Appendix 1

Health and Adult Social Care Scrutiny Committee
11 April 2024

52. Nottinghamshire Healthcare NHS Foundation Trust (NHT) – Care Quality Commission (CQC) Assessment Outcomes

Statement of the Chair

Frequently mentioned reports:

- 2019 CQC Inspection: https://api.cqc.org.uk/public/v1/reports/2607004c-911a-4a63-9760-8b00c2293cbc?20210116072008
- 2022 CQC Inspection: https://api.cqc.org.uk/public/v1/reports/5f8b7065-93e9-4431-8a3a-a656810eb788?20221129062700
- 2023 CQC Inpatient Inspection: https://api.cqc.org.uk/public/v1/reports/c467cb17-416b-44a5-92fc-9f653cb810e2?20240301010515
- 2024 CQC Section 48 Inspection: https://www.cqc.org.uk/publications/nottinghamshire-healthcare-nhsft-special-review

1. Community Mental Health Services

a) CQC Inspection 2019

"The service was easy to access. Staff assessed and treated people who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. The service did not exclude people who would have benefitted from care. The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multi-disciplinary team and with relevant services outside the organisation.

Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. Staff ensured all carers felt listened to and empowered patients to be actively involved in their recovery." – CQC

Note: Prevention of Future Death Notices in November 2017 (https://www.judiciary.uk/wp-content/uploads/2018/02/Ryan-Vout-2017-0376_Redacted.pdf), (March 2021 https://www.judiciary.uk/wp-content/uploads/2021/03/Sean-Fegan-2021-0083-Redacted.pdf) July 2022 (https://www.judiciary.uk/prevention-of-future-death-reports/keith-nottle-prevention-of-future-deaths-report/), January 2023 (https://www.judiciary.uk/prevention-of-future-death-reports/alexander-lyalushko-prevention-of-future-deaths-report/), September 2023 (https://www.judiciary.uk/prevention-of-future-death-reports/gerard-murray-prevention-of-future-deaths-report/), February 2024 (https://www.judiciary.uk/prevention-of-future-death-reports/daniel-tucker-prevention-of-future-deaths-report/) (this was escalated to the Secretary of State) and March 2024 (https://www.judiciary.uk/prevention-of-future-death-

reports/kenneth-baylis-prevention-of-future-deaths-report/) all specifically reference the failure of NHT to involve families in patients care.

b) September 2019

"The future inpatient need for the Nottinghamshire is currently being scoped, due to the number of transformation schemes that are due to start over the next few months this needs to be monitored as the schemes impact is realised. There are clear assumptions that improvements to crisis pathways offering robust alternatives to admission will reduce the overall inpatient need." – NHT

https://www.nottinghamshire.gov.uk/DMS/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=vcOngmXtUQoB1De7cO5%2Bebi%2FOwLvnuehhPjqkpGdzG3xFE6K8Ko8jQ%3D%3D&rUzwRPf%2BZ3zd4E7Ikn8Lyw%3D%3D=pwRE6AGJFLDNlh225F5QMaQWCtPHwdhUfCZ%2FLUQzgA2uL5jNRG4jdQ%3D%3D&mCTIbCubSFfXsDGW9IXnlg%3D%3D=hFflUdN3100%3D&kCx1AnS9%2FpWZQ40DXFvdEw%3D%3D=hFflUdN3100%3D&uJovDxwdjMPoYv%2BAJvYtyA%3D%3D=ctNJFf55vVA%3D&FgPlIEJYlotS%2BYGoBi5olA%3D%3D=NHdURQburHA%3D&d9Qjj0ag1Pd993jsyOJqFvmyB7X0CSQK=ctNJFf55vVA%3D&WGewmoAfeNR9xqBux0r1Q8Za60lavYmz=ctNJFf55vVA%3D&WGewmoAfeNQ16B2MHuCpMRKZMwaG1PaO=ctNJFf55vVA%3D

c) January 2020

The Committee raised people waiting too long, particularly in a crisis, and a lack of a 'waiting well' policy.

https://committee.nottinghamcity.gov.uk/ieListDocuments.aspx?CId=614&MId=7990&Ver=4

d) November 2020

A man completed suicide and the Crisis team was mentioned in a Prevention of Future Death Notice (see also April and June 2022).

e) December 2020

The Committee raised anecdotal evidence of people attempting suicide due to being unable to access appropriate mental health treatment. There was no adequate response to this – simply that, sometimes, GPs make inappropriate referrals. The Committee asked about the training of the staff on the Turning Point helpline and were told that NHT was confident in their ability.

https://committee.nottinghamcity.gov.uk/documents/s114233/Minutes%2017122020%20Health%20Scrutiny%20Committee.pdf

f) March 2021

"Decision making surrounding the need for secondary mental health care … a decision was taken in December 2019 that the patient did not require mental health

treatment at all in the absence of adequate information or assessment and for reasons which appeared incorrect.

Access to mental health treatment – the patient had complex mental health conditions and experienced very high levels of distress and anxiety as a consequence. He was declined mental health treatment on two occasions by the Trust. The patient took an overdose due to his frustration at not being able to access mental health services which he needed. Whilst this was not the cause of the patients death, it created a dangerous state of affairs.

Implementation of care plans – a care plan was devised by the liaison nurse and psychiatrist, only to be overruled by persons who had not themselves assessed the patient, on an incorrect basis, and without a review of the risk assessment justifying that decision. The Patient 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." – HM Coroner (see also June 2022)

https://www.judiciary.uk/wp-content/uploads/2021/03/Sean-Fegan-2021-0083-Redacted.pdf

g) April 2021

The Committee raised the fact there were systemic issues around access to crisis and secondary services, and the fact that people could be left waiting for diagnosis, or diagnosis is not shared with others involved in their care (such as GPs). The Committee again raised anecdotal evidence of people attempting suicide, or self-harm escalating due to an inability to access secondary care.

https://committee.nottinghamcity.gov.uk/ieListDocuments.aspx?CId=614&MId=8769&Ver=4

I shared examples of hers and others experience of people being pushed from one service to another without being able to access care from anywhere, and that the voluntary sector was having to pick people up.

https://www.nottinghampost.com/news/nottingham-news/our-mental-health-services-failing-5302866

I was contacted by NHT a week after that meeting, which said it felt that I had been unduly unfair on them and that they would "have to consider whether they would agree to come to future meetings" unless I withdrew the comment. I refused and reminded NHT of the Committee's ability to require them to attend meetings as a provider of NHS services.

h) June 2021

A man died following an overdose. A Prevention of Future Death Notice published in June 2022 said this was "a cry for help, or to secure secondary mental health

treatment". It also referred to the lack of information shared with his GP, including not telling the GP of a diagnosis.

https://www.judiciary.uk/wp-content/uploads/2022/09/Keith-Nottle-Prevention-of-future-deaths-report-2022-0189_Published.pdf

i) October 2021

"A patient suffered significant symptoms of distress, personality changes, dysfunctional behaviour and possible paranoid or delusional thoughts. The precise nature of the patient's mental health, personality and/or neurological difficulties were not assessed prior to his death.

The patient experienced regular thoughts of ending his life and he engaged in acts consistent with such intentions on numerous occasions including 22 October, on or around 5 November, 11 November, 12 November and 14 November 2020. Against this background, the patient took his own life by means of hanging on 28 November 2020." – HM Coroner

https://www.judiciary.uk/prevention-of-future-death-reports/michelle-whitehead-prevention-of-future-deaths-report-2/

I raised this case multiple times with NHT as it refers to the Crisis team viewing themselves as a 'gatekeeping service', starting in January 2022.

j) January 2022

A Coroner's Inquest and Prevention of Future Death Notice found:

"The assistant coroner said the patient faced repeated rejection from the Trust, as his care was impacted by a lack of communication between different services and no senior Nottinghamshire Healthcare trust member contacting his GP.

She found they did not understand he was in a coercive and controlling relationship and that this was likely a risk factor for his suicidal thoughts and previous suicide attempts. The patient made multiple calls to the trust's crisis team before his death, but when a final plan was decided in January 2022 to refer him for stabilisation work, this was then not communicated to him or his GP.

The patient was also unaware of the Local Mental Health Team (LMHT) treatment plan for him when he died, and reportedly felt that the Trust could not help him as referrals were repeatedly rejected by teams across the Trust." – HM Coroner

https://www.nottinghampost.com/news/nottingham-news/health-services-failed-realise-young-8264154

https://www.judiciary.uk/prevention-of-future-death-reports/thomas-jayamaha-prevention-of-future-deaths-report/

k) April 2022

In a private meeting, I raised concerns about the inequity in service based on location – for example, no psychologists in City South or City North, people not being assigned care coordinators or being reassigned when care coordinators left, longer waiting lists in City Local Mental Health Teams. I was told that I was wrong about the inequity based on location and that the psychologist issue was being resolved. I also raised concerns about a 'waiting well' policy – the Committee has raised this multiple times on a range of community services, notably in relation to Step 4. I was not provided an answer to this, and the response from a NHT member of staff who may no longer work at the NHT was quite combative (see also June 2023).

I raised the issue of a Prevention of Future Death Notice criticising the Crisis team for treating its primary role as a 'gatekeeper' (see also June 2022).

https://www.judiciary.uk/wp-content/uploads/2021/10/Paul-Barton-Prevention-of-future-deaths-report-2021-0338_Published.pdf

l) June 2022

In the Committee's response to the NHT 2021-22 Quality Account, I referred to the April 2022 meeting on several occasions, one being that NHT repeatedly referred to the Crisis team as a 'gatekeeping service'. Despite a Prevention of Future Death Notice in this year criticising NHT for treating the Crisis team as primarily a gatekeeping service, and NHT in their response to the Notice saying this was not the case, NHT continued to do so, including in the Quality Account.

The Committee said "that the Service should be acting as a 'gatekeeper' to inpatient care is of great concern to the Committee and this concern was raised with the Trust. The Trust advised the Committee that this is not the case, but it is not clear from the Quality Account document what learning, if any, has taken place in relation to the issue being raised in the Prevention of Future Death Report, and elsewhere in the Quality Account document there is reference to 'crisis gatekeeping'. In addition, the Committee has met with the Trust both in public meetings, and privately when the phrase 'gatekeeping' has been used by senior Trust officials regarding the CRHTT."

https://committee.nottinghamcity.gov.uk/documents/s135386/NHCT%20Quality%20Account%202021_22%20HASC%20Scrutiny%20Committee%20Comment%20Final.pdf

The Committee also looked at services for people with co-existing substance use and mental health problems due to its concerns of two near identical Prevention of Future Death notices. In my opinion, there was a culture of blame from NHT to the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB). I raised this with the ICB and heard a different opinion. I am not commenting on who is right, but I suspect there are truths and untruths in both views. I escalated this to colleagues in Social Care and Public Health at the Council as the Committee has regrettably been unable to return to this item due to competing pressures. I hope it will be a priority for the next municipal year.

https://www.judiciary.uk/wp-content/uploads/2016/06/Denning-2016-0058.pdf

https://committee.nottinghamcity.gov.uk/documents/s135271/Services%20for%20people%20with%20co-existing%20substance%20misuse%20and%20mental%20health%20issues.pdf

m) November 2022

A man with a known extensive mental health history was referred to an LMHT. This referral was not actioned by NHT. A month later the man completed suicide. The Coroner found failings in NHT's Serious Incident reporting.

https://www.judiciary.uk/prevention-of-future-death-reports/alexander-lyalushko-prevention-of-future-deaths-report/

n) June 2023

A response from NHT to a Prevention of Future Death Notice still shows varying levels of care and safeguards according to location.

https://www.judiciary.uk/wp-content/uploads/2023/04/2023-0116-Response-from-Nottinghamshire-Healthcare-NHS-Foundation-Trust.pdf

o) September 2023

In the Committee's Quality Account response, it once again raised concerns about NHT's lack of a 'waiting well' policy. This was sent to NHT before September, and in turn to the Secretary of State, but due to this being the Committee's first meeting of the municipal year as it was an election year, they were not made public until now.

The Committee also said that it did not believe NHT has a good understanding of patient experience as what the Committee was told by NHT did not usually reflect what patients said. The Committee also said it did not feel that NHT learns from past events, including patient complaints, Serious Incidents and Prevention of Future Death Notices.

https://committee.nottinghamcity.gov.uk/documents/s150479/Enc.%202%20for%20Quality%20Account%20202223.pdf

p) CQC Section 48 Inspection April 2024

"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.

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." – CQC

2. Mental Capacity Act

a) April – March 2022 CQC Inspection (published November 2022)

"The new structure covers both the Mental Health Act and the Mental Capacity Act and provides a clearly defined escalation process. The clinician's role within the team was to embed the Mental Capacity Act across the trust. We heard examples of how they were redeveloping and improving e-learning and providing advice and support to teams across the trust." – CQC

b) June 2022

The Committee raised the poor compliance with the Mental Capacity Act in its Quality Account response.

https://committee.nottinghamcity.gov.uk/documents/s135386/NHCT%20Quality%20Account%202021_22%20HASC%20Scrutiny%20Committee%20Comment%20Final.pdf

c) CQC Section 48 Inspection 2024

"Poor medicines management, including the application of the Mental Health Act consent to treatment forms and mental capacity assessments.

…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." – CQC

3. Turning Point Crisis Helpline

a) December 2020

The Committee asked about the training of the staff on the Turning Point helpline and was told that NHT was confident in their ability.

https://committee.nottinghamcity.gov.uk/documents/s114233/Minutes%2017122020%20Health%20Scrutiny%20Committee.pdf

b) June 2021

A man died following an overdose. A Prevention of Future Death Notice published in June 2022 said this was "a cry for help, or to secure secondary mental health treatment". It also referred to the lack of information shared with his GP, including not telling the GP of a diagnosis.

"Evidence was heard regarding the operation of a triage for patients who may be experiencing a mental health crisis. A practice had developed of bypassing specialist mental health assessment by means of telephone workers making their own judgments about the level of risk a person presents to themselves and others, and a judgment about whether or not they require urgent mental health assessment and / or treatment, based on a very limited criteria. This had the result of only a very small proportion of potentially unwell patients being considered by a person with qualifications to assess and treat mental health. This was a culture and practice which stood in conflict with the procedure the Trust had in writing for the role of the telephone workers.

During the evidence at the inquest the Turning Point staff member stated that Turning Point staff may be placed on the line within their first week of starting work, after shadowing a small number of shifts. It was also stated that there are frequent times when calls are not transferred to CRHT in line with the UK Mental Health Triage Scale." – HM Coroner

https://www.judiciary.uk/wp-content/uploads/2022/09/Keith-Nottle-Prevention-of-future-deaths-report-2022-0189_Published.pdf

https://www.judiciary.uk/wp-content/uploads/2022/09/2022-0189-Response-from-NHS-Nottinghamshire-Healthcare.pdf

https://www.judiciary.uk/wp-content/uploads/2022/09/2022-0189-Response-from-Turning-Point.pdf

c) November 2023

The Healthwatch report into Specialist Mental Health Services in Nottingham had significant critical feedback about the Turning Point Crisis Access Line.

https://hwnn.co.uk/wp-content/uploads/2024/01/HWNN-SMI-Report-Specialist-Mental-Health-Services.pdf

d) CQC Section 48 Inspection 2024

Critical of the Turning Point Crisis Access line, in particular staff skills and training with patient feedback saying it can do more harm than good.

"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." – CQC

e) March 2024

I had an example with NHT of a case where a patient told the Turning Point Crisis Access line had taken an overdose. The patient was told 'that's a shame' and no further action was taken. The patient was taken to hospital after their GP raised concerns after they had not attended an appointment some days after the overdose (and telling the access line). The Committee also flagged concerns at its March 2024 meeting when discussing crisis care.

https://committee.nottinghamcity.gov.uk/ieListDocuments.aspx?CId=614&MId=10184&Ver=4

4. Observations

a) CQC Inspection 2019

Male staff were found to be doing female patient observations without warning them.

"Staff did not follow the trust's policy around the use of observation and did not follow national guidance to monitor deterioration in patients' physical health." – CQC

b) 2019-2024

At least two Prevention of Future Death Notices issued due to patients' physical observations either not being done, or delayed action when needed (see also 2022 CQC Inspection).

c) CQC Inspection 2022

Generally positive comments about observations, except for a comment that "staff told us that there were system pressures and there was therefore sometimes pressure for them to take patients when they did not have enough staff. We reviewed an incident where a patient had fallen as there were not enough staff to observe them. This incident was being investigated by the trust. However, this appeared to be an isolated incident as we did not find evidence of similar incidents." – CQC

Note: Prevention of Future Death Notices found patients died as a result of a failure to act quickly enough after physical concerns noted during observations in January 2022 (https://www.judiciary.uk/wp-content/uploads/2022/01/Michelle-Whitehead-Prevention-of-future-deaths-report-2022-0016_Published.pdf), July 2022 (https://www.judiciary.uk/prevention-of-future-death-reports/andrew-vizard-prevention-of-future-deaths-report/) and October 2023 (https://www.judiciary.uk/prevention-of-future-death-reports/michelle-whitehead-prevention-of-future-deaths-report-2/).

The Coroner said that "Many of these issues have been the subject of scrutiny in at least two previous Inquests, that have followed deaths on inpatient wards of the Trust. I have received reassurance during these Hearings that the issues have been addressed, but this case illustrates that they clearly remain. The issues are very serious in my view." I can find no point at which the CQC noted these, despite ongoing inspections at the same time as the inquests.

d) CQC Inpatient Wards Inspection 2023

"There was an inconsistent approach on which documentation to use when recording seclusion observations.

Observation records completed by staff had been falsified.

Staff did not always raise concerns and report incidents and near misses in line with trust policy.

The service did not always learn from incidents." – CQC

5. Duty of Candour

a) CQC Inspection 2022

"The trust applied their statutory duty of candour effectively. There was a clear process in place when things went wrong. A 'culture of candour' was promoted and had been embedded in the trust investigation process. The trust offered an apology for incidents and followed guidance for statutory duty of candour when required. When there was a serious incident that required investigation duty of candour was considered at the start of the enquiry so that the trust could formally apologise and ensure families were involved in setting the terms of reference for the investigation." – CQC

b) June 2023

"I am told that the Trust is, "committed to continuing our improvement journey in this area", however, I remain concerned that the Trust's investigation was insufficient, lacked robustness and did not fully engage with the duty of candour." – HM Coroner

This patient completed suicide in 2018, but multiple reviews happened in 2022 at the time of the CQC inspection. The Coroner found in 2023 that NHT failed to apply its

Duty of Candour as a result of the poor quality of those reviews. This report was escalated to various MPs with a defence or veteran's brief.

https://www.judiciary.uk/prevention-of-future-death-reports/jonathan-cole-prevention-of-future-deaths-report/

c) CQC Section 48 Inspection 2024

"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." – CQC

6. Discharge

a) November 2017

"The lack of a co-ordinated discharge from in-patient psychiatric care into the community, in particular the failure of appropriate professionals from hospital and community to liaise and for family to be informed as a pre-requisite for discharge." – HM Coroner

https://www.judiciary.uk/wp-content/uploads/2018/02/Ryan-Vout-2017-0376_Redacted.pdf

b) CQC Inspection 2019

"Staff planned and managed discharges well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway." – CQC

c) CQC Section 48 Inspection 2024

"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.

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.

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. 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.

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." – CQC