Care Quality Commission

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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Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust (easy read)

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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.

August 2024 update

The rapid review of the available evidence related to the care of Valdo Calocane has now been published:

- Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2

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.

Background

Following the conviction of Valdo Calocane (VC) 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), where VC was treated for paranoid schizophrenia.

As part of our review, which is complimentary to the Independent Mental Health Homicide Review by NHS England, we were asked to look at 3 specific areas:

1. **A rapid review of the available evidence related to the care of Valdo Calocane**, alongside a small number of other cases (to enable benchmarking), to determine whether this evidence highlights wider patient safety concerns or systemic issues with the provision of mental health services in Nottinghamshire.

2. **An assessment of patient safety and quality of care provided by NHFT**, drawing on our latest inspection findings and other available intelligence. This includes our recent inspections of Rampton High Secure Hospital and acute wards for adults of working age and wards for older people with mental health problems at NHFT. We will also assess care for patients in the community who are presenting with risk to public safety, and the extent to which there is sufficient oversight from the provider. This includes the trust's discharge processes and approaches, including its assessment of patient risk and engagement and working with other local partners.
3. **An assessment of progress made at Rampton Hospital since the most recent CQC inspection activity** to offer an up-to-date assessment of care provided at the hospital.

In this report, we detail the findings of parts 2 and 3: our assessment of patient safety and quality of care provided by NHFT, and our assessment of progress made at Rampton Hospital since our last inspection in July 2023.

We will publish a separate report on part 1 in relation to the care of VC in summer 2024.

Nottinghamshire Healthcare NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust (NHFT) provides learning disability, mental health, community health, forensic and offender healthcare services across Nottinghamshire, Leicestershire, Lincolnshire, and South Yorkshire. The trust delivers services from over 257 locations in the community, in hospital settings and across low, medium and high secure environments, including prisons.

NHFT also provides specialist national and regional services such as the National High Secure Deaf Service, the National High Secure Learning Disability Service and the Nottingham Centre for Transgender Health.

NHFT is part of the Nottingham and Nottinghamshire Integrated Care System, and serves a population of 1,226,000 people. Each year, the trust provides care to more than 2 million people.

As well as serving a large number of people, NHFT cares for a diverse population across a wide geographical area:

- over half (55%) of people who live in the city of Nottingham live in the most deprived areas nationally, but this drops to just over 15% in the wider Nottinghamshire area
- 43% of people who live in the city of Nottingham are from ethnic minority groups, while 88% of the population in the wider Nottinghamshire area are White British.

Community mental health services for adults of working age

NHFT's community mental health service is made up of 12 local mental health teams (LMHT), plus bed management, administrative and psychological services. LMHTs provide mental health services for people aged 18 to 65 years across Nottingham City, Nottinghamshire county and Bassetlaw.

Community mental health teams (including early intervention teams and crisis teams) provide short and long-term support in the community for people with mental health needs. The teams may include a community psychiatric nurse, a psychologist, an occupational therapist, a counsellor and a community support worker, as well as a social worker. As part of the support offered, once they have had an assessment, guidance from the Royal College of Psychiatrists is clear that people should be allocated a care coordinator to keep in regular contact with them and help plan and coordinate their care and treatment.

Following assessment, individuals will be placed on a care pathway. Care pathways define what happens and who does what in terms of diagnosis, treatment and follow up in a healthcare setting. Put simply they are used to inform providers of care, and patients, their families and carers about what to expect during that period of treatment. They define:

- what patients are being seen for
- what assessment or diagnosis tools should be used
- who carries that out, for example, nurse, psychologist, doctor or care coordinator
- what treatment is indicated.

The trust has a separate specialist service for early intervention in psychosis. Psychosis is characterised by hallucinations and delusions, and affects people's perception of reality, with the potential to cause considerable distress and disability for the person and their family or carers. National Institute for Health and Care Excellence (NICE) clinical guideline CG178 states that treatment can begin as soon as a first episode of psychosis has been identified – it does not have to wait for a final diagnosis and services are encouraged to embrace diagnostic uncertainty.

Treatment should be provided by a service capable of providing a full and effective early intervention in psychosis package of NICE recommended care. This is normally a specialist early intervention in psychosis team. People who experience psychosis can and do recover. The time from onset of psychosis to the provision of evidence-based treatment has a significant influence on long-term outcomes. The sooner treatment is started the better the outcome.

At NHFT, the early intervention in psychosis teams work with people for up to 3 years from their first episode of psychosis, and work towards discharge for 6 months before the person is due to be discharged from the service. Patients may be discharged to another LMHT.

High secure hospitals

NHFT runs Rampton Hospital, one of 3 high secure hospitals in England. The other 2 high secure hospitals are Ashworth Hospital in Liverpool and Broadmoor Hospital in Berkshire.

As a high secure service, each hospital has to go through a rigorous relicensing process every 5 years. The current licence for all 3 high secure hospitals expires in March 2024, with new licenses required from April 2024.

As part of the relicensing process, all 3 hospitals have to go through a series of assessments (provider, regional and national) by a relicensing panel to ensure they meet the criteria set by NHS England. Each hospital is reviewed by a dedicated regional relicensing panel, which is made up of regional NHSE staff, CQC and some national specialised commissioning staff. The panels review the hospitals independently of each other and then submit their proposals to the National Oversight Group for High Secure Psychiatric Services for ratification. Following the panels' assessments, the Department of Health and Social Care will recommend to the Secretary of State whether the hospitals should be relicensed, and how long for.

The current assessment process began in January 2023 and is due to finish at the end of March 2024. While the panels for Ashworth and Broadmoor have recommended the hospitals should be relicensed for 5 years from April 2024, this has not yet been agreed for Rampton Hospital as 2 specific criteria have not been met. These are:

- **High secure hospital criteria 5a –** the hospital must be rated good across all areas in their latest CQC inspection, or there is assurance that any ratings below good are being addressed.
- **Provider criteria 7 –** the provider must be rated good across all areas in their latest CQC inspection, or there is assurance that any ratings below good are being addressed.

At the beginning of the process, the panel (including CQC) felt that Rampton Hospital met the high secure hospital criteria 5a. The panel was assured that although Rampton Hospital was rated below the required good, these issues were being addressed. However, as the relicensing process progressed, concerns emerged about deterioration across the trust, and we were no longer assured that issues were being addressed.

In addition, throughout the process the panel could not be assured that provider criteria 7 had been met. While Rampton Hospital appeared to be making improvements, other parts of NHFT continued to deteriorate. The panel felt that a full 5-year licence for Rampton Hospital would not be suitable, but that a 12-month licence should be offered with conditions added to ensure improvement. This would then result in further monitoring at Rampton Hospital for a 12-month period, ensuring that the appropriate improvements were being made. If the improvements at both hospital and trust level continued, a further license for 4 years could be awarded at the end of 12 months bringing the hospital back in line with the other 2 high secure hospitals. The 12-month period would also allow NHS England to consider and identify alternative high secure provision within another Trust should improvements not be made or be sustained.

Evidence used in this report

In this report, we use information gathered from our onsite visits, reviews of the trust's services, data from previous inspections and ratings, along with other information and personal experiences, including those from people who use services, their families and carers, to inform our judgements about the quality of care within the trust.

We reviewed data, reports and policies, drew on findings from surveys, and analysed publicly available datasets to assess the patient safety and quality of care provided by the trust.

Where possible in the report, we have compared data from NHFT with other trusts or national data. However, in many places this has not been possible due to a lack of standardised data collection.

Conclusions we draw in our report are not solely based on the findings of our rapid review, but take into account findings from our previous inspection activity at NHFT and Rampton Hospital over the last 5 years. We have then looked at these findings within the context of our wider understanding and evidence around the challenges facing mental health services. This includes drawing on evidence from our statutory State of Care and Mental Health Act annual reports, and other thematic reviews.

Feedback to CQC

To inform our view of quality and safety we reviewed information that has been shared with us from people who use services, families and carers, feedback from staff and from partner organisations. This feedback is collected through our Give feedback on care webform, as well as phone calls and emails to our National Customer Service Centre.

Between 18 July 2023 and 5 February 2024 there were 247 records referring to Nottinghamshire Healthcare NHS Foundation Trust (NHFT), of which 173 provided information on quality and safety of care to support the report.

Some cases concerned the trust as a whole, while others related to the service. Analysis is presented at trust or 'setting' level (for example, inpatient, secure setting), except for Rampton Hospital, which was included in trust level analysis as well as reported separately.

Surveys

To better understand the experiences of people who use services, as part of this review we carried out quantitative and qualitative analysis of responses to 2023 Community Mental Health Survey for Nottinghamshire Healthcare NHS Foundation Trust (NHFT). Our analysis does not include national figures or compare results with other participating trusts. National survey results, including trust level results for NHFT, will be published in Spring 2024.

Unless otherwise stated, people's experiences used in this report are based on a combined analysis of qualitative comments from the community mental health survey analysis and all other feedback received by us.

The feedback we received from people who use services, families and carers, and staff, is from individuals who have chosen to contact us directly to share their experience. This means we may be more likely to receive feedback on less favourable or more extreme experiences. We analysed survey responses in response to both what was good, and what could be improved about care. However, as with all feedback to CQC, responses detailing positive experiences tend to be general in nature, and as a result have limited scope for analysis. Negative experiences are commonly more detailed and provide more opportunity for actionable insight. As a result, our analysis focuses on experiences of poorer care, while acknowledging it may not be representative of every experience.

Prevention of future death reports

We analysed 15 prevention of future death reports for NHFT, which were sourced from both the courts and tribunals judiciary websites. These reports highlight the most serious concerns relevant to a service. The sample contained reports published after 1 January 2021, but some dates of death pre-date this, owing to the time taken to conduct an inquest. Reports such as those relating to acute healthcare provision not relevant to the review and some of historic concern were not included in the analysis.

Healthwatch

In November 2023, Healthwatch produced a report on specialist mental health services in Nottingham and Nottinghamshire. We reviewed this report and summarised the key points in order to corroborate findings from this rapid review. The response from NHFT to the report has not been reviewed or included in this summary.

Mental Health Act reviews

CQC has a duty under the Mental Health Act 1983 (MHA) to monitor how services exercise their powers and discharge their duties when patients are detained in hospital, subject to community treatment orders or guardianship under this legislation.

Following MHA reviewer visits to locations, a letter is sent to report on findings. There were 20 letters from MHA reviewers relating to different locations in Nottinghamshire, issued between July 2023 and November 2023.

Each of the MHA reviewers' letters ends with any actions that the provider must carry out (under Section 120B of the MHA). MHA reviewers raise these actions when they have some concerns about the use of the MHA, compliance with the Code of Practice and/or the experience of detained patients. Each action is linked to the MHA Code of Practice – one of the 5 guiding principles, and often also the relevant chapter/section.

There was one MHA reviewer visit to Rampton Hospital (Evans ward) in this time period.

Analysis of these letters focused on the actions raised by MHA Reviewers to give us an overview of issues raised.

Data sources

We used data and insight gained through our routine monitoring of and engagement with NHFT. Where data was sent directly to CQC from NHFT this was analysed and, where possible, benchmarking analysis is referenced in the report.

Staffing data was analysed for staffing levels (fill rates), staffing sickness and staff training requirements for NHFT. When relevant, NHS Staff Survey 2022 data was analysed as supporting information on findings.

This report also provided an analysis of data within bed occupancy rates, discharge information and out of area placements data. In addition, a review of data, policies and papers relating to the overall running of the trust supports findings in the report.

To assess patient safety and the quality of care at NHFT, we visited and assessed a number of services in the trust, including community health services for adults of working age, crisis services and the University of Nottingham Health Service, due to their involvement with VC.

During these visits we spoke with 37 members of staff including doctors, nurses, care assistants and allied health professionals.

We were able to observe the care that patients receive, and directly speak to 34 people using services, 10 carers, relatives and loved ones. In addition, we were able to review 30 records of care and treatment provided to people using these services.

We reviewed and incorporated findings from our inspections of the trust's acute wards and psychiatric intensive care units (October 2023) and wards for older people with mental health needs (November 2023).

Rampton Hospital

We visited and assessed Rampton Hospital on multiple occasions to review what progress had been made since our last inspection. These visits included 4 out of hours visits. All visits allowed us to observe the care that patients receive. We spoke directly to 50 patients currently being treated at Rampton Hospital.

In addition, we reviewed 34 records of care and treatment, 40 records regarding consent to treatment, and 21 records regarding medicine administration provided by the trust for patients.

We spoke with 50 members of staff currently employed in the hospital including doctors, nurses, health care assistants and allied health professionals.

We used the data and insight gained through our routine monitoring of Rampton Hospital and engagement with NHFT. Where data was sent directly to us from the trust, this was analysed and where possible, benchmarking analysis is referenced in the report.

Safety and quality of care at Nottinghamshire Healthcare NHS Foundation Trust

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).

Excluding Rampton Hospital and prison services, since 2020 we have inspected 10 mental health services at NHFT. With the exception of forensic inpatient services which was rated as good in February 2022, all of these services were rated as requires improvement or inadequate.

We suspended the trust's rating on 29 January 2024 after we were commissioned to carry out a Section 48 review, and concerns were raised about the trust's ability to keep people and patients safe.

This section of the report, which sets out our findings around safety and quality of care provided by NHFT, draws on a range of evidence sources, including findings from our October and November 2023 inspections.

Access to care

Key points:

- High demand and long waiting times at NHFT meant that people were not able to access care when they need it.
- People's mental health was not monitored for signs of deterioration while waiting for support.
- Too many people did not have an allocated care coordinator, putting them and the public at the risk of harm.
- The crisis teams did not always respond to people's immediate needs to minimise any discomfort, concern, or distress, and did not always provide care and treatment to people quickly.
- The flow to inpatient beds was ineffective and people could not access a bed when needed for their mental health needs.

Referrals and waiting times for community services

As reported in our 2022/23 State of Care report and 2021/22 Mental Health Act (MHA) annual report, access to mental health care continues to be an area of concern nationally. In these reports we highlighted how unavailability of community care is putting pressure on mental health inpatient services, with many services struggling to provide a bed.

While we found no issues with referrals into community mental health services at NHFT, declined referrals was a concern flagged by the integrated care board (see section on system working). We found that high demand and lengthy waiting lists meant that people were not able to get the care they needed when they needed it. Many people told us that they were unhappy with access to community mental health and crisis services at NHFT. This was reflected in their feedback with many people reporting that they felt frustrated by "immense" or "extraordinary" waiting times:

> "I have now been on it [waiting list] over 1 year, and was told when I first asked for help, that it would be 3 to 4 months. I was totally forgotten after my initial assessment, which was traumatic... I have had to chase numerous times to get feedback, updates etc, I have gone backwards on the waiting list."

> "Accessing crisis team has always been poor for both myself and brother during the acute stages of psychosis. Emergency services too. It is only the police that have ever responded and then I get treatment."

This was supported by a November 2023 Healthwatch review of specialist and community mental health services at NHFT, which found significant issues with people accessing care. The process to access specialist mental health support was described as difficult, fraught, or impossible to navigate. Many criticised the long waiting lists, which led some people's conditions to deteriorate and added further strain on crisis services.

Each of the local mental health teams (LMHTs) had a waiting list, with 1,233 people in total on a waiting list at the time of the review. A further 39 people were waiting for treatment on the urgent LMHT pathway. We found that the number of people waiting for treatment and the length of time they were waiting varied significantly between the teams and across geographical areas. For example, there were 3 people on the family intervention and medical follow-up pathway, compared to 347 people on the care coordination pathway. The longest wait was 135 weeks in the Broxtowe and Hucknall team, compared to 2 weeks for the Mansfield team.

A lack of clear standards in waiting times for community mental health services meant that we were unable to compare NHFT waiting times against other trusts. However, we were concerned that variation in waiting times at NHFT meant access to services was not equitable. The makeup of teams also meant that some teams worked in silo and caseloads were not shared by urgency or need, but by locality.

The trust did not have a policy in place on how to manage people who were on the waiting list for mental health services. Staff told us they were worried about the length of the waiting lists and unsure of how to manage these. It was also unclear how teams managed people whose symptoms were getting worse. This seemed to be managed differently across the teams we visited. We raised this with the trust at the time of our review as we were concerned about the risk to people using the service. The trust took immediate action and they informed us that the adult community mental health service had subsequently reviewed everyone waiting for a service. This included calling people to check how they are and that they have support around them, explaining the current position regarding waiting times, when they were likely to be offered an appointment and where necessary, escalating support via the duty system or in exceptional circumstances via crisis resolution home treatment team.

As well as long waiting lists, we were concerned that too many people did not have an allocated care coordinator at the time of our review. The Royal College of Psychiatry Standards for Community Mental Health Services is clear that patients should know who is coordinating their care and how to contact them if they have any questions. However, we found that 724 patients (7% of the LMHT caseload) did not have a care coordinator. This varied across the trust ranging from 7 people in the early intervention in psychosis team without a care coordinator, to 158 people in Newark and Sherwood LMHT. Without the oversight of a care coordinator, staff and services cannot monitor any deterioration of people's condition, putting them at risk of harm.

We were also concerned that this put other people and the public at risk of harm. Through our review we heard of a few examples where a person known to NHFT community mental health services not assigned a care coordinator despite increasing risk to them and to the public. At the time of publication, we were reviewing these incidents in line with our specific incident guidance.

Crisis care

In our 2022/23 State of Care report, we highlighted ongoing concerns around community mental health care and people not getting the help they need when they need it, which can lead to people reaching crisis point.

As part of our review, we looked at the care provided by the crisis teams at NHFT. We found that the crisis teams at NHFT do not always respond to people's immediate needs to minimise any discomfort, concern, or distress, and do not always treat people quickly. This was supported by feedback from people who use services.

Almost all respondents to the 2023 Community mental health survey who provided additional comments, and had used the crisis care service at NHFT, said they felt the service was inadequate for people's needs. People were particularly negative about the crisis helpline, with comments ranging from the helpline being "useless" to being actively detrimental to their care. Some people reported that they were told simply to distract themselves when experiencing suicidal ideation. Advice like this made them feel unheard in moments of acute distress, amplifying feelings of loneliness and isolation.

> "No – the crisis team and the mental health team. If I leave a message, mostly they'll get back but once I rang at midnight and they didn't get back to me till 4am. That was the crisis team."

> "The crisis team response to any crisis was uninformed and disinterested."

NHFT's Crisis Resolution and Home Treatment (CRHT) is a 24-hour, 7 day-a-week service for adults with a serious mental illness who are in an acute crisis which is so severe that, without intervention from this service, the patient would need to be admitted to hospital. The team aims to act to prevent hospital admission by providing intensive interventions in the community. In cases where it is necessary to admit the person to hospital, the CRHT will consider a package of care aimed at speeding up the date of discharge and reducing the length of the admission.

The crisis resolution and home treatment team are also responsible for the management of, and flow to, inpatient acute and psychiatric intensive care beds for people needing an admission from the community to hospital.

The trust's crisis service was in high demand. Between February 2023 and January 2024, the crisis service received 9,210 referrals. It may be that this demand was being exacerbated by the waiting times for people who need longer term support from the LMHTs.

The crisis team aims to see very urgent referrals within 4 hours, and urgent referrals within 24 hours, in line with Royal College of Psychiatrist best practice guidelines. However, how well they met these standards varied. On average:

- Between February 2023 and January 2024, the team saw 72% of very urgent patients within 4 hours, but in December 2023 only 54% of patients were seen in this time
- Between February 2023 and January 2024, the team saw 69% of urgent patients within 24 hours, but in December 2023 only 56% of urgent referrals were seen in this time.

The team's crisis line is run with a third-party provider. People calling the line will initially speak to a call handler who can provide an initial non-medical response. These calls can be transferred to crisis team staff as required. Between February 2023 and January 2024, 130,103 calls were made to the crisis line. Of these, 88,887 (68%) were answered and 35,210 calls were abandoned or the call cut out.

Staff we spoke with told us that they received a high level of complaints in relation to failed calls to the crisis line. However, data from NHFT showed that there were only 5 complaints about the crisis service since November 2023, and none of these related to call wait times or response times. As a result, we were unclear about how these concerns were being escalated and reported.

When we raised this issue with the trust, they told us, "We had previously established that the telephone system used by the crisis line was not meeting the needs of the patient group and presented an organisational risk and was not a stable platform. A working group was implemented to oversee the development of a new platform, which would also accommodate the NHS 111 option 2, mental health calls and as such would require increased capacity. This is now well advanced and expected to be launched in April 2024. Recruitment has also started to support this increased function. The new system will also provide more detailed reports on callers and abandoned calls than we are currently able to undertake."

Access to inpatient beds

Admission to hospital is not the least restrictive option for people experiencing a mental health crisis and remains a last resort. As a result, there are strict criteria for admitting people to hospital, either as an informal patient or when detained under the Mental Health Act 1983.

As highlighted in our 2021/22 Mental Health Act annual report, demand for inpatient mental health services nationally is continuing to increase, with gaps in community care and issues with bed availability adding to this pressure. As well as increasing pressure on inpatient services, gaps in community and social care services can also lead to delays in discharging patients from hospital. While admitting people with mental health needs to hospital remains a clinical decision, there is evidence to suggest that pressures on inpatient beds have had, and continue to have, an impact on decisions about whether to admit them.

We found that issues with bed management and NHFT's ability to admit people to hospital had a knock-on effect on mental health care in the community. Poor access to inpatient beds meant that community teams were having to manage caseloads with higher levels of complexity and acuity. This created greater risk and pressure on community teams, whose therapeutic input lessens as they manage increasing levels of crisis.

After our review, the trust told us that, "As a trust, we prioritise patient safety and acknowledge this causes significant pressure on our services, which at times requires the use of out of area beds. We have invested heavily in bed management support in the form of a bed management team. The team sits outside of the crisis resolution and home treatment team, which provides the clinical gatekeeping function. We have a clinical oversight lead of all patients cited on out of area hospitals with their responsibility being to link in with the respective clinical teams and support the transition back to Nottingham. There is also a quality lead that supports the oversight of our subcontracted out of area placements."

High levels of bed occupancy in mental health hospitals are a known indicator of pressure in other parts of the system. The Royal College of Psychiatrists recommends a maximum bed occupancy of 85%. While we did not see high bed occupancy levels across NHFT, the trust had difficulties with people staying in hospital for long periods and delayed discharges, which affected the flow of patients through adult mental health services. Leaders at NHFT recognised this as an issue and were monitoring it as part of their Board performance reports.

The wards for working age adults and psychiatric intensive care units had a high number of patients (26) clinically ready for discharge, but where transfers were delayed because of the complexity and risk of individual patients. Delayed transfers rose to 11.1% in November across the mental health care group, with mental health services for older people reporting 13.8%. As a result, the trust was not meeting the aims of the NHS Mental Health Implementation Plan 2019/20 to 2023/4, which aims to reduce length of inpatient psychiatric stays to a maximum of 32 days.

When people need treatment in hospital, they should be able to access the inpatient services they need, for the shortest time possible, in a therapeutic environment close to home. However, due to issues with patient flow through NHFT's acute and psychiatric intensive care unit inpatient beds, we found that a high number of people were being admitted to services out of the local area.

We have been reporting on our wider concerns about out of area placements for a number of years. As we highlighted in our 2022/23 State of Care and 2021/22 MHA annual reports, out of area placements are not beneficial to patients, they impact on consistency and quality of care people receive, limit the opportunities to work with a person's local care coordinator and reduce the likelihood of people being able to stay in close contact with their loved ones throughout their admission. People being placed in hospitals far from home and away from friends and family can also increase the risk of closed cultures developing.

Between 1 January 2022 and 31 November 2023, NHFT reported 190 inappropriate out of area placements to the Mental Health Services Data Set (MHSDS). In total, this meant that patients were out of area for 6,450 days. Between 2022 and 2023, the monthly average number of days that NHFT patients were placed in inappropriate out of area placements nearly doubled from 152 to 420.

The January 2024 NHFT board report highlighted that there were 846 out of area placements days reported for November 2023, the highest for 24 months. The farthest distance travelled by individuals was 301 kilometres (187 miles) between March to May 2023. This was on the trust's risk register and was being monitored.

From 2022 to 2023, the Midlands region saw an increase of 23% in inappropriate out of area placements. NHFT accounted for 15% of all inappropriate out of area placed patients in the Midlands in 2023.

Quality of care

Key points:

- When in contact with community mental health services, most people said staff had treated them with kindness, compassion and dignity. However, people in inpatient services were less positive and described concerns around the attitudes of staff, and restrictions.
- The quality of care planning and risk assessment was inconsistent, and we saw limited evidence of patients and their families and carers being involved in their care plans. In addition, assessments were not always personalised and holistic.
- NHFT had redesigned and reorganised its community mental health teams in line with national guidance, but pathways of care were not clear and the make-up and size of teams did not meet the needs of the local populations.
- Care and treatment provided by NHFT was not always in line with the Mental Health Act 1983 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and current evidence-based good practice and standards.
- Discharge planning across community mental health and crisis services was not robust, with people describing concerns around being discharged too soon or leaving inpatient services in a worse state than when they arrived.

Compassion, kindness and dignity

Whether people were treated with kindness, compassion, and dignity varied across services at NHFT.

As part of our review, we looked at the trust level responses to the 2023 Community mental health survey for NHFT. Overall, respondents to the survey were positive about staff interactions, with staff described as “compassionate”, “kind”, “caring”, “professional”, “friendly”, and “supportive”.

During our site visits of LMHTs and crisis services, we observed 5 direct sessions of care between staff and people using the service, and found staff to be kind, compassionate and understanding. We also found that staff understood individuals’ needs and supported people to understand and manage their care, treatment, or condition.

As part of our review, our Experts by Experience also spoke with 27 people using community mental health and crisis services and 10 of their carers, friends and family. Most said that staff were kind, compassionate and treated people with dignity. Some people described staff going “above and beyond”. People who used the crisis services described it as a “fantastic service” and told us that staff were kind and treated people who use services and their carers with dignity and respect. People told us:

> “They were so kind to me when I was crying in appointments, the psychiatrist had a great bedside manner, eye contact, her face shows she cares. I don’t feel belittled, she discusses options with me openly and honestly. The Community Support Worker is really compassionate, empathetic, a warm human being. I have a wonderful rapport with them and I feel I am respected and treated with dignity.”

> “The Community Psychiatric Nurse’s approach is that he is very compassionate, professional and competent, he doesn’t promise what he can’t give, he gives explanations, builds on trust, communication is clear, direct and professional. I have limited responses to certain things, with them for the first time I have trust and respect for everything he has helped me with. I have achieved more in the last 6 months than in the last 14 years.”

> "I was always treated with kindness, they were always willing to listen, they would remember lots of details about me, my children's names, they were interested in me as a person. If I didn't have the courage say to ring the doctor, she has done that for me, has got the doctor to ring me, she wrote a letter to help me get my current home, she got on to the council, so kind."

However, we also received negative feedback from people using services. Most negative feedback we received came from people using inpatient services. They described not being listened to and that staff were "rude", "unprofessional" and "dismissive".

Between July 2023 and February 2024 our Mental Health Act reviewers carried out 20 visits to different parts of the trust. During these visits, reviewers found evidence of blanket restrictions being used and that, as a result, staff did not always ensure they protected people's privacy, dignity, and human rights.

The findings of these MHA reviewer visits triggered our October 2023 inspection of wards for adults of working age and November 2023 inspection of wards for older people.

Other feedback we received from people who used services, their friends, family and staff from July 2023 highlighted concerns around basic needs not being met in inpatient settings. Issues often included the cleanliness of rooms, issues with pests, lack of bedding or a mattress, lack of suitable clothes, and the hospital not providing personal care assistance.

Care planning and involvement

The Royal College of Psychiatry Standards for Community Mental Health Services is clear that every patient should have a written care plan that reflects their individual needs. It states that when developing the care plan, staff members should collaborate with patients and their carers (with patient consent) and offer the patient a copy of their care plan.

Feedback from people who used services, their friends and family and staff showed repeated concerns about a lack of person-centred care, including people not feeling involved in creating their care plans or with changes to their medication, feeling dismissed, and not listened to. There were also recurring reports of care plans not being shared, or individuals not being updated about any changes to them. One person told us:

> "I didn't know who my named nurse was until week 3, I didn't see a care plan until a week ago. When I did see it, it was full of errors and not worth the paper that it was written on."

Families also felt excluded, for example, we heard reports of staff refusing to speak with family and not allowing them to attend ward rounds or meetings despite the person wanting their family's involvement and for them to advocate on their behalf.

This was supported by findings of the November 2023 Healthwatch report which found issues with professionals not listening and/or not communicating effectively, as well as feelings that services revolved around 'tick-box' exercises.

In general, people identified the need for more person-centred care that considers people as individuals instead of focusing solely on the diagnosis. Some also suggested that family and loved ones need to be involved more in the treatment plan.

As part of our review, we looked at more than 30 care records of people who use services to assess the quality of care planning and involvement of people and their carers and families. We saw that the approach to care planning and risk assessment was inconsistent and there was limited evidence of people being involved in their care plans. Training for staff in the writing of holistic and person-centred care plans was not mandatory. This was not in line with Royal College of Psychiatry Standards for Community Mental Health Services, which require that people have a risk assessment and management plan that is co-produced where possible, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality).

The people we spoke with who used community mental health and crisis services and their carers agreed that care planning was inconsistent. While some people we spoke with said that they had a care plan and risk assessment, which they had been involved in writing and updating, 4 other people we spoke with did not know whether they had a care plan.

These findings reflect the findings of our November 2023 inspection of wards for older people with mental health problems. On this inspection we found that care plans were not always personalised and holistic and they did not give a holistic viewpoint of the patient as a whole.

Quality of care and treatment

How services are structured has an impact on the quality of care people receive. To support the delivery of the NHS Long Term Plan, NHS England commissioned the Royal College of Psychiatrists to develop a new place-based community mental health model that provides more effective support, care and treatment for adults. The Royal College of Psychiatrists Community Mental Health Framework for Adults and Older Adults suggests that at the centre of the new model, should be an integrated, single core community mental health service that delivers:

1. assessment and advice or brief treatments

2. specific psychological and pharmacological interventions and care planning and coordination
3. support to access community assets.

NHFT had redesigned and reorganised its community mental health teams in line with the Royal College of Psychiatrists' framework. However, we found that teams were not well structured and the make-up and size of teams was not standardised and did not meet the needs of the local populations.

The Royal College of Psychiatrists' framework outlines that, to give people the best chance to get better and to stay well, it is critical that in the new community based offer, adults and older adults with severe mental illness can access evidence-based NICE recommended psychological therapies in a timely manner.

We found that the approach to psychological therapies in community mental health and crisis services was inconsistent. In addition, care and treatment provided by the trust was not always in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Mental Health Act 1983, and current evidence-based good practice and standards, such as the community mental health framework. The length of waiting lists also meant that the trust was not able to deliver care and treatment in a safe and consistent manner.

At the time of our review there were 724 people who were not allocated to a care coordinator, and whose needs were complex and high risk. The Royal College of Psychiatrists' framework highlights the important role of care coordinators for people with more complex needs:

> "Interventions for people with more complex problems are likely to be multi-professional in nature with one person having responsibility for coordinating the care and treatment. This coordination role can be provided by workers from different professional backgrounds."

Our review found that the structure of pathways for assessment and treatment for people with complex mental health problems (other than to early intervention in psychosis) was unclear. This meant that staff felt their specialist skills were diluted, and that people were not able to access specialist care and advice in a timely manner, with clear access to those services.

The Royal College of Psychiatrists' guidance acknowledges that, as part of the new community mental health model, there need to be services that have the expertise and capacity to care for people with complex needs. This includes:

- specialist community mental health teams to provide care and treatment for people with more complex needs, such as those with an associated personality disorder.
- rehabilitation teams to provide support for people with long-term complex needs who may need additional support with activities of daily living and community support. This includes, for example, support with accommodation, care coordination, and additional support and planning tailored to meet specific rehabilitation needs.
- specialist treatment services for people whose needs cannot be effectively met by core community mental health services. This includes, for example, perinatal mental health services, eating disorder services or community forensic mental health services.
- support for those who may be at risk of being excluded from their community, such as rough sleepers, and people leaving the criminal justice system or people who are frequently in contact with the police.

While it may be the case that professionals with these skills were in place at the NHFT, the pathways to receive treatment from them were complex, unclear and waiting times were lengthy. This meant that some people with complex needs who presented with high risks were lost in the system and were not receiving appropriate support.

In February 2023, NHS England produced guidance on Implementing the early intervention in psychosis access and waiting time standard. This defines the standard as:

> "At least 60% of people with a first episode psychosis would start treatment with a NICE-recommended package of care with a specialist early intervention in psychosis service within 2 weeks of referral."

As of January 2024, NHFT's early intervention in psychosis service was seeing 86% of referrals in less than 2 weeks. This had improved from 80% in August 2023.

Discharge

We found that the discharge planning process across the community mental health and crisis services was not robust, with little evidence of discharge planning in care plans.

As part of our review, we looked at a sample of prevention of future death reports. Several of these reports raised concerns about the quality of care provided by NHFT and individuals' discharges. Issues included a 'lack of clarity of thinking' in the multidisciplinary team in relation to the decision to discharge, and people not being involved or notified in this decision. In one report, the coroner noted that:

> "[X] was called and invited to agree to the withdrawal of services. Such a practice runs the significant risk that patients who are less assertive or who have poor insight into their mental health needs will be said to have 'agreed' that a service is no longer required."

This mirrors feedback from the Community mental health survey and people who use services. People described issues including being discharged "too soon" or leaving inpatient services in a "worse state" than when they arrived. Some people felt they were not ready to be discharged, especially if they had been receiving support for a long time, or there was no emergency plan or community support in place before being discharged. This could lead to people being readmitted to services very soon after discharge or rapidly deteriorating in the community.

Responses to the community mental health survey highlighted multiple incidents of people being discharged from inpatient services without the support of community mental health teams in place, or a lack of timely follow-ups from the community mental health team. Feedback included comments as follows:

> "Stop pushing for patients to be discharged against their will. I have been in the system a long time, that is because my illness has proved treatment resistant... Removing me from services is as good as a death sentence."

> "Doctors shrug and said 'don't really know what to do'. Had an episode in front of [the] mental health worker and was discharged next day. No support put in place afterwards. Locum doctor said, 'We can't help unless you actually want to kill yourself.'"

As part of our review, we looked at how GPs were involved in discharge planning from inpatient mental health wards, but found no evidence of them being involved in this. University of Nottingham Health Service, who we assessed as part of our review, told us that their GPs have never been invited to be involved in assessment planning.

Of all people discharged from community mental health, crisis and early intervention in psychosis teams between 1 January 2023 to 31 December 2023, 12,712 (96%) were discharged back to their GP. Of the discharges back to GPs, only 3,657 (29%) were recognised as needing ongoing mental health care and treatment.

In February 2024, the Parliamentary and Health Service Ombudsman (PHSO) published its report Discharge from mental health care: making it safe and patient-centred, which looked at failings in discharge and transitions from mental health settings from their casework. The report highlighted that unsafe discharge potentially leads to poorer outcomes for people and risks repeated cycles of readmission, and that discharge experiences and outcomes are impacted by:

- poor record keeping
- failings in carer and family involvement
- poor communication between clinical professionals and teams in planning transfers of care.

Staff in the early intervention in psychosis services told us that historically there was not a discharge flow chart in place. However, one had been created in June 2023 following the deaths of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber. In one of the local mental health teams, they had developed a project to consider which patients may be ready for discharge from the team. Leaders talked of some team members' reluctance to discharge patients due to the complexities of their caseload, as well as team members' anxiety about working with new people.

The PHSO supports the view that the community mental health framework:

> "... refers to the ambition of 'maximising continuity of care' to make sure there is no care 'cliff-edge'. It aims to end a system that is centred around 'referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support'. Instead, it represents a 'move towards a flexible system that proactively responds to ongoing care needs'."

However, the discharge and transition processes at NHFT were not yet in line with the community mental health framework and affected the outcomes of people who use services.

Safety of services

Key points:

- We were concerned about the safety of services at NHFT. In community mental health and crisis services, and some inpatient services, the trust did not have enough staff to keep patients safe.
- High demand for services, and complex staffing arrangements meant that staffing levels were not equitable to caseload sizes and the number of referrals received.
- How well staff assessed and managed risk in community health and crisis services varied, and we found that the approach to risk assessment was inconsistent. This increased the risk of people coming to harm.
- While there was evidence of good practice around safeguarding, feedback from people who use services highlighted worrying evidence of safeguarding concerns, with multiple accounts of individuals being placed in harm's way due to the actions or inactions of people responsible for their care.

Staffing levels and skill mix

As highlighted in our 2022/23 State of Care report recruitment and retention of staff remains one of the biggest challenges for the mental health sector, with the use of bank and agency staff remaining high and almost 1 in 5 mental health nursing posts vacant.

We found some concerns around staff turnover and sickness rates at NHFT. While data shows that the trust is not an outlier for sickness or turnover rates compared to other trusts, results from the 2022 NHS staff survey show that the proportion of staff who have felt burnt out due to work is worse than the national average. The survey also shows that the proportion of staff who feel the trust is adequately staffed is worse than the national average.

The vacancy rate at NHFT, as reported in the trust's January 2024 integrated performance report, was 11%. This had improved since December 2022 when it was 14.9%. Across all community mental health and crisis teams there were 38.58 vacant posts. The highest level of vacancies was in local mental health teams (30.97 vacancies). Most vacancies were for band 6 community mental health nurses.

Staffing arrangements in community mental health and crisis teams were complex, and it was unclear how staffing levels had been reached as they were not equitable to caseload sizes. For example, the budget for the Ashfield team was relatively the same as the budget for the Broxtowe and Hucknall team, yet Broxtowe and Hucknall team had 400 more people on their caseload. The City South team had the smallest team caseload, but had 7 more whole time equivalent staff.

We found several vacancies for psychologists across all teams at NHFT, and not all teams had access to the same number of practitioners. This is an issue we have seen elsewhere and, as highlighted in our 2022/23 State of Care report, we continue to see recruitment difficulties for mental health services in all areas, such as for psychologists.

We were concerned that all psychology posts in the crisis resolution and home treatment team were vacant at the time of the review. Early intervention in psychosis teams also had vacancies for psychologists and at the time of our review there were no psychologists in post. This is not in line with NHS England guidance or NICE guidance on access to psychological therapies, and means that people may not be able to access psychological treatments in a timely way.

During our review, people who use services told us that they felt there were not enough staff across many locations, including Lings Bar Hospital and Seacole Ward of the Wells Road Centre. Staff-to-patient ratios at these locations fell well below the required standards. For example, at times, we heard that there were only 5 staff available for 24 patients. This significantly increased the risk of harm to both staff and patients.

At another rehabilitation unit, a person using the service reported that there was only 1 nurse and 2 healthcare assistants on a night shift, highlighting the challenge of providing even minimal care under such staffing constraints. Specific cases of staff being removed from their assigned wards to cover shortages elsewhere suggest issues with resource management, increasing the risk of harm and compromising the quality of patient care.

These issues reflected findings from our inspection of acute wards for adults of working age and psychiatric intensive care units in October 2023, and our inspection of wards for older people with mental health problems in November 2023. In both of these inspections we found that the services did not have enough staff to keep people safe. We also found evidence of high vacancy rates and high use of agency staff to fill shifts. As highlighted in our 2022/23 State of Care report and 2022/23 MHA annual report, the use of agency staff increases the risk to people using services as it can be difficult for agency staff to build meaningful therapeutic relationships and provide personalised care to people they are not familiar with.

To address staffing issues, we heard examples of staff being moved from their assigned wards to cover shortages elsewhere, suggesting issues with resource management. As we highlight in our section on Rampton Hospital, moving staff around to cover gaps elsewhere increases the risk of harm and compromises the quality of patient care.

As reported in our section on access, demand for support from LMHTs was high, with 9,492 open referrals to the 12 LMHTs. However, we found that teams were not well structured and the make-up and size of teams was not aligned to the needs of the local population. This meant caseloads varied between the LMHTs. Broxtowe and Hucknall, and Newark and Sherwood had the highest caseloads (1,092 and 1,125 respectively), while City South had the lowest (616).

While we found that the caseloads of individual staff in community mental health teams did not prevent them from giving each patient the time they needed, as reported in our section on access to care, this meant that people were facing lengthy waits to receive care and treatment. However, we did find examples where a number of people with complex needs who were high risk were not assigned a member of staff who was able to coordinate their care.

At the time of the review, the trust were progressing a staffing review, which would be completed by March 2024 to support them with staffing decisions across services.

Training

As part of our review, we looked at NHFT's training data for the community mental health teams to assess whether staff had received the right type and amount of training to keep people safe. We found that staff had not completed all training and there was a risk that people may not be being cared for safely.

At NHFT there are 16 different mandatory training programmes that staff are required to complete. The trust had a target for 75% of staff to have completed mandatory training at any one time. We found that the rates of community mental health staff who had completed the mandatory training varied by training programme and by team. Figures also varied month on month, but 6 training programmes had consistently high rates of completion of 88% and above. These included training on clinical risk, equality and diversity, and promoting safer and therapeutic services.

However, for the 12 months between January 2023 and December 2023 there were 3 training programmes that were consistently below the 75% target:

- basic life support / hospital life support
- breakaway / management of violence and aggression
- Infection prevention and control – level 2.

Three out of the 12 local mental health teams stood out as having low numbers of staff who had completed mandatory training. These included:

- LMHT City North – below the 75% target for 13 of 15 training programmes they are eligible for.
- LMHT City East – below the 75% target for 9 of 15 training programmes they are eligible for.
- LMHT Broxtowe and Hucknall – below the 75% target for 8 of 15 training programmes they are eligible for.

These figures support the findings from our inspection of wards for older people with mental health needs in November 2023, where we found that staff had not always completed and kept up to date with their mandatory training. On this inspection, we were concerned that not all staff had received enough training on observing patients safely and that the mandatory training programme was not always comprehensive and met the needs of patients and staff.

Safeguarding

Through our review we found that staff understood how to protect patients from abuse, and had achieved reasonable levels of training in safeguarding children and adults. Staff we spoke with during the review had a good knowledge of safeguarding processes and procedures, and had access to a range of policies and procedures to support them to safeguard the people in their care. They were also able to access support from the trust's internal safeguarding team.

However, leaders in one community mental health team recognised that the team had not always reported safeguarding concerns. When safeguarding concerns were identified, leaders instructed the team to complete an incident reporting (IR1) form retrospectively. They felt the non-reporting had developed from a culture of lack of confidence and, before their appointment, staff did not have any autonomy. They also felt there was a training issue. They told us that they had asked the trust's safeguarding team to support with additional training but were told this was not something they did, and the online training was enough. They have encouraged staff to use the safeguarding team for advice if they are unsure.

While there was evidence of good practice around safeguarding, feedback from people who use services highlighted worrying evidence of safeguarding concerns, with multiple accounts of individuals being placed in harm's way due to the actions or inactions of people responsible for their care. In the feedback we received, we found examples of bullying and exploitation, where individuals made vulnerable by their circumstances were manipulated or harmed by others. In one piece of feedback, we were told:

> "This patient is also not suitable for this ward as her needs are more complex and staff do not seem to know what to do with her. I have even seen staff call her a brat in front of other patients family members and remove her ear defenders stating 'this is why you can't hear.'"

In their feedback to us, people also told us about abusive behaviour by staff towards patients and prisoners, ranging from verbal abuse to physical assaults. One safeguarding referral we saw stated that there was "frequent verbal abuse from staff, threatening and humiliating manner at [the] patient without reasonable cause. Staff would act in derogatory and abusive manners. One patient could not go out on leave as he would not share his chocolate with staff."

The use of restrictive practice can be traumatic for people and have a devastating impact on them. We are clear that restrictive practice must never be used to cause pain, suffering, humiliation or as a punishment as highlighted in our reducing restrictive practices policy position.

Managing risk

How well staff assessed and managed risk in community mental health and crisis services varied, and the approach to risk assessment was inconsistent. In our review of records, we found that many people who use services did not have an updated crisis or risk plan.

This reflected feedback from people who use services, which highlighted significant shortcomings in managing risk. For example, we heard of repeated instances of risk to individuals' physical and mental health that was not adequately addressed. This included failing to manage interpersonal conflicts that escalated into violence, improper handling of medication, and neglecting the mental health needs of individuals in distress. Other issues included people self-harming without intervention, and individuals being cared for in conditions that made their mental health issues worse, such as being isolated or exposed to bullying.

We also found issues across a number of inpatient settings, excluding Rampton Hospital, relating to the falsification of records and, as a result, a number of staff were suspended. Concerns around record keeping were raised following the inquests into the deaths of 2 inpatients. Of the staff suspensions, 22 were a result of reactive work to improve patient safety across NHFT services following the inquests into the deaths of the inpatients. CCTV audits carried out by NHFT uncovered alleged incidences of poor patient care and falsification of mental health observations, which led to these suspensions. Through our inspection in October 2023 we found similar concerns over the falsification of records following an attempted suicide. This was immediately added to the investigation already being carried out by NHFT.

Senior leaders told us that as part of the transformation of community mental health services, a safety process was being implemented that would allow teams to 'RAG' rate people in their care each day according to their level of risk and the severity of their needs. These individuals would be discussed at daily risk assessment meetings (RAM) to enable teams to manage and respond to risk. Leaders told us that this was being 'rolled' out, which meant that not all teams were using this system. We also found that teams did not keep clinical records of RAM meetings to allow audit and learning.

In addition, we found issues with how NHFT managed environmental risks in their estate, and we were not assured the trust was taking immediate action to manage these risks. For example, we found that the Newark community mental health base was not fit for purpose; people who use services were able to access all toilets, all of which had ligature points. We asked about ligature risk assessments and were told that the quality and safety team had reviewed these. We were also told that people who use service would not be in areas on their own and if they were using a toilet staff would be aware and waiting. However, the toilet near the waiting area could be accessed by people without being seen. In addition, there were no window restrictors in place. In first floor rooms, including the bathroom, the windows could be opened as wide as a person chose to push them. This issue was raised at the last CQC inspection in 2022 for community based mental health services for older people.

To keep staff and people who use services safe, services should have a call system in place to enable people who use services, staff and visitors to alert staff that they need support. In community services, staff can find themselves interviewing people who use services alone and may need immediate assistance if the person becomes aggressive or violent, or there is a medical emergency. Staff at Newark told us that they all had personal alarms. However, the contract was up in October 2023 for the old system, and there was about a month where no one had any alarms. In addition, there were no push button alarms in offices should staff need to alert others for immediate assistance, which posed a risk to the safety of staff.

Leadership and governance

Key points:

- There have been a lot of changes in leadership in recent years, with 3 out of the 7 executive directors having taken up post since 2023.
- Leaders were aware of some of the current risks in safety and quality of services, but we were concerned senior leaders did not appear to have clear oversight of these risks.
- While there was evidence of the trust taking action to address safety concerns, including those raised by our review, we are concerned that trust activities are predominantly reactive.

Overview

In the timescales for this review, it has not been possible to entirely understand the trust's governance structure and whether the board functions effectively and cohesively. We will review this as part of our regulatory activity in the future.

Over the last 5 years there have been significant changes to the executive directors at Nottinghamshire Healthcare NHS Foundation Trust (NHFT). Three out of the 7 executive directors have taken up post since 2023, and another 2 since 2022, one has been in post since 2020 and the other since 2009. Only one director has experience in high secure hospitals. See also the section on leadership at Rampton Hospital.

While there were some established policies and governance processes in place, these were not fully embedded. For example, NHFT had a 'did not attend' (DNA) policy, which acknowledged that failure to attend appointments or the cancellation of appointments can indicate a risk or safety concern for the individual. However, the policy was overdue for review, and had not been updated since October 2021.

Our concerns around governance processes reflected the findings of our last well led review of the trust, published in November 2022, which found:

> "Governance systems and processes, and the strategy of the organisation had been extensively reviewed since our last inspection but was not fully embedded into services. It was not clear how the divisional teams used governance processes and measures to make positive, sustainable changes. Many of the leaders within mental health and community health core services did not use the trust governance process and reports effectively within their roles."

Our findings were similar to feedback from staff who told us that there had been a lot of changes in leadership across the trust recently. We heard that these had been implemented without apparent support or comprehensive planning for the staff affected. As a result, staff told us that leadership felt disorganised and that there was lack of oversight. While staff spoke positively about their local managers, they told us that they didn't really know who the executive team were and referred to them as "them up there". This comment is in contrast to feedback from the trust who told us about the work carried out by the executive team to improve visibility and strengthen leadership. Over the previous 12 months, the executive team told us they had visited around 200 clinical services across the trust.

Management of risk, issues and performance of services

Patient safety is at the heart of health and social care quality. In order to keep people safe, healthcare organisations must have a plan in place that identifies risks to people who use their services and allows them to stop incidents before they happen. Among other benefits, effective risk management can:

- help the provider maintain patient safety
- minimise harm and damage
- drive organisational learning.

We found that senior leaders did not appear to have clear oversight of the risks to quality and safety of care in services, and had not acted with the required grip and pace to make rapid improvements. This was reflected in comments from staff who told us that despite the high-profile cases involving the service, senior leaders have not visited to support them and the chief executive had cancelled a meeting with them.

A few members of staff suggested the trust's activities were predominantly reactive, focusing on addressing immediate issues as they arise. One member of staff described an environment that feels chaotic and 'drama orientated', even without major incidents or system pressures.

We found that the trust monitored and measured outcomes and quality in a variety of ways, including through its integrated performance report. Presented to the trust's board each month, the report provides data on how the trust is meeting its key performance indicators and quality measures. Areas of focus included:

- quality of care
- people and culture
- community health services
- forensic services
- mental health services
- trust finances.

Each risk outlined in the performance report had a key action identified. The trust had several quality improvement plans, recovery plans and ongoing work noted to resolve these issues. However, we were concerned that these were not being addressed fast enough and had remained as risks for significant lengths of time.

To ensure care is person-centred and designed around the patient journey, most NHS trusts have structures in place to identify and bring together groups of people. Each trust has their own approach that can be based, for example, on geography, diagnosis or type of service. NHFT grouped patients by types of care, and had 4 groups: mental health care group, community (including offender health care), forensic and corporate. The trust had a risk register for each care group.

The mental health care group risk register, which was updated on 23 January 2024, contained 20 risks that reflected many of those we identified during our review, including:

- incidents of violence and aggression
- staffing
- bed management
- crisis call access
- physical health monitoring
- environmental concerns (including ligatures)
- delays in serious incident reporting and learning.

Some of the risks to safety and quality were identified in November 2023. Since then, the trust had taken a number of actions, including reviewing performance and quality together at one single meeting, allowing leaders to triangulate issues and early warning signs from near misses, serious incidents and complaints. The trust had also commissioned an external review into community mental health and crisis teams, and was working with other NHS trusts to learn from their modelling and outcomes.

However, there were also some areas of high risk that the trust had not identified and taken action against. These included:

- gaps in mandatory training
- supervision and appraisal
- risks associated with waiting lists
- multidisciplinary team working.

Following our review, we shared our concerns about community mental health and crisis services with NHFT's executive team. They responded quickly with a clear action plan to address our concerns. We will follow up on this through engagement with the trust and future inspection activities.

Reporting and learning from patient safety incidents

Patient safety incidents are any unintended or unexpected incidents which could have, or has led to harm for one or more patient(s) receiving healthcare. Reporting them supports healthcare organisations to learn from mistakes and to take action to keep patients safe.

When patient safety incidents or preventable incidents are reported, they are graded according to the impact or harm they have caused to patients. This ensures consistency and allows local and national comparison of data to learn from incidents. In the National Reporting and Learning System (NRLS) (a central database of patient safety incident reports), incidents are graded by degree of harm as follows:

- No harm
- Low (minimal harm – patient(s) required extra observation or minor treatment)
- Moderate (short term harm – patient(s) required further treatment, or procedure)
- Severe (permanent or long-term harm)
- Death (caused by the patient safety incident).

To assess how well NHFT monitored and learnt from patient safety incidents, we reviewed data from the NRLS from 1 February 2023 to 31 January 2024. During this period, the trust reported 13,766 incidents to the NRLS. However, from 2 October 2023 the trust had stopped reporting to NRLS as they transferred reporting to the Learning from Patient Safety Events (LSPSE) service. Due to transferring from NRLS to LSPSE, we found that there was a backlog in processing some NRLS incidents, so we did not have access to all incident data.

Most incidents reported to the NRLS related to 'self-harming behaviour' (35%) and implementation of care and ongoing monitoring/review' (22%). Although not picked up via the incident type figures, there were at least 267 incidents that involved patient pressure ulcers (identified by searching for 'pressure ulcers' in the incidents description), yet these were almost always reported as 'implementation of care and ongoing monitoring/review' incidents.

Most (41%) incidents were reported within 14 days. However, 15% took over 60 days. All of these incidents were recorded as no or low harm. The median time taken to report incidents was 19 days for NHFT, compared to 33 days for all similar trusts.

Of these 13,766 incidents, 96% were no or low-harm incidents. Most incidents were related to adult mental health, forensic mental health, and community nursing specialties. Community mental health, early intervention and crisis services had reported 1,499 of these incidents.

The high rate of no or low harm incidents across the trust may suggest that staff and leaders are not recording the severity of incidents appropriately. When incidents are reported as minimal or no harm, it is less likely that they will be reviewed by senior leaders and that there will be learning from these incidents. This increases risks to patients and staff. We will review this data in further detail in line with NHFT's risk reporting procedure and matrix at the next well led review.

There were some reports of environmental incidents. These largely involved early incidents of people who use services being locked in their hospital rooms for longer than agreed times because of staff shortages. Nearly all of these incidents were at Rampton Hospital.

Following our review, NHFT responded to our concerns and told us that they have a patient safety team that reviews every incident for accuracy, completeness and consistency. Any anomalies in grading, that are not consistent with the incident grading matrix, are re-categorised by the patient safety team. The member of staff who reported the grade incorrectly is informed about the reasons for this so they can learn for the future.

NHFT also told us that they review incident data, for all types of harm, to understand themes and trends, as well as identify potential risks and where improvements may be needed. The trust is in the process of developing a quarterly patient safety incident report, which will feed into the patient safety group.

Feedback from staff, along with evidence of poor quality internal investigations and lack of engagement with the inquest process, suggest that the trust did not have a learning culture. For example, our review of coroner reports highlighted concerns with the serious incident investigation process or reports, inaccurate or false information, the trust's failure to identify key concerns, and witness statements that the HM Coroner "found difficult to reconcile with the chronology of events".

Staff also told us that there was little time for reflective practice and we found that they did not always know what this meant.

We also found that the trust did not learn from serious incidents well and make rapid changes to services to improve safety and reduce the chance of them reoccurring. During our review we saw evidence to suggest there were previous cases where mental health played a factor in harm to others. At the time of our review, the trust told us they had been advised against carrying out their own internal investigations as these incidents were under criminal investigation.

We know that the care of people with complex needs in the community can be complex and high risk. However, the fact that these incidents took place within a short time may suggest a wider issue around the safety of services in Nottingham. NHFT had not made rapid changes in response to these incidents, and we found ongoing failures, such as significant waiting times and people not being allocated a care coordinator. This highlighted that lessons had not been learned and risks had not been wholly addressed.

Leaders at the trust told us they were aware of the need to rapidly develop a learning culture across the organisation and were taking action towards this. The actions included:

- learning forums for staff every 6 weeks, which were to be co-facilitated by people with lived experience
- the appointment of 2 new patient safety leads
- the implementation of the new NHS England Patient Safety Incident Response Framework (PSIRF).

Culture

In organisations with a good culture, we would expect to see leaders who are compassionate and inclusive so staff feel respected, valued and supported. In these types of organisations leaders at every level live the vision and embody shared values, encouraging candour, openness, honesty, transparency and challenges to poor practice. This supports staff to feel confident to speak up when things go wrong, and helps to protect the safety of people who use services.

We were concerned about the culture at NHFT, but due to tight timescales for this review, we were not able to look at this in depth and we would benefit from exploring this further on future inspections and assessments. Feedback from staff showed evidence of bullying and harassment by senior managers towards employees. Allegations included inappropriate conduct among senior nursing staff and favouritism in staff rota assignments, contributing to a workplace environment that lacks professionalism and effective team dynamics.

Staff referred to there being a toxic service environment and told us that staff with poor professional conduct had been promoted. In addition, staff in several departments, such as Lings Bar Hospital and Seacole Ward at the Wells Road Centre, told us they felt unsupported by managers due to operational strain, breaches of confidentiality regarding staff personal issues, and a prevailing sentiment of being urged to "get on with it" amidst challenges. Some staff also raised concerns about closed cultures on certain wards.

The concerns raised by staff are supported by the findings of the trust's quarterly Freedom to Speak Up Guardians report, which was presented to the NHFT board in January 2024. Of the 141 cases reported to the 2 Freedom to Speak Up Guardians between July and September 2023, just over a quarter (47 out of 141) related to inappropriate attitudes and behaviours, including bullying and harassment. Other themes included:

- low staffing levels
- low staff morale/burnout
- high sickness levels
- sickness management
- wellbeing support
- high levels of patient acuity and shortage of experienced staff.

The incidents of bullying, which occurred over extended periods, were acknowledged and upheld by the trust, suggesting a persistent issue with workplace culture and the behaviour of senior leaders. The feedback we received from staff also highlighted the need for leaders to engage more effectively with staff grievances to foster a more open and supportive workplace culture.

We also found concerns around transparency, accountability, and ethical standards. For example, some staff reported issues including:

- misrepresentation to external organisations like CQC, this included for example, changing things in people's rooms so they appeared a certain way (causing distress to the individual), or preventing us from speaking to some individuals, and changing staffing levels during our inspections
- alteration of clinical records
- ongoing inappropriate practices despite identified breaches of guidance, this included for example, incidents of staff misconduct, often relating to allegations of abuse/bullying and falsification of documents, which are known but no action was taken.

Trust improvement work

Following our review, we shared our concerns about community mental health and crisis services with NHFT's executive team. They responded in a timely and efficient manner with a clear action plan to rectify our high-risk concerns. The trust told us that they would take the following actions:

- Strengthen the leadership of local mental health teams and crisis teams to increase capacity and leadership experience in mental health.
- Identify everyone waiting for assessment and a treatment or care package.

- Contact everyone waiting for care and treatment and ensure they have a clear plan based on current need.
- Monitor the progress in each team through daily huddles.
- Review the purpose and format of the risk assessment meetings (RAMs), supported by a revised standard operating procedure. The deputy chief nurse and suicide prevention lead will spend time at the RAM meetings in each team embedding changes and ensuring consistency and effectiveness. The trust told us this work had already started and was due to be completed at the beginning of March 2024.
- Review and make changes to the waiting well policy to ensure that people are cared for safely while waiting to be triaged or receive care and support.
- Complete a review of the did not attend policy.
- Strengthen the operational systems and processes across local mental health teams and crisis teams, and revise the governance arrangements with strengthened protocols for escalating concerns.
- Identify teams with disproportionate pressures and put in place staffing arrangements to ensure minimum staffing levels are achieved by early March 2024.
- Carry out a review of community caseloads to identify people who were not engaged or at risk of disengaging, with each team tasked with reviewing the treatment and care offered against their risk profile.
- Establish a monthly programme of audits, which will include monitoring the quality of safety plans.

The trust told us that in the medium term they would:

- review ligature risk assessments and all community bases
- review the crisis line offer in its entirety

- commission a thematic review of homicides
- commission a review of crisis teams and community mental health teams.

System working

Key points:

- People who use services told us they experienced difficulties when transferring between inpatient care and crisis care into community care, and services did not always ensure continuity of care when people were being transferred.
- Communication between services was also an issue, with people expressing frustration at the lack of communication between inpatient services and the community mental health teams.
- Due to ongoing concerns with the quality of care provided by NHFT, the integrated care board and NHS England have a range of processes in place to oversee and improve care provided. However, we were concerned that change was not happening quickly enough.

Continuity of care between services

Care that is person-centred and coordinated across healthcare services can improve outcomes for people and reduce:

- confusion
- repetition

- delay
- duplication and gaps in service delivery
- people getting lost in the system.

Responses to the 2023 Community mental health survey and other feedback from people who use services highlighted difficulties in transitions of care for people discharged from inpatient services or the crisis team into community care. We heard that community mental health referrals were not always followed up in a timely way, which affected people's mental health and left them feeling unsupported. Some people told us that moving between services felt fragmented and that it was difficult to move from one service to another. This was also the case when people had to move from one geographical area to another, either from other services to Nottinghamshire or within Nottinghamshire.

This feedback was supported by the findings of 4 prevention of future deaths reports where the HM coroner raised that individuals with complex mental health conditions, including psychosis and suicidal intent, had been unable to access mental health services.

We found that services did not always ensure continuity of care, including when people moved between different services. While some staff told us there were close working relationships between teams, others were less positive about being able to contact other services internally.

As highlighted in our section on access to care, we found that complex pathways and systems did not ensure that people were not able to fall through the cracks into being unsupported or unsafe. However, a small number of respondents to the 2023 Community mental health survey were positive about the support they received from occupational therapists, particularly while they were on the waiting list for talking therapies.

Communication between services was also an issue, with people expressing frustration at the apparent lack of communication between inpatient services and the community mental health teams. This created problems including:

- issues with medication
- care plans not being followed through
- individuals being left unsupported for significant periods of time.

Again, this was supported by findings of our review of HM coroners' prevention of future deaths reports which raised concerns about a lack of coordination and information sharing between services. This had contributed to poor decision making and had put people in the community at risk. Issues included gaps between the crisis home resolution treatment team and GPs, and/or the LMHT.

GP services

One of the most common routes of discharge from community mental health services was to a patient's GP. Due to their involvement with VC, we reviewed mental health care processes at the University of Nottingham Health Service.

Our inspector and national professional advisor spoke with the lead GP and the lead advanced nurse practitioner for mental health care. We also spoke with 6 other members of staff, reviewed 4 sets of medical records and reviewed a range of policies and procedures in place at the practice in relation to the care of patients with mental health needs.

We found that the GP practice had a number of safe processes and systems in place to support the care of people with mental health needs which met national best practice guidance.

Feedback from the GP reflected our concerns around coordination of care and sharing of information. The GP practice told us they were concerned that if people are discharged back to the care of the GP from the mental health teams, it can take 4 weeks or more to receive the information.

The practice also told us that they struggle to access the right contact details for trust staff. They gave an example of an individual who came to see the GP/mental health practitioner and the person reported they had seen the psychiatrist, but there was no evidence available to know what had been discussed or when the person had been seen.

The practice told us that people who use services describe being 'passed around' services, moved from team to team as the right path hadn't been found, because they didn't meet the criteria or were not suitable for the services provided. This causes a lot of frustration for people.

Integrated care board oversight of NHFT

Nottinghamshire Healthcare Foundation NHS Trust (NHFT) is part of the Nottingham and Nottinghamshire Integrated Care System (ICS). The Nottingham and Nottinghamshire Integrated Care Board (NHS Nottingham and Nottinghamshire ICB), was established in July 2022 and its partners include:

- Nottingham City Council
- Nottinghamshire County Council
- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- East Midlands Ambulance NHS Trust

The ICB is responsible for overseeing the provision and quality of healthcare services at the NHFT.

The ICB is aware of the challenges facing the trust. Key concerns shared with us by the ICB, which we have also found on our review, include:

- Quality, including high levels of ongoing serious incident investigations, not meeting requirements of the duty of candour legislation, lack of learning from incidents and the speed of implementing the new NHS England Patient Safety Incident Response Framework (PSIRF). There are also concerns about the trust's quality team who carry out visits to teams/services internally and also to any provider that NHFT commission to provide services on its behalf.
- Performance, including gaps in services, declined referrals, out of area placements, long lengths of stay in hospital, CQUIN achievement (NHS England's Commissioning for Quality and Innovation standards).
- Issues raised in HM Coroner prevention of future death reports including a lack of learning, repeated themes, poor quality of serious incident reports, lack of candour and lack of external information sharing.
- Number of services in rapid improvement boards and/or intensive and enhanced improvement groups, including adult mental health wards, and wards for older people and Lings Bar Hospital. Rampton High Secure Hospital, HMP Lowdham Grange and HMP Nottingham.
- Long waiting lists in adult mental health, child and adolescent mental health and neurodevelopmental assessment.
- Issues with management of the trust 'limited' internal assurance, financial deficit, poor staff survey results, high sickness absence and turnover rates, the level of violence and hate crime incidents reported by staff.

Due to the level of concern related to the NHFT, there are a range of quality oversight arrangements in place between the ICB and the trust, which include support from the ICB quality team. This oversight feeds into the ICB quality and people committee, which in turn reports to the ICS system quality group.

As a result, the trust remains on segment 3 of the NHS system oversight framework. This means that the trust has significant support needs against one or more of the 5 national oversight themes and is in actual or suspected breach of their NHS provider licence. The trust is monitored by NHS England at level 2 'enhanced' national quality board. This is the level at which NHS England has determined it must be monitored.

Focused review of Rampton Hospital

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. Previous inspections have identified a pattern of concerns and breaches of regulations, including:

- not enough staff to meet patient needs. This included a lack of staff trained in British Sign Language (BSL) to communicate with patients in the deaf service.
- therapy staff being used to increase staff numbers on the wards, which led to reductions in patients' therapeutic programmes and meaningful activity.
- confinement being used during the daytime due to lack of staffing. In addition to this we noted an increased level of early nighttime or late unlock from nighttime confinement.

- poor medicines management, including the application of the Mental Health Act consent to treatment forms and mental capacity assessments.
- concerns around mandatory training and clinical supervision of staff, with rates of completion varying over the 5-year period.
- repeated issues of staff not always safeguarding patients from abuse.
- poor access to physical healthcare, lack of physical healthcare plans, and staff not using the National Early Warning Signs (NEWS) to monitor signs of deteriorating physical health or take the required action to improve a patient's physical health.

Throughout this section of the report we take a focused look at issues raised in previous inspections of Rampton Hospital and discuss both areas of improvement and continuing areas for concern.

Quality of care

Key points:

- Communication between staff and patients was poor, particularly between staff and patients in long-term segregation, and did not meet the 5 basic types of communication that will enhance patients' experience and build a therapeutic relationship.
- The trust had taken steps to improve the quality of care for patients at Rampton Hospital who are deaf, with improved access to staff who can communicate using BSL. Despite these changes, there were still times when there were not enough BSL trained staff to meet patients' needs.

- The availability and provision of therapeutic activities had improved since our previous visits and patients from a number of wards were positive about the level of support from staff. However, patients told us that there were still issues with therapeutic activities being cancelled due to issues with staffing.

Communication

We were concerned about communication between staff and patients, particularly with patients in long-term segregation. For example, on Cheltenham Ward we saw staff speaking with a patient through the of a crack of door, as the door could not be opened due to patient risk. Similarly, on Brecon Ward we tried to speak with 3 patients in long-term segregation and were told by the matron it was easier to speak through the crack at the side of the door than the window. The MHA Code of Practice is clear that rooms or areas where seclusion is to be carried out should allow for communication with the patient when the patient is in the room and the door is locked, for example, via an intercom. Many of the buildings in the NHFT estate are old, so will predate the Code of Practice guidelines. However, as part of improvement works we would expect the trust to take action to meet these requirements, including for example, retrospectively fitting an intercom system.

As well as finding it difficult to hear the patients, the inspectors had to raise their voice to be heard, which compromised the patients' privacy. One patient became distressed during their attempt to communicate with our inspector. The matron told us that it was usual for the patient to become distressed when staff or visitors tried to speak with them, but told us "but it's not safe for them to come out to speak". While the inspector understood this was in line with the patient's risk assessment, they were saddened by the lack of empathy shown and concerned that staff had not considered other options, devices or adaptions to rooms to improve communication.

Not only was this way of communication poor, it did not meet the 5 basic types of communication (verbal, non-verbal, written, listening and visual) that will enhance patients' experience and build a therapeutic relationship with the staff. As highlighted in our 2022/23 Mental Health Act Annual Report, therapeutic relationships are "a partnership that promotes safe engagement and constructive, respectful, and non-judgmental intervention." Based on acceptance and trust, therapeutic relationships have the capacity to transform and enrich a patient's experiences. Without this kind of relationship, patients are less likely to engage with treatments and interventions, which can affect their recovery time.

Our findings are supported by feedback from patients who told us that they felt the environment was overly restrictive or, at times, punitive. Some patients reported items being confiscated, such as clothing or remote controls. Others were frustrated that they were not allowed email addresses or were being refused advocates.

NHFT told us that there was an Independent Mental Health Act advocacy (IMHA) service at Rampton Hospital provided by Together for Mental Wellbeing. The advocacy service sees all newly admitted patients within their first week at the hospital. Patients are also given a copy of how to access advocacy on admission and information about advocacy is displayed on each of the wards. There are supported discussions with patients about advocacy at the point of the Section 132 rights being updated, and the mental health legislation office in the hospital also sends reminders to discuss rights annually or on change of section. In addition, there are monthly advocacy drop-in sessions on all the wards.

However, feedback we received from patients suggested that they had to advocate for themselves, and that contacting CQC was often part of this self-advocacy. While we could not substantiate this as part of our review, if true, this could be a breach of the patient's fundamental human rights.

As part of our responsibilities under the MHA, people can make a complaint to us about the use of MHA powers or how duties have been carried out under the Act, which we will investigate.

A few patients reported not understanding their diagnoses, medication regimes or disagreeing with their care plan entirely. Others told us they did not receive health care, even when they needed it after becoming acutely unwell.

Patients detained under the Mental Health Act or on a community treatment order (CTO), can have their doctor request a Second Opinion Appointed Doctor (SOAD) to check whether their treatment is appropriate, and that the patient's views and rights have been considered. We reviewed paperwork relating to consent, capacity and second opinion. We found limited evidence of discussions about consent to treatment between the responsible clinician and patients. In a small number of cases, where we found evidence of discussions taking place, the quality of recording was not acceptable, for example, "patient complaint with medication".

We did not find evidence of mental capacity assessments for patients who had a T3 form. This is a certificate of second opinion under Section 58(3)(b) of the MHA for patients who are not capable of understanding the nature, purpose and likely effects of the treatment or are capable of understanding but do not consent to the treatment. See section on medicines management for more information.

National deaf high secure service

Rampton Hospital has the only National Deaf High Secure Service for men in the country. However, since 2019 we have raised ongoing concerns about the quality of care for patients who are deaf, including the lack of staff trained in British Sign Language (BSL) to support patients who are deaf to communicate or make informed choices about their care and treatment.

Following our last inspection in July 2023, we imposed conditions on the trust's registration because of the concerns we identified. One of these conditions related directly to the National Deaf High Secure Service for men and stated:

> "The registered provider must ensure that there are sufficient, suitably competent, and

> experienced staff trained in BSL to Level 3 as per national guidance. Within 7 days of this notice being adopted, the registered provider must submit a plan to the Care Quality Commission to ensure sufficient staff receive training in British Sign Language. The registered provider must also carry out reviews every 28 days to ensure that appropriate BSL trained staffing levels are being maintained."

Following this condition being imposed, the trust aimed to train all non-clinical staff to BSL level 1, clinical staff to BSL level 2 and expert clinical staff (such as therapists who work in the deaf service) to BSL level 3. As of January 2023, 36 out of 39 staff in the multidisciplinary team in the deaf service had been trained to level 1. As a result, we found that patients who are deaf had better access to staff who can communicate using BSL. During our site visits in February 2024, we saw many positive examples of staff using BSL in the deaf service, for example, when playing pool with patients.

Staff trained in BSL were highlighted in the duty rostering system. This meant that when staff needed to be moved to the deaf service, managers could see which staff are trained in BSL, or ensure that staff trained in BSL were not moved away from patients who use BSL to communicate. Between July 2023 and the end of January 2024, all day shifts had BSL staff on duty.

The trust had also taken other steps to improve the quality of care for patients who are deaf. For example, across the hospital all patients who are deaf had a new communication video panel in their bedrooms. The panel enabled patients to see their rights under the Mental Health Act and what to do in case of fire. There were videos of different environments (for example, forests and waterfalls) to help calm patients.

Despite improvements, we found that the trust was not always meeting the Accessible Information Standards in relation to deaf patients. For example, although the ward had improved the number of BSL trained staff on duty at night, we found that there were 5 nights since December 2023 when there were no BSL trained staff to meet patients' needs. We also found that staff trained in BSL were still being moved around the hospital to support staffing numbers in other areas.

This was supported by feedback from patients who said that although they had seen improvement in the number of staff able to use BSL, access to staff who could sign varied. We heard access depended on which staff were on shift or if staff who use BSL were moved to other parts of the hospital. Some patients acknowledged that it would take some time for the learning and some staff are only just starting. Although staff were receiving appropriate training in BSL, patients themselves were also helping staff with signing while on the ward which showed good relationships between staff and patients.

Some patients told us that new staff or staff who had not worked in the National Deaf High Secure Service before did not understand how people who use BSL behave when signing. They described how people who use BSL can 'become big with laugh and banter', but that staff unfamiliar with this behaviour could see this as a sign of aggression, which could lead to restraint or seclusion.

As stated in the Mental Health Act Code of Practice, the trust has a duty under the Equality Act 2010 to ensure it takes reasonable adjustments to avoid putting a person with a disability at a substantial disadvantage compared to those without a disability. This includes, for example, ensuring there are staff available who can use sign language or can communicate in the person's first language. In not meeting these requirements, we are concerned that patients who are deaf are not able to effectively communicate their needs and staff lack of understanding about BSL could put patients at risk of unnecessary restraint, seclusion and segregation.

Therapeutic activities

In our 2021/22 and 2022/23 Mental Health Act Annual reports, we highlighted our concerns around the impact of staffing shortages on therapeutic activities in mental health hospitals. Activities such as music, art or physical activity that are tailored to people's individual needs are important as they give people a sense of purpose, structure to the day and aid their recovery.

We identified a lack of therapeutic activities as an issue at Rampton Hospital during our last inspection, with activities for patients routinely cancelled due to staff being redeployed. Between February 2023 and July 2023, we found that therapeutic activities were cancelled on 473 separate occasions.

During our latest review, the availability and provision of therapeutic activities had improved, with a variety of activities taking place both on and off the wards, 7 days a week and in early evenings.

This was supported by feedback from patients from a number of wards who told us that the number of activities had increased since our last visit, and they were positive about the level of support staff gave during these sessions. In particular, patients were complimentary about their education and therapy sessions. In addition, patients were being assessed to be able to develop their life skills.

However, patients told us that there were still issues with therapeutic activities being cancelled, such as the library being closed due to staffing. Between July 2023 and the end of January 2024, 90 planned therapies or activities were cancelled due to staff being redeployed.

Some patients told us that they were worried that there were not enough activities, and as a result were feeling unstimulated in a difficult environment. They described the impact of being locked in rooms at night without any form of entertainment as exacerbating their conditions (see section on confinement at Rampton Hospital). Some believed a lack of activities or distraction contributed to their self-harming behaviour or suicidal ideation.

Further work is needed to make sure that patients routinely receive their therapeutic activities.

Safety

Key points:

- Management and auditing of medicines at Rampton Hospital had improved since our last visit. However, we were concerned that staff were not always following the correct procedure for prescribing and administering patients' medicines, which could constitute an assault and trespass against the person.
- The monitoring of high dose antipsychotic therapy was poor and potentially exposed patients to risk of harm.
- While the monitoring of patients' physical health following rapid tranquilisations had improved, we were concerned about the amount of rapid tranquilisations that appeared to be in use as well as the accuracy of recording.
- While we observed staff providing person-centred care, we remain concerned that people in long-term segregation were not always treated with dignity, compassion, and respect.

Medicines management

In previous inspections, we raised concerns about poor medicines management at Rampton. However, at our inspection in February we saw evidence of improvement. This included an excellent example of patient involvement. In this case, staff discussed the rationale for the patient's treatment, the benefits and side effects, likelihood of success, alternatives and the consequences of not continuing treatment. The patient was also offered leaflets about the medicine to help them make an informed decision.

We found that staff reviewed patients' medicines regularly as part of the multidisciplinary meeting and provided specific advice to patients and carers about their medicines, in easy read format if required. There was a system in place to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Decision-making processes were in place to ensure patients' behaviour was not controlled by excessive and inappropriate use of medicines. Staff were aware of STOMP (Stopping over medication of people with a learning disability or autism or both) and followed the principles.

When patients detained under the Mental Health Act (MHA) 1983 are prescribed medicines, they must have a completed T2 or T3 form. A T2 form is a certificate of consent to treatment under Section 58(3)(a) of the MHA. A T3 form is a certificate of second opinion under Section 58(3)(b) of the MHA for patients where the patient is not capable of understanding the nature, purpose and likely effects of the treatment, or where the patient is capable of understanding but does not consent to the treatment.

All medicines prescribed for patients who have consented or are not able to consent to the treatment must be written on the T2/T3 forms, including:

- the class of drug as indicated in the British National Formulary
- the number of medicines prescribed in each class and whether any medicines are excluded
- the maximum dosage
- how the medicine will be administered.

The forms must be attached to the medication chart. Only medicines listed on the T2/T3 form can be prescribed and administered to the patient.

Since our last visit, the trust had introduced a new, electronic system for auditing patients' medicines, which replaced the previous paper-based medication audit. T2 and T3 forms were checked as part of this process. Local managers were accountable for the audits and were expected to take action to address any issues identified. Audits were overseen by the local quality and risk meetings, and then escalated to the overarching forensic quality oversight group, which is chaired by the associate director.

Despite these improvements, patients told us that they had experienced:

- medication errors, especially regarding anti-psychotic drugs
- issues with administering medication
- being given the wrong medication
- being refused their PRN (pro re nata) or 'when required' medication
- not being given any medication at all.

Other issues we found in a very small number of cases included:

- consent to treatment (T2) forms not accurately reflecting the medicine being prescribed and administered
- current consent to treatment (T2) paperwork not being kept with the medication charts
- lack of evidence to show that the responsible clinician had discussed treatments with the patient.

We also found issues relating to high dose antipsychotic therapy (HDAT). This is defined by the Royal College of Psychiatrists as either a total daily dose of a single antipsychotic which exceeds the upper limit stated in the British National Formulary (BNF), or a total daily dose of 2 or more antipsychotics which exceeds the BNF maximum calculated by percentage. The doctor prescribing HDAT should clearly record the rationale for its use, and that the risks and benefits have been discussed with the patient. Using HDAT increases the risk of physical health complications and the patient requires regular monitoring.

A HDAT audit completed at Rampton Hospital in June 2023 found that 20% of inpatients were not receiving an annual review of their treatment, which was significantly higher than the national average. This audit also highlighted poor performance in monitoring of physical health.

During our review in February 2024, we found concerns with the monitoring of patients on HDAT. Staff had not recorded monitoring of 2 patients on HDAT on the appropriate form to ensure the correct physical monitoring had taken place. The rationale for continuing with HDAT prescribing was not always recorded as part of the multidisciplinary team review. Records of physical monitoring were stored on a separate electronic system that ward nursing staff did not have access to.

Previously, we have also raised concerns about the inconsistent monitoring of patients' physical health following rapid tranquilisation. Our review shows that this has improved since the inspection in 2022.

Rapid tranquilisation is oral medication or intramuscular injections that are used to calm or lightly sedate a patient to reduce the risk to themselves and/or others, and reduce agitation and aggression in the optimal way. The National Institute for Health and Care Excellence guidance on Violence and aggression: short-term management in mental health, health and community settings states that people given rapid tranquilisation need to be monitored at least every hour until there are no further concerns about their physical health. If the patient is in seclusion, then additional monitoring may be needed to ensure safety. The monitoring includes looking for side effects, vital signs hydration levels and levels of consciousness.

Between July 2023 to December 2023, there were 171 occasions where rapid tranquilisation was administered to patients. Staff had monitored the physical health of patients on 161 occasions. However, this meant that 10 people did not receive the monitoring needed to keep them safe.

Due to the way in which the data is recorded in the other 2 high secure hospitals we were not able to compare the use of rapid tranquilisation at Rampton Hospital with the other hospitals. However, we remain concerned about how much this is being used at Rampton Hospital.

The trust provided training for staff in rapid tranquilisation and had set a performance indicator of 85% of staff to be trained. At the time of our review, 73% of staff had completed the training, with only 8 out of 25 wards achieving or exceeding the target.

Nursing observations

To ensure patient safety and promote therapeutic engagement, mental health nursing staff carry out routine observations of patients. In previous inspections in September 2022, and June and July 2023, we raised concerns that nursing observations at Rampton Hospital were not being carried out in line with patients' needs, care plans or the hospital's policy. In some cases, patients were put on timed observations, for example, every 30 minutes, to ensure they were safe. This meant that staff had to observe the patients at the interval specified in their care plans and record what they observed. However, in one example, we found that a patient who needed to be observed every 30 minutes had been given a razor and then observations were not carried out as required in the care plan.

Since our previous inspections, nursing observations had improved. This included, for example, the introduction of CCTV reviews alongside nursing observations in January 2024. The reviews were introduced following incidents of records being falsified in different parts of the trust outside of Rampton Hospital (as reported in our section on managing risk at NHFT), and aim to assure leaders that observations are being carried out as per the trust's policy.

During this review we did not identify any issues of note in relation to nursing observations. Staff carried out observations in line with the hospital's policy and recorded them on electronic tablets. While we noted some late recording of observations, this was minimal and appeared to be caused by external factors, such as IT connectivity and equipment. For example, during October and November, we found evidence that IT connectivity issues at Rampton had led to an increase in the number of observations recorded as late.

Staff told us they liked using the tablets, but that there was small window of opportunity to record the observations before they were flagged as late. For example, we heard that if a nurse carried out an observation and then supported the patient before recording the observation, this would be marked as late. We are concerned that the time specified in the hospital's policy for late entries is too restrictive.

On previous inspections, we found that monitoring of observations was carried out at ward level without oversight from the hospital's leadership team. This would result in variable oversight across the hospital. Since our last inspections, the leadership team at the hospital is sent a daily monitoring report on observations. This data supports Rampton's quality matrons to identify and address hot spot areas, as well as support staff to improve practice. It also ensures patients are being observed and supported in line with their needs.

Restrictive interventions

Restrictive interventions including restraint, seclusion and long-term segregation, can have a devastating impact on people and cause them trauma. Since our report Out of Sight — Who Cares?, we've repeatedly called for providers to act immediately to reduce the use of restrictive practice, and to ensure they provide person-centred, trauma-informed care at all times.

In August 2023, we published our policy position on the use of restrictive practice. This recognises that the use of restrictive practices may be appropriate in limited, legally justified, and ethically sound circumstances in line with people's human rights. However, it is also clear that wherever restraint, seclusion or segregation is perceived to be the only safe option, providers must consider whether services provided meet the needs of the individual and are preventative in their approach to stop situations reaching crisis point.

On our previous inspections at Rampton Hospital we found elevated levels of restrictive practice that were not reviewed or recorded in line with the Mental Health Act (MHA) Code of Practice. This included individual care plans for patients when restrictive interventions had been used in risk management. While we have seen improvements in the use of restrictive interventions, there are still areas for concern.

Data from the Mental Health Services Data Set (MHSDS) restrictive interventions dashboard shows that between February and October 2023 there was a high rate of restrictive interventions at Rampton Hospital (ranging from 38 to 51 per 1,000 occupied bed days), when compared to the other 2 high secure hospitals. High rates may suggest that restrictive interventions are being used excessively. This may be due to a variety of reasons including, but not limited to, being understaffed and lack of de-escalation training for staff. However, it is important to note that high rates of reporting could also reflect accurate and successful recording of restrictive interventions. Between February 2023 and October 2023, the number of restrictive interventions for Rampton Hospital were consistently above 400 per month, rising to 570 per month in the latest data set. This was higher than the other trusts operating high secure units.

Data from the trust shows that from July 2023 to December 2023 there were 581 incidents of seclusion. Seclusion is defined in the MHA Code of Practice as, 'the supervised confinement and isolation of a patient, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of containment of severe behavioural disturbance which is likely to cause harm to others.' Of the 581 incidents, 154 had been reviewed. The trust found that 148 of the seclusions were in line with the MHA Code of Practice. However, 6 were not and the trust investigated these further. The trust took action in all 6 investigations, including staff conduct investigation, reporting a staff member to the police, reflective practice and discussion with staff in supervision.

Through our review, we saw evidence that staff at Rampton Hospital are attempting to get more patients out of long-term segregation. Long-term segregation is defined in the MHA Code of Practice as a situation where, in order to reduce a sustained risk of harm posed by the patient or others, which is a constant feature of their presentation, a multidisciplinary review and the commission authority determine that a patient should not be allowed to freely mix with other patients on the ward on a long-term basis.

Although it is currently lawful to isolate people for prolonged periods, if this is the least restrictive way of keeping them safe, long-term segregation has real implications for people's human rights and long-term psychological wellbeing.

Between October 2023 and December 2023, the overall number of patients in long-term segregation reduced from 48 to 41. While this is a positive step forward, we are concerned that patients still in long-term segregation are not supported to access fresh air or reintegrate back in the ward safely. As highlighted in our 2022/23 MHA annual report, access to fresh air and leave are important for people's recovery, and decisions around people's ability to take leave should be based on risk.

In our 2020 report Out of Sight: Who cares? we reported how prolonged isolation in artificial environments can be detrimental to people's health and recovery and lead to issues such as:

- people sleeping too much and getting into unhelpful sleeping patterns, which affects their opportunities to access therapeutic interventions
- people's physical health deteriorating, such as a decrease in mobility.

Our report also showed that for some people, as they get used to being away from others, their comfort zone can shrink and it can become harder for them to be able to integrate with others because of the loss of social skills.

In December 2023, 18 patients of 41 did not have access to leave their rooms. While reasons for patients not being allowed to leave their rooms were usually recorded, no rationale was given for 3 patients. In addition we found no oversight or monitoring of the reasons why patients were not allowed out of their room while on long-term segregation.

Staffing

Key points:

- Staffing levels have improved since our previous inspections, but we were concerned that the minimum staffing levels at Rampton Hospital did not always meet the needs of the patients on the wards.
- We were concerned there is still a culture of relying on therapy and education staff to cover nursing gaps. While this had improved, we heard that this practice is still happening and leads to therapies, such as exercise, being cancelled.
- We previously raised concerns about confinement being used inappropriately at Rampton Hospital, often linked to low levels of staff. While this had improved, we are concerned that some staff felt that not having the option of day confinement placed them at risk when staffing levels were low.
- We remain concerned about the numbers of staff not completing mandatory training and not having clinical supervision.

Staffing levels

In our 2022/23 State of Care report we raised our concerns about longstanding issues with staffing at all 3 of England's high secure hospitals. We reported that at each inspection, all 3 high secure hospitals had a significant shortage of staff, particularly registered nurses.

Consistent staffing is fundamental to therapeutic relationships, so a high turnover of staff can have negative impacts on patient recovery and lead to longer stays in hospital. A lack of staff can also affect services' ability to provide therapeutic care.

Following our inspection in June 2023, we raised our specific concerns around staffing levels at Rampton Hospital. While the data suggests that staffing levels have improved since our last inspection, they were still variable and not yet sustainable.

Safe staffing levels at Rampton Hospital were classed as 80% or above in relation to staff on duty. The actual number of staff on duty changed daily, as well as throughout the day depending on patient needs. Actual numbers of staff needed would regularly be in the high 100s or low 200s on shift at any one time.

In June 2023, the average staffing level was 62% against safe staffing levels of 80%. To put this into context, on 22 June 2023 there should have been 205 staff on shift. Safe staffing levels would have been a minimum of 164 staff based on the figures used by the trust. On this particular day, there were only 126 staff on duty, meaning that the staffing level was at 61.5% of staff rostered on, or 79 staff below planned staffing levels. This meant that staffing levels were significantly below what was planned, and also what was classed as safe.

From July to October 2023 actual staffing levels against planned staffing varied with an average of 68% of staff on shift. Staffing levels did exceed the minimum safe staffing levels in November 2023 with a rate of 84%, maintained in December 2023 at 96% and then in January 2024 at 94%.

Since early July 2023, Rampton Hospital has been able to fill all weekday early shifts by at least 80%, but struggled to achieve the 80% target for late shifts and at weekends and bank holidays. The average fill rate for night shifts at Rampton Hospital between 20 July 2023 and 7 February 2024 was 80.7%.

All staff we spoke with mentioned 'Z' levels of staffing. The 'Z' level is the minimum number of staff needed to safely manage the ward; this number includes one patient being cared for on enhanced observations. When we reviewed the 'Z' levels of staffing it became clear that these numbers were significantly lower than the numbers of staff required to manage the acuity of some wards, meet patient needs and improve the perceived safety for staff.

For example, on one of our out of hours visits, the nurse in charge told us that they should have 14 staff on duty for the day, but there were only 11 staff on duty. The nurse in charge was allocated a morning shift but had stayed at work until 7.30pm. We heard how this shortage of staff had affected the care delivered, with one patient not allowed out of long-term segregation for the whole day, and other patients not given all of their planned time out of long-term segregation. As well as the negative impact on patient care, as highlighted in our 2022/23 Mental Health Act annual report, the July 2023 report from the Public Accounts Committee (PAC), has warned how increasing workloads are leading to burnout for staff.

We also heard concerns about the culture of relying on therapy and education staff to cover nursing gaps. While the staff we spoke with told us the amount of time they were asked to cover observations was less, we heard that this practice is still happening.

As highlighted in our section on therapeutic activities, therapy staff told us they had been placed on wards with inadequate training to make up staff numbers, which had led to therapies, such as exercise, being cancelled. A former member of staff made clear the effects of having to cancel activities, such as exercise, on patients' wellbeing, claiming they became more aggressive, and staff were more likely to be attacked. This is supported by the findings from our 2022/23 Mental Health Act annual report where we reported that patients told us how a lack of therapeutic activities leads to boredom and could, in turn, lead to patient-on-staff violence, patient-on-patient aggression or self-harm.

Staff who are asked to cover nursing gaps also told us that when they were on the wards they were not made to feel part of the team, did not get a full handover of the patients' needs or risks and were not asked if they needed food or drink. They reported feeling undervalued, stressed and not suitably trained, competent or confident.

Leaders at the trust recognise that further improvements are needed in relation to staffing. Communication around the staffing levels and how staffing numbers are set needs to be escalated to ensure understanding.

Confinement

Night-time confinement is a practice used at the 3 high secure hospitals where patients are locked in their rooms overnight. The High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2019 state that each high secure hospital, in line with guidance from the Secretary of State, may only lock a patient's room at night if:

1. the room has toilet and washing facilities and a staff call system; or
2. the patient is subject to continuous observation by a member of staff.

In line with guidance, the policy for night-time confinement at Rampton Hospital is from 8.30pm to 8am. However, we previously raised our concerns about the inappropriate use of confinement at the hospital. For example, between April 2023 and June 2023, there were 127 episodes of confinement outside of these hours. At the inspections in June and July 2023, we found that staff across the hospital routinely used confinement as the 'go to' measure to deal with most matters. We also found that confinement was being planned several weeks in advance of known staff shortages, rather than less restrictive measures being considered.

Confinement had unfortunately become part of the culture at the hospital and staff did not recognise when it was being used inappropriately. For example, during our July 2023 inspection, whistleblowers reported to us that some new members of staff were being instructed to 'lock up the patients at the first chance they get, otherwise the patients will eat them'. We are clear that it is unacceptable to lock patients in their room outside of the High security psychiatric services directions: Security and Safety.

Leaders at both hospital and trust level did not have appropriate oversight of confinement in Rampton Hospital other than knowing it was happening. It had not been recognised by leaders that confinement was being use inappropriately, nor had any alternative measures been put in place to minimise its use.

In July 2023, based on findings from our inspection in June 2023, we wrote to the Independent Chair of the National Oversight Group for High Secure Psychiatric Services raising our concerns about staffing shortages and the use of daytime confinement and extended night-time confinement at Rampton Hospital, including restricting patients' access to communal ward areas during parts of the day. We escalated these concerns to the Independent Chair to help lever improvements at the hospital quickly.

Since our last inspection, the trust has redesigned its processes for requesting the use of daytime confinement. This means that the leadership team are now immediately aware when it is being used, and could move staff across the hospital safely to end confinement. In addition, the trust no longer uses confinement as an option for contingency planning when staffing levels are low.

As a result of the changes, the use of confinement has decreased. From July 2023 to the end of December 2023, there were 28 episodes of daytime confinement. This is supported by feedback from patients and staff who told us that the use of daytime confinement had either stopped or reduced significantly. While the use of daytime confinement was arguably still too high, it was an improvement and patients told us they were pleased with this change.

Although the majority of staff were also pleased with confinement being used less, some felt that that not having the option of day confinement placed them at risk when staffing levels were low. We are concerned that some staff feel this way when there is evidence that staffing levels were improving.

Training and clinical supervision

Over the last 5 years, we have consistently raised concerns about training for staff at Rampton Hospital. While there have been some improvements, we remain concerned about the numbers of staff completing mandatory training and clinical supervision.

On previous inspections, we have raised particular concerns about low levels of staff trained in hospital life support. We were not assured that in an emergency there would be enough trained and competent staff to provide life support to patients until medical or emergency services arrived. At the June and July 2023 inspections, this had improved, with 87% of all staff recorded as having received this training. However, we are concerned that as at December 2023 this had dropped back down to 81%. The trust have provided evidence of planned training for staff, which will mean that by the end of March 2024 all staff (100%) will have received the training.

Since 1 July 2022, all registered health and social care providers are required to provide training for their staff in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. Between July 2023 and February 2024, we carried out 20 Mental Health Act (MHA) reviewer visits to Rampton Hospital. Through these reviews, staff on Evans Ward told MHA reviewers they had not completed training in autism and learning disability. Not only is this a legal requirement, but it means that people may not receive person-centred care that meets their needs.

As part our review, the trust updated us that e-learning for learning disability and autism training became available to staff in January and, to date, 43% of staff had completed the training.

However, as highlighted in our section on communication at Rampton Hospital, we were concerned that staff were not confident in caring for patients with a learning disability. For example, one person with a learning disability who was in long-term segregation said they felt lonely. We reported this to the matron who said that staff do not always know how to speak with them or what about. The inspector noted the patient had stickers or animals and their football team on the wall. They found using these as prompts helped the conversation to flow. Therefore, we questioned whether communication was difficult. Regardless of the reason, the patient's communication needs were not being supported, which needs to be addressed.

It was noted that 94% of staff had completed training in the Mental Capacity Act (MCA) and 97% had completed Mental Health Act (MHA) training. This had improved since the September 2022 inspection, when 80% had completed MCA training and 84% had completed MHA training.

However, we are concerned that clinical supervision and support for staff has decreased. Since our last inspection, the trust has revised down its requirements for clinical supervision from once a month to once every 3 months. While the figures suggest the performance rates for supervision taking place have improved, the actual number of clinical supervisions taking place have reduced. We are concerned that reducing attendance at supervision to every 3 months will have a detrimental effect on both staff and ultimately patients within the hospital. In addition it is concerning that the requirements have been reduced rather than improvements made to meet the original target.

Leadership and governance

Key points:

- Within the last 3 years, the trust has reviewed governance and capacity across the forensic care group. As part of this review, the trust has made changes to align the governance structures across the care group.
- At the point of our inspection in July 2023, we found that many of the issues we identified on previous inspections, such as staffing levels and BSL provision, were still prevalent.

- Since October 2022, the trust has reconfigured its recruitment process and the high secure waiting payment has been reintroduced for staff to improve the pay offer. In addition, we found trust-wide sickness and turnover rates have reduced.
- There was a noticeable improvement, but we still found some ongoing concerns with the culture at Rampton Hospital. The senior leadership team has recognised that the culture needs to be scrutinised, understood, and developed.

Leadership team at Rampton

As highlighted in our section on leadership in the first part of this report, over the last 5 years there have been a lot of changes in senior leaders at NHFT. Alongside the changes at a trust wide level, the senior leadership team at Rampton Hospital has changed too. Out of the 11 senior leaders, 5 have been appointed to their roles since 2020, the others have been working at Rampton for over 5 years in various roles and grades. However, they have been employed in their current roles and grade since within the last 5 years. Five leaders started their current role in the senior leadership team in 2023; 3 in 2022, 1 in 2021 and 2 in 2020.

Although Rampton Hospital has had changes to its leadership team, NHFT told us this was to strengthen the capacity of local management and leadership at the hospital, which was required to deliver the necessary improvements. A number of senior staff have worked at the hospital for a significant period of time from 3 years to 25 years.

Linked to this and the fact that there have been repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 over the last 5 years, it does raise the question of whether more support is needed to drive through the necessary improvements at Rampton Hospital.

Within the last 3 years, the trust has reviewed the governance and capacity across the forensic care group. This identified that governance of quality and processes for escalating concerns were not in place. This prevented the care group senior leadership team from effectively supporting each care unit, particularly Rampton Hospital.

As part of the trust's review and investment into Rampton Hospital, it made changes to align the governance structures across the care group. This restructure included:

- creating an additional 8 new clinical nurse roles with responsibility for security and patient care
- introducing quality matrons who were dedicated to quality oversight
- employing a ward clerk for each ward to support with administration duties, as well as a dedicated HR lead
- introducing a dedicated recruitment lead.

Due to these changes a 12-month leadership training programme was delivered to all these staff, to support them in their new roles, working together and understanding how their roles link with the governance across the trust from ward to board.

Oversight

Following the Warning Notice we served in October 2022, NHFT set up the Rampton Improvement Group to coordinate the action plan response and monitor whether targets were being met. The group met monthly and was chaired by the deputy chief executive of the trust, and was attended by senior leadership from both the trust and the hospital.

At the point of our inspection in July 2023, we found that the necessary improvements had not been made despite the introduction of the Rampton Improvement Group. Many of the issues identified in the Warning Notice, such as staffing levels and BSL provision, were still prevalent.

Lack of staffing has been, and remains, a prominent concern at Rampton Hospital, with enforcement action taken in relation to this in 4 out of the last 5 inspections. At the inspection in July 2023, we reported that there had been times when there was a staffing deficit of between 40% to 49%. While we did not find such a large staffing deficit this time, we were concerned that governance processes and oversight of the actual required numbers of staff to meet the needs of the patients were still not fully implemented.

Since July 2023, the trust has submitted staffing situation reports to us initially on daily basis, then on a monthly basis. Looking at the data the trust has provided and evidence gathered during our initial assessment, we are not assured that leaders have recruited enough staff, with relevant qualifications, to meet patients' needs.

As noted in our section on staffing, we continue to hear concerns from staff that there are not adequate levels of staff to operate a safe and therapeutic environment. Staff, relatives, and patients suggested wards were understaffed, with seclusion sometimes used to mitigate low staffing levels.

> "Short staffed on the ward again, so patients were placed in segregation for the whole day, nurses and staff have documented it as the patients having diarrhoea and sickness."

We are particularly concerned about staffing for the learning disability service. As a national service, we would expect to see a full multidisciplinary team in place to assess and meet the individual needs of the patients. However, we are not currently assured that this is case. There is only 1 occupational therapist, who works 1 day a week that is trained to carry out sensory processing assessments. This type of assessment determines how sensitive an individual is to various types of sensory information, and allows the team to plan care to meet the sensory and communication needs to of the patient.

We found that not all patients in the service had a sensory processing assessment and care plans did not reflect individuals' sensory needs. We know that the very nature of hospital environments means that they are not always suitable for the sensory needs of autistic people and people with a learning disability. The noise and bright lights of the hospital wards can cause people distress.

As highlighted in our thematic review Out of sight – Who cares? not understanding or considering the impact of the environment on people with sensory needs can lead to people expressing their distress in a way that others find challenging, and lead to staff resorting to using restrictive practices. Being placed in an inappropriate environment can be damaging and creates a pattern of distress, restraint and seclusion, which often cannot be broken.

Recruitment and retention

The senior leadership team in Rampton have recognised that recruitment and retention of staff has been a risk for a long time.

Since October 2022, the trust has reconfigured its recruitment process and reintroduced the high secure waiting payment to improve the pay offer for staff. In addition, in May 2023 the hospital appointed a dedicated head of people and culture, who has developed a workforce plan for the next 18 months with clear actions to complete in a set timescale.

The workforce plan identifies that the hospital needs to recruit the required number of staff as determined by the safer nursing care tool, which is endorsed by the National Institute of Health and Care Excellence (NICE). It is an evidence-based tool that supports organisations to determine optimal nurse staffing levels, or to deliver evidence-based workforce plans to support existing services.

Data on staff starting and leaving employment at Rampton Hospital highlight the benefits from these positive changes. Between October 2023 and January 2024 there have been 18.69 whole time equivalent qualified nurses start employment at Rampton with 12.69 whole time equivalent nurses leaving. For healthcare assistants in the same time period, there were 42 whole time equivalent starters and 8.87 whole time equivalent healthcare assistants who left.

In addition, trust-wide, sickness and turnover rates have reduced since early 2023, meaning staff have been able to deliver a higher number of care hours per patient day.

Culture

We have previously reported a culture of bullying and verbal and/or racist abuse at Rampton Hospital. While our latest review shows this has improved, it has not been eradicated, with 2 patients telling us that staff had made derogatory comments about their weight or physical health issues.

The senior leadership team has recognised that the culture in Rampton Hospital needs to be scrutinised, understood, and developed in order to not only be successful in developing the services and outcomes for patients but to bring about positive changes. In response the trust has recruited an experienced clinical psychologist, with a team of 6 psychology assistants, to carry out a review and improve the culture of the hospital.

Conclusions

Following our review, we have identified 3 enduring areas of concern at Nottinghamshire Healthcare NHS Foundation Trust (NHFT):

- **Demand for services and access to care:** High demand for services is leading to long waiting times, with a lack of oversight of people's mental health while they are waiting. Limited numbers of inpatient beds mean that patients are not always able to access the care they need in good time, with delays in admissions leading to people seeking care from emergency or crisis services. Once in contact with services, care planning and risk assessment is inconsistent and teams are not meeting the needs of the local populations. In addition, discharge planning across community mental health and crisis services is not robust, with concerns around people being discharged too soon or leaving inpatient services in a worse state than when they arrived.
- **Staffing:** NHFT do not have enough staff to keep patients safe across community mental health and crisis services and some inpatient services. High demand for services, and complex staffing arrangements mean that staffing levels are not equitable to caseload sizes and the number of referrals received.
- **Leadership:** Senior leaders do not appear to have a clear oversight of risks. While there is evidence of the trust taking action to address safety concerns, including those raised by our review, we are concerned that this is predominantly reactive. In addition, leaders are not obviously prioritising engagement with people who use services.

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

As highlighted in our 2022/23 State of Care report, many other mental health services across the country are experiencing high and increasing demand. This is being exacerbated by factors such as population growth, aging demographics and societal pressures, which are straining existing resources and services. Current plans, including NHS England's Community Mental Health Transformation Programme aim to provide a solution. However, the high level of unmet need means that more action is needed.

Ensuring consistent, high-quality care across the 42 systems and mental health organisations can be challenging. Lack of integration between mental health services and other healthcare, social care and support services, like the police, is leading to variations in service provision and outcomes for patients.

Workforce shortage of mental health professionals, including psychiatrists, psychologists and community psychiatric nurses, is increasing staff workloads, creating retention challenges, and leading to staff burnout. In turn, this is having a negative impact on the quality of care of community mental health services. These staffing challenges are being made worse by inadequate supervision and support, which can affect the ability of staff to cope with the demands of their roles. This is a particular issue for staff in remote or under-served areas.

Despite training more staff, figures from the King's Fund mental health 360 paper, published in February 2024, show that the number of vacancies in NHS mental health services remains high. In September 2023, there were 28,600 vacancies (19% of the total workforce), including 1,700 medical and 13,300 nursing vacancies. In every region of England, vacancy rates in mental health services are higher than the overall NHS vacancy rate. Addressing these workforce challenges requires investment in recruitment and retention strategies, improving working conditions and career development opportunities, enhancing diversity within the workforce, and providing adequate support and supervision for mental health professionals.

It is clear that challenges in community based mental health services are having an impact on inpatient mental health services. Despite national aims to intervene early, many patients are getting to a state of crisis and being detained in hospital. The King's Fund 360 report shows that between 2005/6 and 2015/16, the number of times the Mental Health Act was used increased by 40%.

While our review focused on the quality and safety of mental health services at NHFT, our findings highlight the need to look more closely at community mental health services nationally to fully understand the gaps in quality of care, patient safety, public safety, and staff experience in community mental health services.

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