 'critical incident review' was conducted when there should have been a 'serious untoward incident investigation', further adding to the delay. On other occasions, the delay was to enable other organisations to carry out their investigation. Some of the delay could have been reduced by agreeing with those organisations about what action could be taken in parallel. Human factors such as sickness and maternity leave contributed to delays but, again, the trust should have considered ways of working around these problems rather than delaying investigations. There should have been a clear audit trail, with stakeholders being kept informed about the delay and the reasons for it. The reports should also have stated the reasons for the delays.

We are aware that carrying out investigations takes time, resources and expertise. The time required by staff to carry out investigations was noted at the trust's board, but no action was taken. This should have been acknowledged, and some thought should have been given to how this could have been addressed.

### Investigation reports

The quality of some of the investigations and reports was poor: important lines of enquiry were not pursued, leaving some important questions unanswered, and findings did not always match the evidence. Given the number of committees and sub-groups that were in place, these issues should have been identified and fed back to panels to allow them the opportunity to address them.

A serious omission was not consistently sharing reports with senior staff responsible for the service, prior to them being presented at the trust's board. This should have been part of the quality assurance process.

Forensic services established a group to monitor investigations and learn from them, and a central database was established, but delays continued. While there was discussion of incidents at various meetings, on many occasions discussion was not followed up with action.

### Recommendations within reports

Some recommendations were repeated in other, subsequent reports, but this was not recognised and acted on by the trust. Although different investigations may have identified different aspects of an issue, more thought should have been given to reviewing the overall problem rather than taking a piecemeal approach and just addressing the one aspect.

Two important areas where there were recurring recommendations were risk management and the environment (delays in removing ligature points). The problems faced by staff having to care for people in buildings that have been deemed "not for purpose" reinforce the need for good risk assessments.

### Action plans and learning from investigations

There was confusion among some staff about who was responsible for action plans, and the quality of action plans was variable. Although some attempt was made to improve the process, some of the problems persisted, such as who should be involved in their development and the process for approving them. Considering that action plans were key documents to bring about change, they should have been given more attention.

Learning from investigations was problematic. Although there was discussion of incidents at meetings of senior staff, from interviews with staff we know this was not cascaded down to staff delivering the care. Staff received feedback from incidents in their clinical areas. However, the trust did not have a systematic mechanism to share learning across sites.

There were problems with learning from near misses and from serious untoward incident investigations. Consideration should have been given to how this could be improved, for example using time during reflective practice and clinical supervision.

Investigations into serious untoward incidents were hampered by confusion, lack of resources, expertise and a lack of innovative and lateral thinking by the trust. Responsibility for the investigations/reviews was described in the policies, but it was difficult to find who was "driving the process" or who in the trust had an overall view and was accountable for investigations, their findings and recommendations.

The trust was aware of many of the problems found during the investigation and, although it has now started to address them, it has taken some time to grasp the problems and start managing them.

### Other issues affecting the safety of care

We found several other issues that gave us cause for concern about the safety of the environment and the risk of harm to people using the trust's services:

- **Environment:** Many of the buildings at Broadmoor Hospital were old and not fit for purpose. Apart from the increased level of risk the buildings posed, the impact of the environment on a person's sense of wellbeing should also not

be underestimated. Many service users spend a significant period of time there.

We are aware that the redevelopment for Broadmoor Hospital is a complex and significant undertaking, but Broadmoor is a hospital, and service users are entitled to expect to be cared for in a therapeutic safe environment.

The redevelopment of Broadmoor Hospital is complex and has difficult planning issues related to the listed buildings on site. However, it is hard to see that the timescale proposed for the completion of the redevelopment is satisfactory for service users.

A poor inpatient environment is not confined to the Broadmoor Hospital: some of the inpatient wards in the medium secure services and local services at St Bernard's Hospital in Ealing are also "sub-standard", with recurring infestations of vermin. The Mental Health Act Commission raised concerns in 2006 and 2007, but it is only recently that the trust has started work on redevelopment plans for the site.

- **Bed occupancy:** This was a problem at the Hammersmith and Fulham site for a number of years. On some occasions, there simply was not a bed for a service user; on others, the only available bed was on the psychiatric intensive care unit (PICU). While discussed locally with Hammersmith and Fulham PCT, it was only discussed twice at the trust's board.

Apart from the issues of whether or not it is good practice for service users to stay longer on a PICU, or whether people suffering with organic and functional mental health problems should be cared for on the same ward, the trust and PCT should have recognised earlier that there was a fundamental problem with the configuration (or allocation and management) of their inpatient beds. Despite the fact that the problems had existed for a number of years, it was only in late 2008 that work began, in the form of a review of bed usage, that would possibly resolve the problem. Up until this time, the trust and PCT had taken a piecemeal approach, which resulted in short-term solutions, rather than a long-term improvement for people who use services and staff.

## Enabling good outcomes for people through high quality care

We found some other deficiencies in the general quality of care provided by the trust. Many of the problems have been identified in national reports such as the *National confidential enquiry into suicide and homicide by people with mental illness* (December 2006) as factors that will increase the likelihood of incidents occurring.

### Staffing and training

It is generally accepted that low staffing levels can result in poor care and unsafe practice. The trust experienced persistently low staffing levels in many staff groups and across the trust. Attempts to recruit staff were hampered by a prolonged recruitment process. This coupled with sickness seriously impacted on the delivery of care.

In addition, attendance at mandatory training was a persistent problem for the trust – a natural side effect of low staffing levels.

Senior staff referred to the size of the trust and geographical locations of the services as problematic. In order to attract staff, rather than focusing on the negative aspects of this, the trust could have promoted the size and range of services provided to service users, as an opportunity for staff to develop a range of skills.

### The physical healthcare of service users

In the Commission for Healthcare Improvement clinical governance review in 2003, the appointment of a GP for Broadmoor Hospital was highlighted as an area of good practice. Since then, the service has been much reduced and what should have been an opportunity to develop a service that could serve as a blueprint for others has been lost. A review of the physical healthcare needs of people at Broadmoor Hospital, carried out in July 2007 after the departure of the GP, was highly critical of the trust's approach.

Some work has been done to ensure that people who use services have annual physical healthcare checks and that specialist consultants visit the trust. The trust has taken a piecemeal approach with limited effectiveness, which has been commented on by service users.

In medium secure services at Ealing, little action had been taken to introduce a primary care service until very recently.

### **Medicines management**

While the trust had many of the structures and key posts in place, there was a lack of strategic direction for medicines management. The trust made a promising start by appointing a chief pharmacist in 2003, but the post had not been given the authority or recognition it required and progress has been slow. The level of pharmacy support was variable across the trust, and was particularly poor in community services. This was somewhat at odds with the move to provide the majority of mental health care in the community. Considering they were a scarce resource, pharmacists were undertaking work that, in other trusts, would have been done by pharmacy technicians. Given that the trust continually emphasised that it was a large organisation, the resources for pharmacy support were wholly inadequate.

### **Involving people who use services**

The trust was working to improve the involvement of people who use services in service development. Service users had mixed views about their care: while there were some positive comments, their concerns were similar to the ones we found during the investigation. This was, to some degree, reflected in the types of complaints the trust received. Resources for complaints and patient advisory liaison services have been reduced, which is concerning.

### **Care programme approach and risk assessment**

The care programme approach (CPA) and risk assessment continued to be a problem. CPA was fragmented and risk assessment was reactive. While many staff were aware of the importance of risk assessments, investigations into serious untoward incidents frequently highlighted it as a problem. The focus on risk assessment was limited and needs to be expanded to anticipate potential problems and identify more subtle signs of behaviour that may indicate a service user is at risk of harming themselves or others.

### **Activities and engagement with service users**

Across the trust, low staffing levels affected the number of activities that people could attend. Scheduling of activities was also problematic for service users – timings for the more popular activities clashed, forcing service users to choose between activities, and thereby reducing the number that could attend.

Protected time had been implemented in an ad hoc way, resulting in uncertainty among staff and service users about its purpose. On most visits to the trust, we observed limited engagement with service users.

### **Governance arrangements for managing risk and scrutinising the quality of care**

#### **Arrangements for clinical governance**

At local level, there were many sub-groups with responsibility for some aspect of clinical governance: inpatient, community, service specific, ward, professional and cross-divisional groups. At trust level, there were a number of committees with responsibility for clinical governance. While there was much activity, the effectiveness of it was questionable. The trust should have redirected some of its energy to consider if the arrangements were too complex and were hampering progress. There was a lack of mature reflection on whether the arrangements were achieving what they were intended to achieve.

#### **The management of clinical risk and suicide prevention**

The trust's response to clinical risk was reactive, not proactive. Response to concerns about investigating serious incidents was slow and inadequate. The non-executive directors should have been more challenging about why the investigations were delayed and why staff did not respond to their request for the reasons for the delays to be included in the quarterly incident reports.

The system for collecting information about incidents was not robust, and feedback to staff was variable. In terms of the non-reporting of incidents in certain

categories for a year, we were told this was due to a change in the classification system, but this was not clear from the information provided by the trust. Overall, the picture is one of confusion at many levels, with little challenge from senior staff.

The risks of service users committing suicide and of the trust not learning from investigations into serious incidents were given the highest rating on the risk registers for local services and Broadmoor Hospital, but it still took a number of years for the trust to take action to attempt to improve the systems for learning from incidents.

Although there was some work in local services to implement the trust's suicide prevention strategy, attempts to develop divisional groups to oversee the work and share learning were not often successful, although the Broadmoor Hospital group developed with some success towards the end of the investigation period. It was concerning that, although the suicide of service users was one of the highest risks for the trust, out of all the groups with responsibility for clinical governance, these groups generated little interest or purposeful action. Meetings in the forensic directorate were sporadic, and in local services, with the exception of one meeting held in 2005, non-existent.

### **The trust's board**

The trust's board has been stable for a number of years. The chief executive had been in post since 2004 and the previous chair retired at the end of 2008.

While the minutes of many meetings went to the trust's board, there was little discussion of problems such as staffing, bed occupancy and physical healthcare, all of which are crucial to good care. Although discussion may have taken place at other committees, we would expect the chairs of those committees to bring matters of importance to the attention of the trust's board. The response by some of the non-executive and executive directors when asked about these issues was disappointing and, to some extent, indicated they were perhaps unaware of some of the realities and problems that staff faced on a regular basis. There seemed to be a belief that the trust "was no worse than other mental health trusts". We were left with the impression that they

tolerated mediocrity rather than being determined to be leaders in the field of mental health care and there was a lack of vigour in their response to the concerns identified in this report.

In the confidential part of the meeting of the trust's board, investigations into serious incidents were discussed, but when issues such as the amount of time it took to carry out an investigation was raised, no action was taken.

While it would be wrong to say that the trust did not take any action, on many occasions rather than grasping and managing the problem, the response had been slow and fragmented. This resulted in lower standards of care for people who use services and difficult working conditions for staff.

### **Engagement of clinical staff**

Clinical engagement is an important means of improving quality in the NHS. In this area, the trust has done much to include senior medical staff and other clinical staff in the decision-making processes of the trust.

However, there was a small, but not inconsiderable, number of consultant psychiatrists who felt their views were not taken into account and that senior managers and executive directors did not welcome critical comments. This resulted in a sense of professional disempowerment. When we raised these concerns with the trust, the response was somewhat dismissive and complacent in its tone. While we are aware there will always be a few disaffected staff in any organisation, from our meetings with the consultants we did not get the sense that there was any intention to sabotage what the trust was trying to achieve or any vindictiveness towards particular managers or directors; in fact, they acknowledged some of the difficulties facing management. The trust has since provided us with more information about what action they have taken and this is included in the section on progress.

## Summary of conclusions

Like all NHS trusts, West London Mental Health NHS Trust has many competing priorities and nationally set performance targets to achieve. We do not underestimate the energy and time it takes to meet these requirements, and the staff who were responsible for delivering care were working in difficult conditions.

However, one of the fundamental things that a trust must do to ensure that services are safe and people are protected from harm is to learn the lessons from serious incidents and take action to prevent the same things happening again. The system that the trust had in place to do this was seriously flawed.

Many of the trust's buildings are old and deemed "not fit for purpose". In particular, parts of the environment at Broadmoor Hospital are neither safe nor conducive to high quality care. The redevelopment of Broadmoor Hospital is complex and has difficult planning issues related to the listed buildings on site. However, it is hard to see that the timescale proposed for the completion of the redevelopment is satisfactory for service users.

In Hammersmith and Fulham, many people slept on sofas on a number of occasions or stayed too long on the intensive care unit due to insufficient beds – practices that posed a significant risk to safety and unacceptable healthcare in the 21st century for the most vulnerable people.

The trust had significant problems with staffing levels and recruitment and, in some areas, the actions taken by staff to manage the low staffing levels put themselves and the people who used services at risk. The people using the services were aware of the staffing shortages and the impact it was having on their care and treatment.

Finally, users of mental health services have a right – like all people – to receive good care and treatment for their physical health, yet the trust's approach to this was slow and fragmented.

In summary, the particular position that this trust holds, and the nature of the services it provides, means that the public has a right to expect that the services are of a high quality. But, rather than being

determined to be a leader in the field of mental healthcare, the trust tolerated mediocre and, in some instances, low standards of care. People accessing its services were entitled to better than this.

## What action has the trust taken since the start of the investigation?

The following changes have been made at the trust since the investigation was announced in April 2008.

### Changes in organisational structure

In October 2008, the trust introduced a revised service delivery unit (SDU) structure, having been initially agreed in May 2007. The aim of the reorganisation was to improve the governance of the organisation. The five SDUs are:

- Ealing
- Hammersmith & Fulham (including the gender identity service)
- Hounslow (including the Cassel Hospital in Richmond)
- West London forensic
- High secure.

Each SDU is managed jointly by an SDU director and a clinical director, who are both accountable to an executive director of the trust.

Each SDU has responsibility for clinical governance, and monitoring and reviewing incidents.

The trust has also introduced forums to govern the quality of incident reviews and promote learning across the organisation.

### Reporting and investigating incidents

A new policy for the reporting and investigation of incidents and new monitoring arrangements was introduced in April 2008. This includes a new classification system for incidents: level 1 being the most serious. The trust has told us that, between April 2008 and March 2009, a total of eight level 1 reviews were commissioned: of these, two were completed within 60 days and two exceeded 80 days. Of the 23 level 2 reviews commissioned, 18

have been completed: of these, nine were within 60 days, six between 60 and 80 days and three over 80 working days.

In February 2009, the trust achieved level 1 in the NHS Litigation Authority standards for risk management (there are three levels, with level 3 being the highest).

### **Culture**

During 2008, the trust commissioned an independent project to identify some of the issues contributing to staff perceptions of bullying and harassment.

The trust is revising its framework for the reporting and investigating of incidents involving bullying and harassment.

### **Engagement with clinical staff**

Alongside the organisational changes described above, the trust has undertaken to recruit additional medical staff to senior management positions. All five SDU clinical directors are currently medical staff and the new structures also include clinical leads who will be part of the senior management teams. Currently, 15 of the 18 available clinical lead positions are occupied by consultant psychiatrists.

Following a review by the medical director, the medical advisory committees have been restructured. There are now five committees in line with the SDUs. Each of the chairs of the five medical advisory committees has a formal position in the senior management team of each SDU.

The medical director convened two meetings of consultant psychiatrists in Ealing and Hounslow. A follow-up meeting and informal networking over lunch has been arranged (as requested by the group). The meetings were well attended, with some 70% consultants attending one or both meetings.

Since early 2008, visits to clinical areas by the trust's board have been focused on patient safety, and feedback has been noted at the clinical and research governance committee and executive directors' meetings.

### **The role of external organisations**

The SHA, NHS London, was hampered by a lack of information about serious untoward incidents and

the performance of the trust from its predecessor organisation. Although there was evidence that the trust was reporting serious untoward incidents to the SHA, the information is incomplete until 2008. The SHA fulfilled its requirements in terms of more intensive scrutiny of Broadmoor Hospital and, through discussions with the chief executive, was kept informed about staffing levels and the environment at Broadmoor Hospital.

In terms of the remainder of the services, performance monitoring was in line with the agreed process. However, the SHA was not so well informed about serious problem such as bed occupancy, and the trust was generally assessed as good for safety and quality of care.

The SHA has strengthened the arrangements and expectations for the reporting of serious untoward incidents.

The PCTs and local authorities were informed of serious untoward incidents and, although there is evidence of some discussions with PCTs and local authorities, it was generally limited to the numbers of incidents. What was missing from the meetings was discussion about the problems the trust may have been experiencing in relation to the reporting of incidents, carrying out investigations into serious untoward incidents and making the necessary changes. While the trust may not have been very proactive in sharing information, the PCTs as commissioners of services and the local authorities as partners in providing some of the services should have been more proactive in requesting information about serious untoward incidents, and more challenging about the trust's response following serious untoward incidents.

The trust was prompt in informing the Mental Health Act Commission (MHAC) about the deaths of people who were detained under the Mental Health Act. The MHAC identified many of the problems described in this report and included them in ward summaries and annual reports that were presented to the trust. In line with the underlying theme throughout this report, the trust was slow to respond to respond. The MHAC raised the issue of delayed responses with the trust, and the trust responded positively by improving their response times.

# Recommendations

We expect the trust to consider all aspects of this report, including all our findings, which detail serious concerns across different parts of the trust's services. Here we highlight what is particularly important.

Overall, the trust's board must develop and promote a more dynamic, innovative culture that encourages staff to be enthusiastic, up-to-date with current practice and motivated to provide the best care for people and their carers. Staff should be encouraged and enabled to speak up and speak out, and treated fairly. The trust must aspire to become a leader in, and an example of excellence in, mental healthcare, and in particular forensic mental healthcare.

Non-executive directors should have stronger access to information about the experiences of people who use services, and there must be more robust and challenging responses to this, in terms of actions and decisions by the trust about the care of people and their families.

The trust's board should consider strengthening the committees and sub-groups with responsibility for clinical governance and streamlining their number.

## Providing a safe environment and protecting people from harm

1. The trust must improve its management of risk. This should include:
  - Appropriate reporting and proper investigation of incidents.
  - Analysis of the risks raised by incidents and near misses to identify patterns or persistent concerns.
  - Exploring how the learning from incidents can be shared and embedded in practice with staff who already have busy workloads.
2. The trust must ensure that the actual and potential risks that users of services pose to themselves or

others are properly assessed and reflected in the risk management or treatment plans.

3. Commissioners of the trust's services need to develop mechanisms for monitoring the reporting, investigating and learning from incidents in the services they commission, and give more priority to this as part of commissioning.
4. In collaboration with commissioners, the redevelopment plans for Broadmoor Hospital and Ealing must be progressed without further delay.
5. The trust and commissioners must ensure that there are sufficient beds for each patient group and a sufficient range of alternatives to hospital admission. However, all inpatients must have a bed and, where possible, this should be in a unit designed to meet their needs.

## Enabling good outcomes for people through high quality care

6. For people to receive safe and therapeutic care, the trust must ensure that it has sufficient numbers of staff, with the right skills, in all staffing groups.
7. The trust needs to ensure that staff attend mandatory training and that attendance is monitored and accurately reported.
8. The physical healthcare of people who use the trust's services needs to be given a higher priority across the trust, particularly in forensic services. The trust must ensure that all people have access to the same range of primary and secondary services as other people.
9. Medicines management should be given a higher priority by the trust. The role of the chief pharmacist needs to be strengthened by positioning it at the appropriate management level. Resources for pharmaceutical advice

needs to be reviewed and, where appropriate, strengthened with investment, to ensure that staff and people who use services receive appropriate advice and support in relation to medicines management, wherever they are accessing or delivering care.

14. Mental health trusts need to ensure that medicines management is given a high priority, with due consideration of the recommendations made in *Talking about medicines* (Healthcare Commission, 2007).

## National recommendations

In addition to our specific recommendations for the trusts, we think that there are a number of lessons that have a wider application to all mental health trusts and commissioners:

10. Providers of mental health care, along with the relevant NHS, statutory, professional and user-led organisations should work together to devise a robust, clear and proportionate framework for internal and external investigations and reviews. The framework should focus on good practice in nationally published guidance and issues identified in this report, such as the classification of incidents, clear accountability within the organisation for the investigation/review and the sharing of knowledge and outcomes that will lead to continuous service-wide learning, and promotion of understanding and best practice.
11. Strategic health authorities and/or consortia PCTs should work, together with providers, to develop shared mechanisms to manage reviews where a degree of external scrutiny is required. This could include providers identifying experienced and appropriately trained clinicians who would be available to act as external reviewers and share learning from investigations.
12. Commissioners of services need to develop mechanisms to monitor the arrangements for the reporting, investigating and learning from incidents in the services they commission, and give more priority to this as part of commissioning.
13. Mental health trusts need to ensure that the physical healthcare of people who use services is given a high priority, particularly in forensic services. They must ensure that all users of services have access to the same range of primary and secondary service as the rest of the population.

# Appendix A: The investigation team

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Investigation Officer: Michael Curtis

Senior Investigation Analyst: Kathryn Hyde-Bales

Investigation Analysts: Kristin Wilson, Joanna White

## Appendix B: Interviews

The investigation team formally interviewed 189 former or current trust staff (some people were interviewed more than once).

The team was in contact with 137 stakeholders (members of the public, trust staff who contacted us independently or members of external organisations

associated with the trust). They were interviewed face-to-face or by telephone, either as a result of contacting the investigation team or in response to an invitation from the investigation team.

The following shows a breakdown of those interviewed and who contacted the team:

| Table 4: Trust staff and former trust staff interviewed | Interviewees |
|---|--------------|
| Executives (including deputy and associate directors)   | 29           |
| Vice chair and non-executive directors                  | 5            |
| Clinical directors                                      | 7            |
| Pharmacy staff  | 9            |
| Non-clinical senior and middle managers                 | 18           |
| Clinical managers                                       | 14           |
| Ward managers/team leaders                              | 5            |
| Ward nurses and healthcare assistants                   | 21           |
| Senior nurses and specialist nurses                     | 22           |
| Consultants   | 11           |
| Junior and other doctors                                | 7            |
| Psychologists/psychiatrists/psychotherapists            | 11           |
| Allied health professionals and chaplain                | 9            |
| Coordinators/administrative staff                       | 9            |
| Staff side and union representatives                    | 2            |
| Domestic and portering staff                            | 4            |
| Approved social workers                                 | 3            |
| <b>TOTAL</b>  | <b>189</b>   |

**Table 5: Stakeholders interviewed**

| <b>Stakeholders</b>      | <b>Interviews</b> | <b>Interviewees</b> | <b>In writing only</b> |
|--------------------------|-------------------|---------------------|------------------------|
| Service users            | 65                | 65                  | 15                     |
| Trust staff/Former staff | 16                | 31                  | 0                      |
| Relatives/Carers         | 4                 | 4                   | 1                      |
| SHA                      | 3                 | 2                   | 0                      |
| PCT                      | 5                 | 8                   | 0                      |
| Local authorities        | 5                 | 5                   | 0                      |
| Royal College of Nursing | 1                 | 0                   | 0                      |
| MPs                      | 1                 | 0                   | 0                      |
| Unknown/anonymous        | 0                 | 0                   | 4                      |
| Advocates                | 0                 | 0                   | 2                      |
| <b>Total</b>             | <b>100</b>        | <b>115</b>          | <b>22</b>              |

## Appendix C: Sources of information

- Interviews and correspondence with patients, relatives and carers.
- Interviews and correspondence with past and present trust staff.
- Observations on the wards.
- Interviews with organisations in the health community, including local PCTs, NHS London, local authorities, MIND and the Mental Health Act Commission.
- Information and guidance from the Department of Health.
- Interviews and correspondence with Members of Parliament.
- Information on relevant incidents (including reports of serious untoward incidents).
- Information from trust meetings and board reports, including minutes of meetings of the trust board, the executive directors' meeting, the clinical and research governance committee, the trust-wide clinical and research governance executive, the risk management committee, the service user involvement forum, the audit committee, the forensic divisional clinical and research governance group, the local services clinical governance executive, Hounslow audit and performance group, Hounslow clinical effectiveness group, performance management meetings, Broadmoor Operational Meeting, Broadmoor directorate CIG meetings, and Broadmoor directorate management meetings
- Relevant trust policies, with particular reference to risk, governance, incident reporting, engagement, medicines, protection of vulnerable adults, care programme approach, seclusion, training and facilities.
- The trust's annual reports for 2004/05, 2005/06 and 2006/07.
- Clinical and research governance annual reports for 2005/06, 2006/07 and 2007/08.
- Directorate business plans, including clinical governance priorities, for 2005/06, 2006/07 and 2007/08.
- Organisational, management and reporting structures.
- Documentation relating to the trust's management of medicines including policies, structures, minutes, audits and incidents.
- Information on the trust's patient advice and liaison service, incident and complaints reporting procedures and structure.
- Information on relevant complaints, including reports by independent review panels.
- Information on equality and diversity systems in the trust.
- Incident forms (including serious untoward incidents).
- Ligation reviews conducted by the trust between 2005 and 2006.
- CPA Clinical Audit Report, May 2006.
- Trust-wide risk registers 2004-2007, and divisional risk registers.
- Information on bed occupancy within the trust.
- Policies on monitoring of physical healthcare.
- Self-assessments, audits and position statements by the trust.
- Trust and ward safety policies.
- Trust policies relating to patient safety, observation, engagement and seclusion, and care programme approach.
- IT arrangements, reports, policies and plans for the trust.

- Job descriptions and person specifications of trust staff.
- Commission for Health Improvement clinical governance review into West London Mental Health NHS Trust, 2003.
- The Healthcare Commission's annual health check and star rating system for 2004/05, 2005/06 and 2006/07.
- Findings from the Healthcare Commission's 2004-2007 national surveys of staff.
- Findings from the Healthcare Commission's community mental health surveys, 2005-2008.
- The Level 1 clinical negligence scheme for trusts (CNST) assessments of West London Mental Health NHS Trust.
- Reports and analyses of various aspects of the trust's operations.
- Documents and information relating to maintenance of facilities.
- The trust's partnership arrangements, including action plans, joint protocols and service level agreements with NHS London and provider organisations, including PCTs and acute trusts, for the provision of services.
- Copies of minutes of meetings, papers, plans and correspondence from PCTs and SHAs.
- Analysis of staffing figures relating to sickness, vacancies and training between 2005 and 2008.
- Policy framework for the Reporting and Briefing of Incidents and Issues in High Security Hospitals: Department of Health, June 2007.
- Serious Untoward Incidence (SUI) Reporting Guidance: NHS London, October 2007.
- Reporting the Findings from Investigations: National Patient Safety Agency.
- Mental Health Act 1983 Code of Practice: The Stationery Office.
- The National Patient Safety Agency Root Cause Analysis tool kit.

## Appendix D: Glossary

### **Acute**

An acute illness is one that occurs quickly, is intense or severe, and lasts a relatively short period of time.

### **Admission**

The point at which a person begins an episode of care, for example arriving at an inpatient ward.

### **Advocate**

A person who can support a person who uses services or a carer through their contact with health services. Advocates will attend meetings with patients and help service users or carers to express concerns or wishes to healthcare professionals.

### **Aftercare**

The support or care that a person can expect to receive once discharged from inpatient care. Typically a discharge plan will be developed by the multidisciplinary team with the service user, and will make clear what care and support will be provided.

### **Alternative and complementary therapies**

Therapies that are not part of current standard medical practice (for example acupuncture, reflexology and aromatherapy). Therapies are termed as complementary when used in addition to conventional treatment, and as alternative when used instead of conventional treatment.

### **Antipsychotic medication**

Medication that is normally given to treat psychiatric illnesses such as schizophrenia, severe depression or bipolar disorder.

### **Approved Social Worker (ASW)**

People with specialist training and experience in identifying disorders of mental health and are familiar with the problems experienced by users of mental health services and their families. They are employed by local authority social services departments and work in hospitals and in the community as part of the community mental health teams.

### **Assertive outreach**

Assertive outreach services aim to support people in the community who find it difficult keeping in contact with mental health services.

### **Capacity**

This term means that a patient has the ability to understand and retain information about their medical condition and their need for treatment.

### **Care coordinator**

The person responsible for making sure that a patient gets the care they need. Patients and carers should be able to contact their care coordinator (or on-call service) at any reasonable time. The care coordinator is likely to be a community mental health nurse, social worker or occupational therapist.

### **Care plan**

A written plan that describes the care and support that staff will give to a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy.

### **Care programme approach (CPA)**

A standardised way of planning a person's care. It is a multidisciplinary approach that includes the service user and, where appropriate, their carer to develop an appropriate package of care that is acceptable to health professionals, social services and the person receiving care.

### **Carer**

Someone who looks after their relative or friend on an unpaid, voluntary basis.

### **Client**

An alternative term for patient that emphasises the professional nature of the relationship between a clinician or therapist and the patient.

**Clinical audit**

A process used to measure the quality of aspects of care and services and to improve that quality.

**Clinical governance**

A framework that ensures that organisations monitor and improve the quality of services provided and that they are accountable for the care they provide.

**Community care**

Community care aims to provide health and social care services in the community, to enable people to live as independently as possible in their own homes or in other accommodation in the community.

**Community mental health team (CMHT)**

A multidisciplinary team offering specialist assessment, treatment and care to people in their own homes and the community.

**Community psychiatric nurse (CPN)**

CPNs are registered nurses who work with people in the community. They work as part of a team and, like other members of the team, may see people in a variety of settings such as at a GP surgery, in a clinic or health centre or in a client's own home.

**Crisis resolution team**

A crisis resolution team aims to respond to people in crisis. It aims to provide an assessment and treatment service, 24 hours a day, wherever people are.

**Critical incident**

A term used by the trust describing the level of inquiry needed for some incidents.

**Discharge**

The point at which a person formally leaves services. On discharge from hospital, the multidisciplinary team and the service user will develop a care plan.

**Early intervention service**

Early intervention services provide support and treatment in the community for young people with psychosis and their families.

**Healthcare assistant**

Non-qualified nursing staff who undertake assigned tasks involving direct care in support of a registered/qualified nurse.

**Home treatment team**

A team usually consisting of a psychiatrist, nurse and social worker. The team provides a mobile service offering availability 24 hours, seven days a week and an immediate response. The team provides a gate-keeping function to hospital admission and enables earlier discharge from hospital.

**Informal patient**

A person who is in hospital voluntarily, rather than detained under the Mental Health Act.

**Integrated care pathway**

A multidisciplinary and multi-agency approach to mapping patient's care from admission through to discharge and ongoing care. The aim is to pull together all the information from one file that will make it easier for the clinicians involved to give the best care for the patient.

**Locum**

A temporary health or social care professional. This person does not have a permanent contract with a trust.

**Learning disabilities**

These are impairments in a specific mental process that affects learning. The conditions can exist to varying degrees in different people.

**Mental Health Act (1983) (MHA)**

The law that allows the compulsory detention of people in hospital for assessment and/or treatment for mental disorder.

**Monitoring**

Observing activity in relation to defined specifications, standards or targets, directly or through reports or indicators – did what was intended happen? For example, monitoring the effects of antidepressants to treat depression.

**Non-executive director**

A member of the trust board, who acts as a two-way representative. They bring the experiences, views and wishes of the community and patients to the trust's board. They also represent the interests of the NHS organisation to the community.

### **Occupational therapy**

Uses goal-directed activities, appropriate to a person's age and social role, to restore, develop or maintain the ability for independent living.

### **Patient advice and liaison service (PALS)**

All NHS trusts are required to have a patient advice and liaison service. The service offers patients information, advice, quick solution of problems or access to the complaints procedure.

### **People who use services**

This is the preferred term of the Care Quality Commission and simply means anyone who uses health services in the broadest sense. Other common terms are patient, service user and client. Different people prefer different terms.

### **Psychiatric intensive care unit (PICU)**

A unit or ward for the psychiatric intensive care of patients who are compulsorily detained, usually in secure conditions, and who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self control, with a corresponding increase in risk, which does not enable their safe, therapeutic management and treatment in a general, open acute ward.

### **Psychiatrist**

A doctor who specialises in the diagnosis and treatment of people who have a mental health problem. Psychiatrists have undergone specialist training and may diagnose illness, prescribe medication and other forms of appropriate treatment. They also decide whether to admit people to and discharge them from hospital.

### **Psychologist**

Psychologists have skills in the assessment and treatment of mental ill-health and psychological problems. Unlike psychiatrists, they are not medical doctors, their skills include assessing cognitive functions (for example speech and thought) and providing talking interventions including psychotherapy and counselling.

### **Psychotherapist**

Psychotherapists help people to be more in control of their own lives by exploring emotional difficulties and helping them to understand themselves and their relationships with others. They provide consultation and intervention on a one-to-one basis and in groups.

### **Risk assessment**

A clinical risk assessment identifies aspects of a service that could lead to harm to a person who uses services or a member of staff. An organisational risk assessment looks at the general impact of actions on the overall organisation or service.

### **Risk management**

Monitoring and changing aspects of a service or organisation in the light of risk assessments.

### **Section 136**

This section of the Mental Health Act (1983) enables a police officer to remove a person from a public place and take them to a designated place of safety, which may be a police station, a hospital, or other suitable place.

### **Serious untoward incident (SUI)**

This is a term used by many health organisations to describe a serious incident or event which led, or may have led, to the harm of patients or staff. Members of staff who were not involved in the incident investigate these and the lessons learned from each incident are used to improve care in the future.

### **User involvement**

Refers to the variety of ways in which people who use services can be involved in the development, maintenance and improvement of services. This includes patient satisfaction questionnaires, focus groups, representation on committees, involvement in training and user-led presentations and projects.

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