Investigation into West London Mental Health NHS Trust

July 2009
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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 the 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).
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 was 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. 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.