Mental Health Act Annual Statement December 2010

Broadmoor Hospital
West London Mental Health NHS Trust

Executive Summary

This statement reflects the findings of visiting Mental Health Act (MHA) Commissioners in the period between 1 October 2009 and 30 September 2010. Where appropriate this statement includes consideration of the responses given by the provider to those visits. During the reporting period the Care Quality Commission (CQC) Mental Health Act Commissioners have visited Broadmoor Hospital on 28 occasions, visiting 21 wards, interviewing 101 patients in private and scrutinising 98 sets of records.

In general the MHA Commissioners found that the hospital continues to manage the balance between the need to provide conditions of high security and at the same time to ensure that the very best therapeutic care is offered to patients, often in difficult conditions where the fabric of the hospital is not 'fit for purpose' because of its age.

With a few exceptions, the dedication and professionalism of staff is of a high standard. There has been evidence during the reporting period of many staff (at all levels) 'going the extra mile' in what they offer to patients and bring to their jobs.

Main findings

Broadmoor Hospital is one of three high secure hospitals in England and provides care for approximately 230 male patients, the vast majority of whom are subject to a hospital order imposed by the courts.

The following points highlight those Mental Health Act and other issues raised by Commissioners on visits and is drawn from the data presented in annex A. The detailed evidence to support them has already been shared with the provider through the feedback summaries and is not repeated here. For further discussion about the findings of this Annual Statement please contact the author via the Care Quality Commission's Mental Health Operations Office located at The Belgrave Centre, Nottingham.

The average time taken to respond to feedback summaries following ward visits to Broadmoor Hospital is 33.8 working days (i.e. over six weeks). This compares with average time for the trust as a whole of 61.7 working days (i.e. over twelve weeks). The 'default' response period set by the Commission is one month (this will vary, of course, depending on the urgency of the issue(s) raised).The Commission urges the trust to improve the timeliness of responding to the Commission's feedback summaries following visits.

A significant proportion of the issues raised in feedback summaries concern the need for systemic change. It is worthy of note that between 1 November 2009 and 28 September 2010, in 3% of such issues the necessary systemic change was made within the period specified by the Commission whilst in 36% of these issues the necessary systemic change was promised. This would appear to indicate that the trust will often promise what either is not, or cannot be, delivered. The Commission urges a more robust determination to implement systemic changes that are necessary and have been identified by the objective assessment of Mental Health Act Commissioners.

Relationships with the provider in the reporting period

Relations between Mental Health Act Commissioners and senior managers of the hospital have remained constructive throughout the reporting period. The previous Annual Statement was received positively by the Board and an action plan published. This has been monitored by visiting Mental Health Act Commissioners on their visits during the reporting period and considerable progress noted in a number of areas.

In addition to taking part in undertaking the programme of visits to wards and departments as set out in the annex A to this statement, the named Commissioner has also undertaken the following:

- Attended meetings of the Seclusion Monitoring Advisory Group.
- Attended a meeting of the Patients' Forum.
- Attended a meeting of the Suicide Prevention Group.
- Attended meetings of the National Forensic Audit Group.
- Attended meetings of the Incident Monitoring and Review Group.
- Held a discussion with the Chief Executive of the trust.
- Held a discussion with the Director of High Secure Services.
- Held discussions with the Clinical Director (Broadmoor SDU).
- Held discussions with the hospital's Performance Improvement Manager.
- Held discussions with Service Directors for the London, South of England and Dangerous Severe Personality Disorder (DSPD) services.
- Held discussions with Independent Mental Health Advocates concerning specific patient issues.
- Attended a number of ward community meetings.
- Attended an inquest into the death of a Broadmoor Hospital patient.
- Arranged a visit to the hospital by the Head of Mental Health, Care Quality Commission.
- Arranged a visit to the hospital by Members of the Independent Advisory Panel to the Ministerial Council on Deaths in Custody.

Mental Health Act and Code of Practice Issues

Detention

The Care Quality Commission continues to be impressed with the diligence of the Mental Health Act Managers and the staff of the Mental Health Act office in ensuring

that all detentions are lawful. On the rare occasions where this has been in doubt prompt attention has been given to the issue and the necessary action taken and reassurance provided. For example the Commission became aware during the reporting period that the Approved Clinician status of three Responsible Clinicians (RCs) had lapsed resulting in an unlawful detention of a patient. This situation, once recognised, was quickly and effectively remedied, however it does point up the need for both clinicians and Mental Health Act Managers to ensure very careful vigilance in these matters. The Commission will be paying particular attention to this and related legal issues in the future.

Leave and Transfer

The Commission has been concerned during the reporting period to hear of an incidence where community/rehabilitation leave was cancelled at very short notice as a result of 'security issues'. The Commission is of the view that such visits are an essential part of rehabilitation and the pathway towards discharge to conditions of lesser security, for these visits to be cancelled at short notice and with inadequate explanation must surely be counter therapeutic and grossly demoralising.

Equally, the Commission is concerned at the sometimes very slow progress in making the necessary arrangements for the discharge of patients when there has been a successful assessment made by the receiving hospital and a clear recommendation made by the Mental Health Review Tribunal. This leads not only to frustration in the patient concerned, but also disillusionment amongst the wider patient community. The Commission recognises that it is not always within the direct power of the trust to expedite such transfers and matters of funding etc have to be properly dealt with, however it is hoped that all that can be done to ensure that such processes are as timely, smooth and straightforward as possible.

Patient Safety

The Commission has been concerned to identify a number of ligature points whilst undertaking ward visits, this despite the considerable emphasis that the trust has put on instituting suicide prevention measures. It has been reassuring to the Commission however that when the existence of these ligature points has been drawn to the trust's attention prompt action has been taken to remedy these situations.

The Commission is also very concerned at the continued use of 'T' end wards in the Victorian parts of the hospital premises despite the suicide of a patient (not within the reporting period) on such a ward. It is the Commission's continuing wish that these wards are modified to remove the 'T' ends and thus to remove this risk, it is hoped that this can be accommodated in the forthcoming reconfiguration of the inpatient accommodation. A further death on a ward of this nature would be indefensible; the Commission will expect to be advised of the plans to make these changes.

There continue to be allegations of bullying made by patients and there have also been serious breaches of discipline amongst certain members of staff in relation to sexual assault on patients. The Commission commends the trust for the quick and decisive action taken to deal with such matters which inevitably have a detrimental effect on patient, staff and public morale.

Consent to Treatment

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcomes 2C and 9E

Compliance with this aspect of legislation has been found to be less than adequate on a number of occasions during the reporting period. There are still many occasions when the comments of statutory consultees do not appear in the patients' notes and where entries by Responsible Clinicians are equally absent or inadequate. There is also evidence that patients' capacity is not always properly assessed in accordance with the requirements of the Code of Practice, this can result in medication being administered illegally.

The provision of treatment under Section 62 has on occasion given cause for concern during the reporting period. Whilst this treatment is monitored by the hospital's Clinical Director, the Commission expects that this provision is used with caution and as sparingly as possible. There has also been evidence of medication being administered that had not been included on Form T3 following a Second Opinion Appointed Doctor (SOAD), this clearly is illegal and puts the trust and its staff at risk of legal action.

The Commission hopes that it will be possible to facilitate some of its consultant medical staff to offer themselves as Second Opinion Appointed Doctors, the trust will be aware that there is still a shortage of such doctors and at the time of writing none of the trust's medical staff undertake this function.

Section 117 – Care Programme Approach (CPA)

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcome 4A and 4R

The Commission was pleased to attend a ward community meeting when the draft High Secure Hospital Care Programme Approach self-report form was discussed, it is hoped that this approach will assist in enabling patients to play a more active part in the development of their care programmes and thus more clearly fulfil the participation principle underpinning the Code of Practice. In this connection, the Commission stresses the need for patients' own views to be clearly recorded in care plans.

Section 130A – Independent Mental Health Advocacy (IMHA)

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcome 1A

The Commission has been pleased to meet with members of the advocacy team during the reporting period and to receive the quarterly reports from the manager of the service. The quality of the service provided by the advocates has been found to be high. A number of wards have been found not to be properly displaying information about the advocacy service and the availability of advocates on the ward. In addition, some ward staff do not appear to be aware of the requirement for informing patients of the IMHA service. The Commission expects that this will be rectified to ensure that all qualifying patients are made aware of their statutory right to access this service.

Section 132 – Information to Patients

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcome 1A

Generally speaking, the standard of records concerning the provision of information to patients was found to be good. Where exceptions to this were drawn to the attention of ward staff the situation was rectified speedily. As mentioned in previous reports, it is important to ensure that patients are not only given the necessary information so as to 'tick the box' but are helped fully to understand their rights.

Seclusion and the Management of Violence

Concerns in this area may contribute to an understanding of the CQC's evaluation of the Provider's compliance with the Essential Standards of Safety and Quality Regulatory Outcomes 4Q, 7F and 7H

The Commission has been pleased again this year to be included in meetings of the Seclusion Monitoring Advisory Group and continues to be impressed with the care that is taken in monitoring those patients for whom long term seclusion is necessary. The Commission continues to be concerned about those wards with seclusion rooms that do not have ensuite lavatory facilities. It is also important to ensure that seclusion rooms are properly equipped in other respects, for example the use of a radio and a viewing panel that allows the occupant to maintain contact with staff outside the room on observation duty and to be able to have sight of a clock.

Other Patient Issues

Environment

The standard of cleanliness of patient areas has been noted to be improved during the current reporting period. Commissioners have been impressed with the new arrangements for the systematic cleaning and checking of ward areas with the use of the monthly forty-point audit designed for this purpose.

As in previous reports, it would be remiss to fail to continue to draw attention to the inappropriate nature of a good deal of the hospital's patient accommodation. Whilst recognising that the trust has been making efforts to reorganise the ward structure, the Commission would be falling short in its responsibilities if these concerns did not continue to feature in Commission reports.

As noted below, the absence of the long awaited decision about the redevelopment of the hospital continues to take its toll on patients and staff alike. The Commission has had greater difficulty during this reporting period in keeping abreast of these matters in the absence of the Redevelopment Stakeholder Group, meetings of which the Commission had been used to attending.

Physical Health

It appears that the monitoring and recording of physical healthcare of patients has improved over the last twelve months and the Commission is impressed with the programme of checks now instituted in this respect. However, Commissioners continue to see some evidence during visits to wards of poor recording of patients' annual physical health checks. The Commission encourages the trust to continue to put emphasis on this often overlooked aspect of the care of psychiatric patients.

Staffing
A recurring theme arising from visits to wards has been the concern expressed by patients and staff alike about apparent reductions in staffing levels. The Commission is aware of the communications that the trust has made comparing nursing staff levels between 2001 and 2010 which demonstrate that in 2001 there was a nurse/patient ratio of 1.7:1 and in 2010 the same ratio is 2.9:1. Notwithstanding these figures the strong and consistent view at ward level is that there is all too often a shortage of staff 'on the ground' which prevents the delivery of an acceptable standard of patient care with access to fresh air, ability to engage in off-ward activities etc are seriously compromised.

The Commission shares the concerns of patients and staff in this respect and, mindful of the staffing comparisons referred to above, can only conclude that there is a lack of efficiency and effectiveness with which staff are deployed. The Commission will expect to see this concern strenuously and effectively engaged with during the next reporting period.

There have been occasions when Commissioners found that all nursing staff on duty during a shift were female thus resulting in difficulties when level 1 searches needed to be carried out with the knock-on effect of sometimes preventing patients being able to leave the ward and to miss off-ward activities. The Commission recommends that care is taken in ensuring an appropriate gender balance amongst staff.

As the trust is aware, there have been concerns during the reporting period of a small number of staff members disclosing confidential patient information to the media. The Commission supports the trust in its efforts to address this serious issue. Untoward media attention of this nature clearly has a detrimental effect on patient morale, as noted below.

Patient and Staff Morale
As indicated above, Commissioners on visits to wards have become aware of evidence of low morale amongst patients and ward based staff. It is recognised that a good deal of uncertainty surrounds the future of the hospital: some patients are anxious about the prospect of having to return to prison as a result of changes to the policy on DSPD, some staff are anxious about the changes to ward designations and disposition with the consequent reduction in patient numbers and the impact that this will have on job security. There continues to be widespread uncertainty about whether the plans to redevelop the hospital will come to fruition.

It is recognised that the trust is making considerable effort to allay these fears with discussions amongst patient and staff representative groups, however taking account of the propensity for rumours to get out of hand, the Commission believes that it will be necessary to continue to invest time and resource into effective communication and explanation to do all that is possible to prevent these concerns having a detrimental effect on patient care.

Social Work
Since 2001 the London Borough of Ealing has employed social workers placed at Broadmoor Hospital. It is worthy of note that this remains the only high secure

hospital that has this arrangement with a local authority despite the recommendations of the Ashworth Inquiry that social work should have some independence to the high secure hospitals. It is recognised that there are inherent difficulties with the arrangement as Ealing is 34 miles away and social workers inevitably feel isolated from the main base, they also have no access to the local authority intranet but they are able to access training.

During a visit to the Social Work Department the Commission noted that forensic social workers were not being considered for Approved Mental Health Practitioner (AMHP) training. While the Commission appreciates the pressure on the general AMHP service, this inevitably influences the choice of candidates for AMHP training; the Commission was reassured to hear that following the Commission visit it had been decided that this policy would be changed to permit forensic social workers to be considered for this training.

Recommendations and Actions Required

1. The Commission will expect to see greater vigilance in ensuring that statutory provisions are adhered to, especially with regard to consent to treatment and the Approved Clinician status of Responsible Clinicians.

2. The Commission will expect to see a commitment from the trust to the complete phasing out of ‘T’ end designed wards during the next reporting period.

3. The Commission will expect to see a greater efficiency in the deployment of ward based staff in order that patient care no longer suffers as a result of shortages and that the trust continues to invest time and resource in ensuring that staff and patient morale is maintained at as high a level as possible.

4. The Commission will expect to see an improvement in the timeliness of responses made to Commission visits and a greater effort made to achieve systemic change when this is recognised as necessary, rather than simply saying that this will take place at an unspecified date.

Annex A

The quantitative data will only apply to visits completed from 1 April 2010 which is the time that the new data started to be captured uniformly.

Date	Ward	Det. Pats seen	Pats in groups	Records checked
Broadmoor Hospital				
09/10/2009	Sunningdale Ward	3	0	4
09/10/2009	Luton Ward	7	0	7
24/10/2009	Harrogate	5	0	4
02/11/2009	Dunstable Ward	3	0	3
27/11/2009	Epsom	3	0	0
16/02/2010	Isis Ward	5	0	0
09/02/2010	Sandhurst	4	0	4
05/03/2010	Kempton	0	0	0
10/03/2010	Dover Ward (On Leeds)	2	0	2
23/03/2010	Newmarket	1	0	1
23/03/2010	Sandown	2	0	2
27/02/2010	Henley Ward	4	0	4
13/03/2010	Luton Ward	5	0	5
29/04/2010	Milton	2	0	2
23/06/2010	Canterbury Ward (On Harrogate)	4	0	4
28/05/2010	Leeds Ward	2	0	2
17/05/2010	Churchill	3	0	4
22/05/2010	Harrogate	6	0	4
29/05/2010	Banbury Ward	6	0	5
14/06/2010	Ascot	4	0	4
27/07/2010	Henley Ward	2	0	2
12/08/2010	Sunningdale Ward	4	0	4
19/08/2010	Dover Ward (On Leeds)	4	0	4
07/07/2010	Luton Ward	4	0	4
27/07/2010	Sheffield Ward	3	0	4
10/07/2010	Oakley	3	0	4
28/08/2010	Milton	4	0	4
14/09/2010	Epsom	3	0	6
14/09/2010	Chepstow	3	0	4
Totals for Broadmoor Hospital		**101**	**0**	**97**

Total Number of Visits:	28
Total Number of Patients Seen:	101
Total Number of Documents Checked:	97
Total Number of Wards Visited:	21

Findings from Visits - Environment and Culture:	YES	NO	N\A
If the door is locked is there evidence that informal patients are informed of their right to leave the ward and given the means to do so?	1	0	15
Are you satisfied that there is evidence that informal patients are free to leave the ward in line with legal requirements?	0	0	16
Do patients have the ability to lock their rooms securely and the means to do so? [answer no if in dormitories]	14	1	1
Do patients have lockable space which they can control?	15	1	0
Are arrangements to cover viewing panels in bedroom doors adequate to protect patient privacy?	15	0	1
Are curtains or other window coverings in patient bedrooms adequate to protect privacy from people outside the ward?	16	0	0
Does the ward provide single gender sleeping areas, toilets, bathrooms and lounges?	13	0	3
Is there a ward phone for patients' use?	16	0	0
Is it placed in a location which provides privacy?	16	0	0
Are there any circumstances under which patients may have their mobile phones? [answer N/A if HSH]	0	0	16
Do patients have an opportunity to participate in influencing the ward they are on via such mechanisms as community meetings, patients' councils etc?	15	0	1

Findings From Document Checks	YES	NO	N\A
Were the detention papers available for inspection? Did the detention appear lawful	59	1	1
Was there either an interim or a full AMHP report on file?	27	0	34
If the NR was identified was s/he consulted, If there was no consultation, were reasons given?	20	0	41
Where appropriate was all psychotropic medication covered by a T2 and/or T3?	41	2	18
Was there evidence a capacity assessment at the time of first administration of medication following detention?	21	2	39
Was there evidence a discussion about consent at the time of first administration of medication following detention?	18	2	41
Was there a record of the patient's capacity to consent at 3 months?	24	12	25
Was there a record of a meaningful discussion about consent between the AC and the patient at 3 months?	28	1	32
Was there evidence that the RC had advised the patient of the outcome of the SOAD visit or an explanation why not?	7	11	43
Was there evidence of discussions about rights on first detention and an assessment of the patient's level of understanding?	39	1	21
Was there evidence of further attempts to explain rights where necessary?	37	7	17
Was there evidence of continuing explanations for longer stay patients?	47	7	7
Is there evidence that the patient was informed of his/her right to an IMHA?	38	15	8
Are the patient's own views recorded on a range of care planning tools?	23	36	2
Was there evidence that the patient was given a copy of their care plan?	33	11	2
Is there evidence that the patient signed / refused to sign their care plan	44	14	3
Was there evidence of care plans being individualised, holistic, regularly reviewed and evaluated?	55	4	2
Is there evidence of an up to date risk assessment and risk management plan?	58	0	3
Is there evidence that discharge planning is included in the care plan?	7	11	43
Were all superseded Section 17 leave forms struck through or removed?	2	7	52
Was there evidence that the patient had been given a copy of the section 17 leave form?	0	7	54
Are the timescales, frequency and conditions for the use of leave unambiguously specified?	5	3	53
For patients in hospital less than a year, is there evidence of a physical health check on admission?	20	2	39
For patients in hospital over than a year, is there evidence of a physical health check within the last 12 months?	55	1	5

	0	1	2	N\A
If the patient's medication was authorised on a T3, was there a record of the discussion between the SOAD and the statutory consultees [enter 0 for none, 1 for one consultee, 2 for both consultees, and n/a if no T3]?	3	9	10	39

Annex B – CQC Methodology

The Care Quality Commission visits all places where patients are detained under the Mental Health Act 1983. Mental Health Act Commissioners meet and talk with detained patients in private and also talk with staff and managers about how services are provided. Since November 2008, Commissioners have also been meeting with patients who are subject to Community Treatment Orders. As part of the routine visit programme information is recorded relating to:

- Basic factual details for each ward visited, including function, bed occupancy, staffing, and the age range, ethnicity and gender of detained patients.

- Ward environment and culture, including physical environment, rights to leave, patient privacy and dignity, gender separation, choice/access to services/therapies, communication facilities, physical health checks, food, and staff/patient ratios, smoking facilities, staff patient engagement, diversity and cultural sensitivity, cleanliness and upkeep of the ward, fresh air and exercise, physical safety and environmental risks.

- Issues raised by patients and patient views of the service provided, from both private conversations with detained patients and any other patient contacts made during the course of the visit.

- Legal and other statutory matters, including assessing the providers compliance with the Mental Health Act 1983 and the Code of Practice including scrutinising the supporting documentation, records, policies and systems. The Commissioner reviews the basis and evidence of detention, including compliance with Sections 132, 132a (information to the detained patient about their rights), Section 58 and 58A (consent to treatment), the provision of the Independent Mental Health Advocacy (IMHA) service, the use of the Mental Capacity Act Deprivation of Liberty safeguards, Section 17 and 17A (leave and Community Treatment Orders) and reviews the evidence of the patient's participation in their treatment by reference to the Care Programme Approach documentation. The patient's access to physical care and treatment is also assessed.

At the end of each visit a "feedback summary" is issued to the provider identifying any areas requiring attention. The summary may also include observations about service developments and / or good practice. Areas requiring attention are listed and the provider is asked to respond stating what action has been taken. The response is assessed and followed up if further information is required. The information is used by the CQC to inform the process of registration and ongoing compliance with the outcomes and essential standards of safety and quality in accordance with the Health and Social Care Act 2008.

The Care quality Commission has based some of its findings on the use of a series of structured audit tools, which can be downloaded from the CQC website.