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.