Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust

Following the conviction of Valdo Calocane in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber, the Secretary of State for Health and Social Care commissioned us to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008.

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Summary

As part of our review, we were asked to look at 3 specific areas:

1. A rapid review of the available evidence related to the care of Valdo Calocane
2. An assessment of patient safety and quality of care provided by NHFT
3. An assessment of progress made at Rampton Hospital since the most recent CQC inspection activity

In this report, we detail the findings of parts 2 and 3. We will publish a separate report on part 1 in relation to the care of VC in summer 2024.

Over the last 5 years, we have raised ongoing concerns about the quality of community and inpatient mental health services at Nottingham Healthcare NHS Foundation Trust (NHFT), including Rampton Hospital. During this time, all services, except forensic inpatient services, have been rated as requires improvement or inadequate. Previous inspections have identified a pattern of concerns and breaches of regulations.

Our rapid review identified 3 enduring areas of concern at the trust including:

- demand for services and access to care
- staffing
- leadership.

The gaps and challenges we have identified at NHFT are longstanding issues at the trust which need to be addressed. However, looking more widely, we can see that other community mental health services are facing many of the same challenges as NHFT.

What is the quality of care like at Nottinghamshire Healthcare NHS Foundation Trust and are people kept safe?

Over the last 5 years, we have raised a number of concerns about the quality of community and inpatient mental health services at Nottingham Healthcare NHS Foundation Trust (NHFT). While we found some evidence of improvement, we continue to have concerns about the quality of care and safety of patients at NHFT.

- **People struggled to access the care they needed when they needed it, putting them, and members of the public, at risk of harm.** Like many other mental health services across the country, mental health services at NHFT were in high demand, with long waiting lists for community mental health teams, difficulties in accessing crisis care and lack of access inpatient beds. A lack of oversight for people on waiting lists and too many patients without a care coordinator was putting them, and the public, at risk of harm.
- **The quality of care and treatment across the trust varied and care provided did not always meet the needs of individuals.** While most patients were treated with kindness, compassion and dignity, the quality of care planning was inconsistent and patients, their families and carers were not always involved. The make-up and size of teams did not meet the needs of the local populations, and care and treatment was not always in line with the Mental Health Act 1983 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as well as current evidence-based good practice and standards.
- **High demand for services and issues with staffing levels meant that patients were not always being kept safe.** Complex staffing arrangements in community mental health services meant that staffing levels did not always match caseload sizes and the number of referrals received. Staff approach to risk assessment and risk management was inconsistent, which increased the risk of people coming to harm.

- **Leaders were aware of risks and issues faced by NHFT, but action to address safety concerns was often reactive.** There have been a number of changes in leadership in recent years. While leaders were aware of some of the current risks in safety and quality of services, they did not appear to have clear oversight of these. NHFT was taking action to address safety concerns, but these activities were predominantly reactive.
- **At a system level, we found issues with communication between services, which affected continuity of care for people. While the integrated care board was taking steps to improve quality, changes weren't happening quickly enough.** Patients told us that transferring between inpatient care and crisis care into community care was difficult, and that services did not always ensure continuity of care. This was made worse by poor communication between services. While the integrated care board and NHS England were taking steps to oversee and improve care, we were concerned that change was not happening quickly enough.

Has the quality of care at Rampton Hospital improved since our last inspection?

We have had ongoing concerns about the quality of care at Rampton Hospital for nearly 5 years. Since July 2019 we have inspected the hospital 5 times, the last of which was in June 2023. During this time the hospital has not received a rating above requires improvement. While care at Rampton Hospital has improved since our previous inspections, we continue to have concerns in a number of areas.

- **Communication between staff and patients was still poor, particularly for those in long-term segregation. However, we saw improvements for patients who are deaf, with greater access to staff who are trained in British Sign Language.** While access to staff using British Sign Language (BSL) had improved since our last inspection in July 2023, there were still times when there were not enough BSL trained staff to meet patients' needs. The availability and provision of therapeutic activities had also improved since our previous visits, but patients told us that there were still issues with therapeutic activities being cancelled due to staffing pressures.
- **The safety of patients had improved, but issues around the prescribing of medicines and monitoring of people's physical health meant that people were not always being kept safe.** For example, we found that people were being put at risk of harm because of poor monitoring of high dose antipsychotic therapy. While the monitoring of patients' physical health following rapid tranquilisations had also improved, we were concerned about the amount of rapid tranquilisations being used, as well as the accuracy of recording.
- **Staffing levels had improved but they did not always meet the needs of patients on the wards. Despite confinement being used less, this was still part of the culture of a small number of staff in the hospital.** Improved staffing levels meant that fewer therapy and education staff were being used to cover nursing gaps. However, this was still an issue which could lead to therapies, such as exercise, being cancelled. Inappropriate confinement had also improved, but some staff felt that not having the option of day confinement placed them at risk when staffing levels were low.

- **Leaders had addressed many of the issues identified on our previous inspections and recognised ongoing concerns with the culture need to be scrutinised.** Over the last 3 years, NHFT had reviewed governance and capacity across the forensic care group and made changes to align the governance structures across the care group. Recruitment processes have been refined and the high secure weighting payment reintroduced for staff. While there was a noticeable improvement with the culture at Rampton, we were concerned that small pockets of poor culture remain. The senior leadership team recognised that the culture in Rampton Hospital needs to be scrutinised, understood, and developed.

Recommendations

1. At a trust level, Nottinghamshire Healthcare NHS Foundation Trust (NHFT) must:

(a) ensure that services do more to provide safe care and treatment, and to protect patients, families and the public from the risk of harm. This includes, but is not limited to, ensuring:

- all patients receive appropriate ongoing assessment of their risks including those waiting to receive treatment and care
- appropriate and effective risk management plans are formulated and implemented
- patients can access crisis services without delay
- escalations in risk are identified with timely access to inpatient care as appropriate.

(b) review how it monitors and measures waiting times in community mental health services by setting measurable targets at team, service, and trust level. These targets must be monitored to ensure equity of care across services and that deterioration in people's conditions are monitored.

(c) ensure services do more to meet the needs of people who need care and treatment. This includes, but is not limited to, ensuring:

- patients receive timely access to care and treatment
- patients can equitably access the full range of evidence-based care and treatment through multidisciplinary teams with clear pathways, including psychological therapies regardless of where patients live
- services, including GP practices, are integrated and use shared systems to provide patients with seamless transitions in care and treatment.

(d) ensure services do more to identify and learn from incidents where patients, families and the public have come to harm from failures in how treatment and care is provided. This includes, but is not limited to, ensuring:

- incidents and the level of harm caused are identified in a timely way
- incidents are investigated in a timely way by appropriately trained and competent staff, ensuring lessons are learnt and changes in practice are made immediately
- lessons learnt are shared appropriately with all services to improve safety.

2. For community mental health services for working age adults, NHFT must:

(a) change the current ofapproach to providing community mental health services to ensure that evidence-based care and treatment is provided through clear pathways to care and treatment. There must be cohesive multidisciplinary teams, including psychological therapy staff, which are equitable across all geographical areas covered by the trust.

(b) ensure it reviews and amends its approaches to bed management to ensure beds are available when needed.

(c) ensure that community mental health teams' approach to risk management is reviewed to ensure that teams are able to monitor, mitigate and respond to people at risk of harm to themselves or others.

(d) ensure that staff are appropriately trained and that mandatory training is available to support staff in working with autistic people and people with a learning disability.

(e) ensure that joint working protocols are in place with GP practices, which ensure that patients with complex mental health needs have joined up care.

(f) improve their responsiveness to people's immediate needs by ensuring calls to the crisis line are answered and that 4-hour and 24-hour targets are met more often and consistently.

3. In relation to Rampton Hospital, we recommend NHFT:

(a) pair Rampton Hospital with another high secure hospital as a 'critical friend'. This needs to go further than current working relationships, and include regular oversight and monitoring by senior staff from a different NHS trust. NHFT may wish to discuss implementation with the National Oversight Group to ensure expertise from the other two high secure hosting trusts can be engaged.

(b) appoints an independent team, organisation or person to review the staffing requirements of all disciplines across Rampton Hospital. This review should include terminology used and ensure consistency of approach. From this review, clear processes should be implemented to ensure continued safe staffing levels.

(c) properly identifies the scope of the new culture team and devise a plan of action within an agreed timescale.

(d) puts in place a dedicated team at Rampton Hospital to support a full review of the medication audits and medication governance process to bring about positive and sustainable change for the application of Section 58 of the Mental Health Act 1983, high dose antipsychotic therapy and controlled drugs.

(e) immediately stops using therapy and education staff to increase nursing staff numbers on the wards to enhance the therapeutic offer to patients.

(f) ringfences British Sign Language (BSL) trained staff as able to only work with deaf patients to increase support and communication of deaf patients within Rampton Hospital. The trust should ensure that BSL trained staff are not removed from the deaf high secure ward for emergency vehicle keyholder purposes or to prop up staffing in other wards.

(g) ensures that the IT equipment is fit for purpose and used effectively to record patient information (for example, iPads for observations).

4. We recommend NHS England:

(a) recommends to the Secretary of State for Health and Social Care relicenses Rampton Hospital for a period of no more than 12 months, to allow for improvements to continue along with expected improvements at trust level. Throughout the 12-month period, we will carry out further assessment activity along with a well led review.

(b) works with DHSC to define and agree clear standards in waiting times for community mental health services alongside those already established for EIP services and crisis services.

(c) together with CQC work to establish what datasets are needed for monitoring the quality and safety of community mental health services, particularly around waiting times, unexpected deaths and suicide, crisis response times, incidents of serious harm to the public involving people using mental health services and treatment outcomes.

(d) should define clear standards for answering calls to mental health crisis lines so that improvements can be made to the number of calls that are abandoned each year by patients using those services.

(e) works with the Royal College of Psychiatrists and DHSC to review the Community mental health framework for adults to standardise pathways of care and ensure there is a specific pathway for individuals who require assertive support and may be hard to engage.

5. In response to this review, we will:

(a) look in depth at the standard of care in community mental health across the country, given that we continue to see issues with quality and with patient and public safety.

(b) continue to develop and embed our work around observing and understanding cultures where there is a risk of people receiving poor treatment and or care as a result of factors associated with a closed culture.