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.