West London Mental Health NHS Trust

Report of the findings from the follow-up visit by the Care Quality Commission in March 2010

July 2010

About the Care Quality Commission

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

Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we make sure that people get better care 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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Report of the follow-up inspection visit to the West London Mental Health NHS Trust in March 2010

Background

West London Mental Health NHS Trust was created in 2001 by the merger of Ealing, Hammersmith and Fulham Mental Health Trust, and Broadmoor Hospital Authority. The trust was further enlarged in 2002 when Hounslow Mental Health Services was merged into the organisation. The trust provides mental health services to children, adults and older persons in the boroughs of Ealing, Hounslow and Hammersmith & Fulham. In addition, the trust provides specialist and forensic mental health services, including high secure services at Broadmoor Hospital.

The investigation into West London Mental Health NHS Trust was triggered by concerns about the trust's response to suicides within the trust, delays in investigating the incidents and not learning from common themes identified and documented in action plans.

The Investigation into West London Mental Health Trust report was published by the Care Quality Commission (CQC) in July 2009 and made nine local recommendations. In response, the trust has developed, and made public, their action plan to address the recommendations. The action plan was agreed and has been monitored by NHS London through monthly meetings with the Chief Executive to review progress, and exception reports are submitted for actions that are of concern or not meeting the expected target. The action plan has been presented monthly to the Executive Directors and the Trust Board.

Methodology

The focus of the follow-up inspection was to assess the progress made by the trust in implementing the local recommendations and to assess if the stated changes have had a positive effect on the experiences of service users in the service delivery units.

The inspection was conducted over five days (15-19 March 2010) by a team comprising the CQC lead assessor, two Mental Health Act commissioners and two external advisors who had participated in the original investigation. The inspection process included reviews of documentation, data and interviews with executive and non-executive members of the trust's board, service delivery unit clinical directors and directors. Interviews were conducted with ward managers, clinical staff and service users during visits to inpatient wards at the Ealing, Hounslow, Hammersmith & Fulham and Broadmoor Service Delivery Units.

Management at the trust

There have been significant changes in the executive and non-executive membership of the trust's board since the publication of our investigation report in July 2009. The posts appointed to were Chief Executive, Director of Nursing and Patient Experience, Director of Organisation Development and Workforce, and a Director of High Secure Services.

The trust has six non-executive directors (NEDs) on the board, five new NEDs have been appointed and came into post between July and November 2009. The NEDs interviewed as part of the follow-up inspection demonstrated a wide range of experiences, values, insights and positive motivations to make a difference to the experiences of service users, carers and staff. The board appointments were completed in February 2010.

Findings

The findings presented below follow the order of the original recommendations published in the Care Quality Commission's investigation report. Recommendation 3 was not reviewed in-depth as it relates to the setting-up of monitoring systems by commissioners of services provided by the trust and it is planned that CQC will carry out a review of the commissioning of services in relation to this recommendation at a later date.

Providing a safe environment and protecting people from harm.

Recommendation 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.**

The trust has reviewed the management of risk in the organisation. The Incident and Risk Management Policy (I8 policy) has been updated following a detailed review and clearly outlines the reporting, classification and investigation of incidents. The I8 policy includes the establishment of an incident review facilitator to assist the Chair and to coordinate the investigation process to ensure that key actions and timescales are met. The latest version of the policy includes a 'Chair's checklist' which is acknowledged as an example of good practice. The trust has introduced new templates for the final report and action plan to aid consistency in the way information is presented. A reporting process flow chart is included in the policy which details the actions, contacts and timescales for each stage of the management of an incident, including how learning will be disseminated and

feedback given to staff, relatives and patients. The policy is very detailed and concerns were raised by staff at all levels about the 'usability' of the document. Ward-based staff interviewed during visits to the clinical areas demonstrated an awareness of the policy and changes within it. Whilst this is encouraging, further targeted work will be necessary during Phase 2 of the project, in presenting the main points for easy reference in a more reader friendly way.

The trust has implemented an online reporting process for incidents and appointed an SUI (serious untoward incident) Manager to manage the process and act as a key contact point with external partners. The system enables tracking and interrogation for audit purposes. The Director of Nursing & Patient Experience (DoNPE) reports that monthly meetings are held with the Risk Management Department to assess progress on outstanding reviews.

Service Delivery Units (SDU) have established incident management review groups (IMRG), which report to a trust-wide IMRG, which forms part of the trust's integrated governance structure. The groups are responsible for reviewing all incidents and the action plans arising from investigated incidents and are now required to identify three learning points and three positive practices which are cascaded to the SDU wards and departments and feed into the trust IMRG.

The trust provided evidence of presentations to share learning arising from SDU incident reviews across the trust at staff events/conferences/clinical and staff team meetings.

Staff were aware of recent incidents and lessons learnt particularly in their SDU, there was limited evidence of formal shared learning trustwide. They reported a more visible and accessible management team with visits from the Chief Executive, executive directors and line managers being 'more frequent than before'. The trust acknowledged that trust wide shared learning has not been fully embedded and is identified as continuing in phase 2 of the implementation process.

The trust has also published leaflets for staff entitled *Managing risk: Your part in our change*. The leaflet details the specific actions for each grade of staff for risk management, incident reporting, admission procedures, clinical practice and training. These are based on the recommendations arising from the PBRL (Independent inquiry into the care and treatment of Peter Bryan and Richard Loudwell, report for NHS London) and the Care Quality Commission's investigation reports.

The trust was asked to provide the last six incident reports for review by the inspection team. The reports related to incidents investigated prior to the introduction and implementation of the latest processes and documentation. In the majority of cases the investigations were thorough and detailed, it was noted that in the majority of cases relatives had been involved in the process but not in all. Concerns were documented and recommendations for learning

noted. In all reports it was unclear how recommendations are followed up and those responsible for the services address professional performance issues. The processes to follow up recommendations and take action are now outlined in the updated I8 policy with the SDU review groups, feeding into the trust IMRG group and the DoNPE reports SUI outcomes to the monthly board meeting.

The DoNPE described the trust carer's strategy which he reported as needing further work. This was to include the addition of local recommendations from carers in Ealing (What professionals can do for carers) which describe changes professionals can make to include carers in the care process and help to improve staff attitudes. The recommendations needed to be incorporated in policy and then implemented. This does not seem to have filtered down the organisation as no other managers or staff in the trust raised it with the inspection team. The DoNPE acknowledged that this was an area for further work and action.

The involvement of carer's and the implementation of the strategy should be given a higher profile in the trust.

The trust provided evidence that it was making good progress against this recommendation and was continuing to give reporting and management of risks and incidents in the trust a high profile. The trust has further events and training planned to implement the I8 policy and embed learning in practice.

Recommendation 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.

In interviews, the trust's executives confirmed that care programme approach (CPA) and individual risk assessments should be undertaken within seven days of admission and reviewed at six-monthly intervals.

The trust has implemented monthly monitoring of care plans through the IT system (RiO), although it was reported that there were problems with the version of RiO used in the trust. These were reported as being addressed. Training in using RiO is provided to staff. The medical director reported that a case notes review was planned.

During the inspection 43 service users were interviewed using a standard set of questions.

When asked if they had a care plan, only 19 confirmed they had, and two patients reported that they had been given their care plans the evening before the CQC inspection.

They were also asked if they had a primary/named nurse; 29 confirmed they had. The majority of the positive responses were from patients interviewed at Broadmoor, Hounslow and Ealing sites.

The DoNPE confirmed that the clinical risk policy had been updated and team-based training sessions were planned to take place in April 2010, with the intention of SDUs rolling out the training to the clinical staff. The policy includes guidance for staff to raise and discuss concerns with others and the process to follow to escalate those concerns if needed. The trust has commenced team clinical risk training to improve risk management and lessons learnt from incident reviews are used in the sessions.

Ligature audits are undertaken locally in the wards. The process was seen and confirmed by the inspection team on ward visits. The trust has an action plan and a capital works programme to address issues and minimise risks. Concerns have been raised by Mental Health Act commissioners following visits at the lack of progress to address known ligature problems. It should be noted that such an issue was only addressed after being brought to the attention of the CEO during a recent visit to a ward on the Ealing site despite assurances being provided that the work would be undertaken over a year ago. SDU managers maintain the risk registers for their areas which are then aligned to the trust risk register which is monitored at trust board meetings. It is a concern that delays in addressing known ligature risks may not be adequately highlighted in the risk register.

The trust provided some evidence of progress in meeting this recommendation. It is addressing estates issues to minimise the risks associated with ligature points, however, local managers must be held accountable for ensuring the identified works are carried out within a reasonable timeframe and identify when delays occur.

Whilst recognising the small sample of service users interviewed, it is concerning that over 50% were not aware that they had a plan of care or knew what arrangements were in place for their ongoing treatment. CQC would expect to have seen greater progress in this area.

Recommendation 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.

The trust reports incidents and the outcome of investigations to commissioners and NHS London.

Service Delivery Unit clinical directors and directors report regular meetings with commissioners. They reported their involvement in contract monitoring meetings and in negotiations for the next years' activity.

The Care Quality Commission will review the commissioning of services later in 2010.

Recommendation 4:

In collaboration with commissioners, the redevelopment plans for Broadmoor Hospital and Ealing must be progressed without further delay.

The trust has updated the outline business case proposal (OBC) for Broadmoor Hospital following a review of capacity needs in the service and this has had second level agreement by NHS London. The Chair and CEO have presented the OBC to the Department of Health for consideration and approval.

The trust's managers have reconfigured the wards at Broadmoor Hospital and have closed off most wards with 'T ends'. The Director of High Secure Services confirmed that further 'old style' wards will close in April 2010 and where wards remain operational plans are in place to manage risk. Staff report that this has reduced the numbers of beds available on the wards but has improved the observation and monitoring of service users.

The trust has an ongoing action plan and a capital works programme to address ligature issues and minimise risks to service users.

Following a health care associated infection (HCAI) inspection, the trust established an action plan and systematic plan of works to address breaches in standards of cleanliness and fabric of the buildings at all SDUs. The Finance Director has responsibility for estates and facilities. She confirmed that a new vermin control contract had been awarded, patients are no longer allowed to keep food in their rooms and the cleaning contract had been reviewed with housekeepers and cleaners being ward based. The reported sightings/incidents of pest/vermin problems were confirmed as reduced.

Works to replace flooring and carry out essential maintenance have been undertaken in phases on the wards and patients have had to move wards or 'sleep out' (ie patients sleep in a different ward to the one on which they receive treatment and care) during this time as the trust could not shut down whole wards to carry out the works. A re-inspection by CQC's HCAI inspectors in February 2010 found no breaches of the Hygiene Code and noted the improvements made.

Service users overall felt that the ward environments were cleaner and that facilities had improved over time. They did report feeling disturbed during the works with several being asked to move rooms or sleep out. One service user on the Ealing site, reported that he had no where to go during the day time to get some peace and quiet as the community room was constantly in use and he couldn't go to his room. Arrangements for service users sleeping out should include a place of safety for them to rest or be solitary if wanted.

Staff reported that they have been empowered to report and take responsibility to manage estates and facilities issues on the ward and said there was an improved response to maintenance requests. It was noted during ward visits that staff in refurbished wards appeared proud of the ward environments. The trust has also been rolling out the Star Wards and Productive Ward initiatives which have also impacted positively on the ward environment. The initiatives are designed to improve the experiences and treatment outcomes for patients in acute mental health settings.

The trust is making good progress in meeting this recommendation, however until decisions are made by the Department of Health (DH), redevelopment of the Broadmoor and Ealing sites cannot be progressed. A re inspection by the CQC HCAI inspectors found no breaches of the Hygiene Code and noted the improvements made.

Recommendation 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.

The CEO confirmed that service users admitted to the trust in any SDU are admitted to an allocated bed.

Clinical Directors and SDU Directors report that bed pressures were experienced across the trust at times but all admitted patients had an allocated bed.

The investigation report highlighted delayed discharges and bed pressures particularly at the Hammersmith and Fulham SDU. In interview, the Clinical Director and Director of Hammersmith & Fulham SDU reported on improved liaison with the local authority housing department to reduce the numbers of delayed discharges, improved gate keeping and involvement of the crisis resolution team to prevent admission to acute mental health services. Bed occupancy figures presented at the time of the inspection showed that in the Hammersmith & Fulham SDU occupancy was 98%.

The managers outlined plans to reconfigure the wards at the Hammersmith & Fulham SDU in April 2010 to create an admission ward with an additional four beds, and recovery wards. The admission ward will have a dedicated lead consultant psychiatrist, social worker and ward team to ensure issues are identified on admission and onward referral commenced.

The unit will also have one room kept available for service users returning from leave in the event of their bed being reallocated during their absence.

Service users report that they have been moved several times during their admission (Hammersmith and Fulham SDU) or have had to sleep out (Ealing SDU) due to refurbishment works.

The trust has provided evidence that it has met this recommendation.

Enabling good outcomes for people through high quality care

Recommendation 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.

The trust monitors vacancy rates by SDU in the trust performance report, which is presented at the monthly trust board meeting. At the time of the inspection, the trust-wide vacancy rate was 14%.

Human resource support and recruitment processes have been reviewed to streamline the process and reduce the time taken to recruit new staff. The SDUs have an HR consultant allocated to them to focus on recruitment. SDU managers report that vacancies are being filled more quickly and rates are reducing. The key workforce performance indicator report for February 2010 shows a downward trend in the average time taken to fill vacancies. The trust target is 16 weeks and this was achieved in the February data. The report is reviewed by the trust board.

There continue to be issues in recruiting to Community Mental Health Teams who have higher than trust average vacancy rates. A project was being proposed to profile staff who work in hard to recruit areas to ascertain the essential qualities required to work there and try to recruit accordingly.

Sickness absence is monitored and reported in the workforce performance report monthly to the trust board, the report shows the rates are lower than in previous years and were slightly above the trust target of 5% in January 2010.

The trust voiced concerns about the competency of student nurses graduating from the local university which impacted on the ability to recruit to junior posts. The Trust is now working with local universities to ensure that graduating student nurses have the right competencies in terms of the skills, knowledge and values to work as registered nurses. Joint appointments were being established with universities to influence the training and ensure a university presence in the trust campus.

The DoNPE reported that the Nursing and Midwifery Council (NMC) had recently reviewed the learning environment in the trust and rated it as good.

The acting Head of Allied Professionals (HAP) confirmed that it remained difficult to recruit to Band 6 occupational therapy posts but this was a London-

wide problem and not specific to the trust. The acting HAP was looking to provide a development programme for Band 6 occupational therapists. She reported that recruitment had improved, with recruitment taking on average 12 weeks. A consultant grade occupational therapist was commencing employment in April 2010 with responsibility for patient employment and a Band 7 occupational therapist to support a new adolescent service had been recruited. The acting HAP reported that she was considering a variety of ways to attract and retain staff to work in the trust, examples included rotational posts, secondments, return to work posts and 'keep your hand in' posts for occupational therapists taking career breaks.

The acting HAP reported some examples of innovation including the implementation of an integrated care plan in seven pilot areas in the trust. This is a new project and has yet to be reported on.

The trust is making progress against this recommendation.

Recommendation 7:

The trust needs to ensure that staff attend mandatory training and that attendance is monitored and accurately reported.

The trust has made significant improvements to ensure that staff attend mandatory training. Staff attendance is monitored locally by the ward, at SDU level and reported monthly to the trust board.

It was evident in interviews with staff at all levels in the organisation that staff attendance at training was a key priority with additional monies being made available to 'backfill' to enable staff to be released for training and sessions being held at weekends.

Recording of attendance at training has improved with staff keeping a personal training passport. Ward managers reported they keep a record of staff attendance and online training profiles have been established on the trust intranet, which are updated centrally.

Staff showed the inspection team a training passport and the person's online profile; there was a discrepancy noted between training documented in the passport and that documented on the profile. There is an obvious time lag in the updating of the profiles and the trust may wish to review this if reporting is to be accurate.

The trust has commenced training programmes for staff in root cause analysis, incident management and clinical risk management as part of the management of risk work stream.

The Chief Executive stated that changing the culture of the organisation would be a slow process that required sustained effort, over a number of years. The Director of Organisation Development and Workforce confirmed changing and

sustaining cultural change was a top priority. The inspection team recognise the trust board and senior management teams' sense of direction and the purpose and energy underpinning developments. However, views expressed to the inspection team by staff indicate that there remain anxieties that the staff and work carried out under the previous management was of value, and that this should continue to be recognised by the current senior management team. The inspection team were also conscious of the risk of staff being overwhelmed by the number and pace of initiatives in the management teams' obvious need to demonstrate improvement.

The trust has commenced the VALUES project which has been established to identify and promote the trust values linked to responsibilities and accountability. Staff and service users are contributing to the project through workshops and group meetings and this was confirmed in staff interviews and by service user representatives. This is a positive progression and will enable staff to achieve a stated ambition to 'look forward to the future, not back at the past'.

The Chief Executive has established and chairs a clinical engagement and leadership forum for senior clinical staff as a forum to raise issues and become involved in the design and implementation of service changes. The inaugural meeting was held in January 2010. The trust also has an established Medical Advisory Committee and clinical directors reported that there was an impetus in the trust to move things on, thereby reducing the level of clinical disenfranchisement expressed previously.

The staff survey results for 2009/10 again identifies bullying and harassment as an issue. The trust has an anti bullying policy and posters observed in the clinical areas detail how and who to report issues to. Staff did not complain of bullying behaviours to the inspection team and most commented favourably about being supported by their line manager. Staff reported a more visible management presence around the trust.

The Chief Executive writes a blog on the trust intranet to update staff on developments and send key messages, however as not all staff access the intranet other forms of communication should be developed. The trust also publishes a bimonthly newsletter which includes commentary by the Chief Executive. Staff forums are held every two months with the CEO and executive directors attend. Service delivery unit managers also cascade key messages through their unit meetings.

Service users were asked their views about staffing on their wards, protected time, interaction with staff and the standard of care experienced.

Hounslow: the majority of service users reported that there were sufficient numbers of staff on the ward; a small majority stated that they spoke regularly to a nurse and the majority were happy with the care provided.
There was a mixed response to the question about protected time, for staff/service user interaction, it was evident that some wards were doing it, others were not.

Ealing: the majority of service users reported that there were sufficient numbers of staff on the ward, although escorted leave especially for smoking was an issue and a majority stated that they did not speak regularly to a nurse. Whilst the majority of service users were happy with the care provided, comments were less positive than for the previous SDU. No service users were aware of protected time.

Hammersmith & Fulham: the majority of service users reported that there were sufficient numbers of staff on the ward, although escorted leave was an issue and a majority stated that they did not speak regularly to a nurse. The comments about the care provided were mixed, comments were much less positive than for the other SDUs. The majority of service users were not aware of protected time, those that were stated that it rarely happened.

Broadmoor: the comments were the most positive with most service users reporting there were usually sufficient numbers of staff on the ward; that they spoke regularly to staff and were positive about the care provided.
The majority of service users were aware of protected time.

Service users in the Ealing, Hammersmith & Fulham and Hounslow units raised staff attitude as a recurring issue to be addressed and improved, when asked about the care provided on their ward.

The trust has commenced a Patient Experience Tracker (PET) pilot to gain immediate feedback about a service user's experience in the trust. It is envisaged that this will enable issues to be dealt with in real time. Each SDU has a service user forum and it was reported that wards held community meetings as forums in which users can discuss concerns.

It is of concern to the inspection team that service users in some areas reported that they do not speak regularly to a member of staff and that staff attitude was poor.

The trust is making progress against the recommendation and recognises that there are still challenges to be addressed. The trust will be monitored via ongoing compliance with the Essential standards of quality and safety.

Recommendation 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.

The trust has invested in providing primary care services to ensure that service users have access to GP services. The trust board made an interim appointment of a Director of Primary Care (DPC) in December 2009 to oversee and lead the development of primary care services at Broadmoor

Hospital primarily. At the time of the inspection an in house tender to provide healthcare services was about to be presented to the trust board for approval.

The DoNPE reported that the trust had developed a physical healthcare strategy which had yet to be finalised and was linked to the 'New Horizons' initiative focusing on prevention and health promotion. He reported that the plans included establishing gyms, appointing physical activity coordinators and physical health assessments to be undertaken within 72 hours of admission. This was to be supported by physiotherapy, dietetic and speech therapy staff.

A healthcare suite has been established and opened on the Ealing site and the GP service is currently provided by an external GP provider. The healthcare suite at Broadmoor includes an inpatient ward and there are plans to upgrade the facilities. GPs are on site four days a week, service users are seen within 48 hours of referral, visiting consultants provide specialist support for diabetes, dermatology and general surgery. It was confirmed that the GPs can request support from any medical speciality. The primary care service provision includes dentistry, podiatry, radiography and dietetics.

There was evidence provided that healthcare assessments had been undertaken for service users in Broadmoor. The DPC attends CPA review meetings for service users with physical healthcare problems. Screening programmes have been established and the Quality Outcome Framework (QOF) is used to monitor performance. Weekly physical healthcare team meetings are held to discuss patients with problems, update on projects and developments in the service. The trust has purchased the latest version of EMIS and it was due to be installed in the healthcare suite within days of the inspection.

The DPC and Physical Healthcare Service Manager reported that ward-based staff had been trained as healthcare champions to act as a resource for staff and service users to help establish healthy lifestyle initiatives. One ward visited had purchased a running machine to encourage service users to increase their levels of exercise.

The healthcare service has piloted the use of a modified early warning score (MEWS) system which helps ward based staff to determine when to seek advice if service users physical health state is giving concern. Monthly recordings of BP, pulse, respiratory rate, temperature and conscious state are made and scored, any deviation in the score results in either the senior nurse being contacted or the duty doctor being called.

Service users reported that they were happy with the access to GPs and the services provided. The healthcare staff have recently developed a patient satisfaction survey, user forums had provided feedback on the implementation of the survey and individuals will be asked to complete forms when attending appointments in the Healthcare Suite.

Service users in the local units reported that their physical healthcare needs were addressed promptly. Service users in Ealing forensic services reported that they could see a GP on the same day as requested.

The trust has provided evidence that it has made significant progress against this recommendation. The trust should provide evidence that the in house tender to provide healthcare services at Broadmoor Hospital has been agreed.

Recommendation 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.

The trust has provided evidence that medicines management has a higher profile in the trust.

The Chief Pharmacist (CP) confirmed that a medicines management strategy had been developed, agreed and implemented. She reported that the strategy was incorporated into the business plans of each SDU and this was confirmed by SDU managers.

She confirmed that a lead pharmacist was in post for each of the five SDUs and from February 2010, she had taken on the line management responsibility for all pharmacists in the trust.

Pharmacy arrangements have been strengthened to provide support to ward and community-based staff, pharmacists attend ward rounds and provide prescription medications within two hours of request. A pharmacist is allocated to each community health team and the aspiration is for these individuals to attend community review meetings to advise on medication issues.

The CP reported that to improve the information available, the pharmacy service had produced the ‘Handy Charts’. This is a bound directory of 14 mental health conditions with comparison charts of the medication available, usual dosage and side effects. This is provided to wards and junior medical staff to assist them in making suitable medication decisions for mental health conditions. A DVD entitled ‘Living with Clozapine’ has been developed as a teaching and information aid for service users, carers and staff. Staff reported that the pharmacist at Hammersmith & Fulham SDU holds a regular ‘medicines matters’ group for service users.

Staff reported that they had good access to pharmacy advice, with pharmacists making daily ward visits and being available to talk to users either ad hoc or through attending ward rounds.

The role of the chief pharmacist was still under review by the trust and is an outstanding item on the trust action plan with an expected completion date of 30 March 2010. The Chief Executive was due to meet with the CP the week after the inspection visit to discuss the role and clarify responsibilities.

The trust has made good progress against this recommendation. The trust however must provide evidence that the role of the chief pharmacist has been agreed to fully meet the recommendation.

Conclusion

The Trust has demonstrated that it is making progress in meeting the recommendations of the investigation report.

There have been significant improvements in the assessment of service users' physical healthcare and in the provision of primary healthcare services and staff attendance at mandatory training. Improvements are noted in the following areas:

- management of medicines and pharmacy support to all clinical areas
- the availability of beds
- cleanliness of wards
- risk management in the reporting and investigating untoward incidents.

However, there are areas in which the trust must demonstrate further improvement, for example in:

- care planning
- service user experiences of care
- meaningful staff interaction with service users
- demonstrating lessons learnt are shared across the trust.

Further regulatory follow-up activity at West London Mental Health NHS Trust will be undertaken in accordance with CQC's monitoring of compliance processes following the trust's registration with compliance conditions.

WLMHT investigation recommendation	Essential standards of quality and safety outcome	Regulation	Ongoing monitoring
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.	Outcome 16 – Assessing and monitoring the quality of service provision	Regulation 10 - Assessing and monitoring the quality of service provision. • 10 (1(b)), • 10(2(b(ii)(vi)) • 10(2(c(ii))	The trust was registered in April 2010 with a compliance condition to be met by 30 September 2010.
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.	Outcome 16 – Assessing and monitoring the quality of service provision	Regulation 10 - Assessing and monitoring the quality of service provision. • 10(1(b))	The trust was registered in April 2010 with a compliance condition to be met by 30 September 2010.
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.	N/A		The Care Quality Commission will review the commissioning of services later in 2010.
4: In collaboration with commissioners, the redevelopment plans for Broadmoor Hospital and Ealing must be progressed	Outcome 10 – Safety & suitability of premises	Regulation 15 – safety and suitability of premises. • 15 (1)	Ongoing monitoring as per CQC processes

without further delay.		• 15(2(a)(b)(c(i)))	
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.	Outcome 10 – Safety & suitability of premises	Regulation 15 – safety and suitability of premises. • 15 (1) • 15(2(a)(c(i))	Ongoing monitoring as per CQC processes
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.	Outcome 13 – Staffing	Regulation 22	The trust was registered in April 2010 with a compliance condition to be met by 30 September 2010 for 1 location (St Bernards & Ealing Community services). Ongoing monitoring as per CQC processes for all other locations.
7: The trust needs to ensure that staff attend mandatory training and that attendance is monitored and accurately reported.	Outcome 14 – Supporting staff	Regulation 23 – Supporting workers. • 23(1(a)) • 23(2) • 23(3(a)(b))	Ongoing monitoring as per CQC processes
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.	Outcome 4 – Care and welfare of people who use the service	Regulation 9 – Care & welfare of service users. • 9(1(a) • 9(1(b(i)(ii)(iii))	Ongoing monitoring as per CQC processes

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.	Outcome 9 – Management of medicines Outcome 13 – Staffing	Regulation 13 – Management of medicines. • 13 (1)(2) Regulation 22 - Staffing	Ongoing monitoring as per CQC processes