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.