NHS
Nottinghamshire Healthcare
NHS Foundation Trust

Nottinghamshire Healthcare NHS FT: CQC inspections and reviews

Briefing for Nottingham Health and Adult Social Care Scrutiny Committee

April 2024

Introduction

1. This briefing will provide an update on recent Care Quality Commission (CQC) reports on Nottinghamshire Healthcare NHS FT, including the reports on Rampton, Adult Inpatient Services and Older Adult Inpatient Services as well as the Section 48 review commissioned by the Secretary of State for Health and Social Care. The briefing outlines some of the key actions the Trust has taken in response and to the plans for improving our services further.

Background

2. Over the past three months, the CQC have published several key reports into services provided by Nottinghamshire Healthcare NHS FT. These are:

    - **Report into Rampton Hospital – Overall finding Inadequate.**
      Report Published 17th January 2024; Inspection took place June/July 2023
      Core Service - High secure hospitals - (17/01/2024) INS2-18268147597 (cqc.org.uk)

    - **Acute Wards for adults of working age and psychiatric intensive care wards – Overall finding Inadequate**
      Report published 1st March 2024
      Core Service - Wards for older people with mental health problems - (01/03/2024) INS2-18347625871 (cqc.org.uk)

    - **Wards for Older People with mental health problems – Overall finding Inadequate**
      Report published – 1st March 2024
      Core Service - Wards for older people with mental health problems - (01/03/2024) INS2-18347625871 (cqc.org.uk)

    - **Section 48 Special Review of Mental Health Services at Nottinghamshire Healthcare NHS FT – Published 26th March 2024**
      Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust - Care Quality Commission (cqc.org.uk)

Section 48 Review

3. This review was commissioned by the Secretary of State for Health and Social Care and covered 3 workstreams:

- An assessment of the improvements made at Rampton Hospital
- A review of the quality and safety of our community mental health services, crisis services, and Early Intervention in Psychosis service.
- A review of records relating to the care and treatment of Valdo Calocane including care provided in non-Trust providers, such as primary care and independent hospitals.

Only the first two workstreams have reported to date, and given the Committee's concerns, we have focused on the issues relating to the second of these workstreams.

Section 48 Review Summary:

4. The CQC summary of their report is as follows:

- **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.

Trust Response

5. **Adult and Older Adult In-Patient services**

Enhanced Observations

- Written briefings on the importance and effective observations and the possible consequences of these not being carried out have been provided for staff, displayed in all wards.
- A programme of delivering face to face explanations of the importance of enhanced observations was carried out on all wards.
- Senior Managers have attended handovers to ensure they include allocation of observation responsibilities and ward meetings to complement the above.
- Training on effective observations has been provided to all staff who then complete competency checks. Observation training is included in inductions inc. Agency staff orientation.
- Assurance is provided by reviewing CCTV records against plan. We have now reviewed over 1,000 episodes of CCTV which confirmed a compliance rate of over 95%, with many wards now seeing no instances of non-compliance for several months.
- The Participation Team are investigating patient experience of being on enhanced observations.
- Therapeutic observations collaborative commenced.

Staffing

- Safety Huddles were introduced to all wards. Further work is required to fully exploit their potential.
- Daily Demand Meetings/Operational Huddles in place to oversee staffing and ensure staffing is distributed to address clinical demand.
- Support the use of regular Agency staff where the need is identified and derogation confirmed, thereby promoting continuity.
- Developed a recruitment campaign to include open days, college engagement, international recruitment, local advertising, career development, Preceptorship and wrap around support for newly qualified staff.
- Roster oversight and sign off improved.
- Establishment review panel chaired by Executive Director of Nursing and Finance Director to review local reviews using a triangulated approach to ensure establishments meet demand.

Medicine Management

- Across MHSOP wards, prescription charts are reviewed at each handover for signatures, T forms. Any omissions are challenged and addressed with the staff responsible in real time.
- Head of Nursing reviews prescription charts each week.
- Medication administration best practice learning/reflection sessions are in place on Silver Birch Ward. These are facilitated by the Advanced Clinical Practitioner and include all registered nurses. This model is designed to address concerns highlighted and if successful will be rolled out across MHSOP wards.

Seclusion

- The Reducing Restrictive Interventions Team delivered an intensive training program to ward staff across Adult Acute wards where seclusion is operated.
- Each episode of seclusion is attended by the Matron, Head of Nursing or Duty Senior Nurse
- All episodes of seclusion are reviewed by the Head of Nursing, where records are triangulated with CCTV video reviews. These reviews show an improvement in compliance, usefully they also highlight areas for further work.

Physical Healthcare

- Introduced Board Reviews on Adult Wards each morning. These meetings are led by medical colleagues and the Nurse-in-Charge. They have a set agenda which includes individual Physical Health Assessment and care needs.
- Established Physical Health Matron and Registered General Nurses in MHSOP wards.
- Staff are trained in Hospital Life Support.
- 96% of staff have received NEWS2 training and how to recognise the deteriorating patient.
- Introduced NEWS2 aid memoire – details parameters, medical response and responsibilities for emergency equipment of a named nurse each shift.
- Nutrition and Fluid training in place and charts are reviewed at each handover.

Learning from Incidents

- The Trust had undertaken a review of all outstanding incident reports clearing a significant backlog.
- A monthly Care Group Clinical Learning Forum has been established. These exist within the Governance framework and include learning from; After Action Reviews, ILRs, MDT reviews and complaints.
- We will commission a Making Families Count event to share the experience of families affected by suicide and homicide.
- The Trust is transitioning at pace to Patient Safety Incident Response Framework - PISRF – which focuses on we can learn from incidents.

Privacy, Dignity and Personalised Care

- Arrangements were put in place for personalised wash kit including toothbrushes which are kept separate.
- Bowel charts and bath books were discontinued and personalised records implemented.

Environment

- Providing J-track curtain tracking to remaining shower areas at Highbury Hospital.
- Replaced toilet dispensers at Highbury that could conceivably be used as a ligature anchor point.
- Ensured staff on all wards at Highbury can access ligature cutters.

6. **Adult Community Mental Health services**

Adult Community Teams

- We have now triaged and identified all those people waiting for assessment and a treatment or care package. We have ensured that all people waiting have a safety plan in place and know where to go.
- We have updated our Waiting Well policy and have ensured that all teams are following this, ensuring contact is maintained with those waiting.
- Our local Mental Health teams are using the risk assessment process to understand the needs of those waiting and to review those most in need of support. The Deputy Director of Nursing and Suicide prevention lead have spent time at the RAM meetings embedding changes and ensuring consistency and effectiveness.
- We have reviewed our Did Not Attend policy to place a greater emphasis on what we need to do to reach out to those people who are struggling, and to embed a greater safety process prior to discharge to GPs.

- We identified those teams with disproportionate pressures and put in place cover arrangements to ensure minimum staffing levels are achieved, and we are progressing the recruitment drive already in place and including the development of new roles.

Crisis Resolution and Home Treatment Teams

- The risk assessments of all people under the Crisis Teams were reviewed, and all risk assessments are in place.
- We have established a monthly programme of audits which will include quality monitoring of safety plans.

Crisis Line – 111

- We are reviewing our Crisis Line offer in its entirety.
- We have secured a different telephony system which will support the reduction of the number of unanswered calls and provide much improved reporting functionality. Further work will be completed to enhance the technical ability of the systems used.

Medicines

- Our pharmacy team reviewed all those people in receipt of depot medication and other medicines dispensed by local community teams to ensure the necessary controls are in place and adherence to the individual's treatment plan.

Estates and Facilities

- A review of all ligature assessments for all community bases have been undertaken. This included working with teams to strengthen controls and understanding of risk in the context of the buildings they occupy.

Learning

- We have commissioned a thematic review of homicides which will be conducted by four clinically credible, highly experienced people. The Terms of Reference have been agreed and the work has commenced. We will share the learning with systems partners including colleagues at the CQC.
- We are also carrying out a review of people who may have come to harm whilst waiting for one of our services.
- The patient safety team are organising a number of learning events for the mental health care group using the voice of those who use services and their families.

- Phase 2 of this work will run in parallel and focus upon delivering cultural and systemic change.
- We had commissioned a review of both our Crisis Services and Local Mental Health Teams prior to the section 48 review. This review is underway, and we will ensure findings from the CQC review are included. We have extended the Terms of Reference in addition to the work around contemporary models, place-based care, the number of teams we have in place and the improvements we know we need to make.

7. Next Steps

As a result of the CQC reports listed above and the Section 48 review, the Trust has been placed in Segment 4 of the NHS National Oversight Framework. This segment if for those Trusts where it has been identified that there are very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support.

The Trust is now working at pace to develop an Integrated Improvement Plan capturing all of the actions and recommendations arising from the various CQC reports, alongside Prevention of Future Deaths notices and other external reviews. This will be finalised by the end of April and will cover the full scope of Trust challenges including patient safety, quality, people and culture, finances and leadership. The Trust is being supported by the national NHS England Recovery Support Team in developing this plan, which will be delivered as a whole Trust Improvement Programme.