Leicestershire Partnership NHS Trust

Nottingham Healthcare Foundation Trust (NHFT) Section 48 review

Trust Board 24th September 2024

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Nottingham Healthcare Foundation Trust (NHFT) Sect 48 review

- Following the conviction of Valdo Calocane (VC) in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber, the Secretary of State for Health and Social Care commissioned CQC to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008.
- Part 1 was published in March 2024 and a review undertaken within LPT.
- This is the first time a section 48 has been undertaken into an individual case.
- The case of Valdo C was reviewed against 10 benchmark cases also from Notts.
- This rapid review is intended to be complementary to the Independent Mental Health Homicide Review which will be conducted by NHS England over a longer timeframe and will provide more detailed scrutiny of Valdo Calocane's interaction with mental health services.

NHFT Section 48 review Part 1

- In March 2024, the first part of the review on the findings of CQC assessment of patient safety and quality of care provided by Notts HC.
- The review focussed on Adult community mental health teams and progress made at Rampton Hospital since the last CQC inspection in July 2023.
- A deep dive of the findings and learning for adult community mental health teams was presented to EMB in June and July 2024.

What the CQC plan to do nationally

“This review has focused on one NHS trust but…the issues we have identified at Nottinghamshire Healthcare NHS Foundation Trust are not unique. We found systemic issues with community mental health care, including a shortage of mental health staff, a lack of integration between mental health services and other healthcare, social care, and support services, including the police. Without action, this will continue to pose an inherent risk to patient and public safety.

CQC has begun work to look in detail at the standard of care in community mental health across the country to fully understand the gaps in the quality of care, patient safety, public safety, and staff experience in community mental health services. We are also working with NHS England to improve data on the quality and safety of community mental health services.

There must also be wider national action to ensure that people in need get care, treatment and support at the right time in the most suitable environments to prevent more tragedies”.

What did the CQC find?

1. **Access to care** People struggled to access the care they needed when they needed it, putting them, and members of the public, at risk of harm.
2. **Quality of Care** The quality of care and treatment across the trust varied and care provided did not always meet the needs of individuals.
3. **Safety of Services** High demand for services and issues with staffing levels meant that patients were not always being kept safe.
4. **Leadership and Governance** Leaders were aware of risks and issues faced by NHFT, but action to address safety concerns was often reactive.
5. **System Working** At a system level, there were 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.

What have the CQC asked of us?

To update them of the names, addresses, phone numbers and opening times of all the following community teams:

Community-based mental health services for adults of working age

Community-based mental health services for older people

Specialist community mental health services for children and young people

Community-based mental health services for people with a learning disability and autistic people

Mental health crisis services and health-based places of safety

The CQC want to gather information about the standard of care in community mental health services. They have asked us to explore how LPT trust board has:

Reflected on the issues and recommendations identified in the review

Self-assessed and/or audited community mental health services

Identified areas for improvement in quality of care, patient safety, public safety and staff experience

Put in place, or are putting in place, action plans and timescales to address the areas for improvement

We will need to complete a survey before the 30th September and be prepared to discuss this at our engagement meetings.

What have we done/what do we need to do following the report?

- Addresses, phone numbers and team opening hours have been submitted to the CQC
- We have completed an initial self assessment of our core community MH services and those services which are considered to be additional services by the CQC.
- We will submit our survey (from our reviews) to the CQC by 30th September.
- We have completed a deep dive following review of the 1st report and a further in review will be going to SEB in October.
- Quality and service visits and data reviews are planned for these teams to prepare for potential CQC assessment alongside making sure all staff are familiar with the new CQC approach.

NHFT Sect 48 review Part 2

- Part 2 published 13th August 2024
- The report acknowledges that while it is not possible to say that the devastating events of 13 June 2023 would not have happened if Valdo Calocane had received additional support, what is clear is that the risk he presented to the public was not managed well and that opportunities to mitigate that risk were missed.
- LPT have reviewed the findings and assessed ourselves against the key findings and a summary is provided across the following slides. The review has been undertaken with input from enabling services and clinical leads.
- A workshop has been arranged to engage with staff to hear how we can support them further to work in these different ways and to commence the actions/learning.

Care plans and engagement

Theme from Report	Learning for LPT
Care plans should always be balanced with other sources of information, such as information from the person's family, education provider or work, and should look at any incidents of violence Care Plans and Assessments to consider the wishes, feelings, beliefs and values of the individual, but it must also consider what is in the person's best interests.	• All service user communication needs should be considered and documented on System One under the Accessible Information Standard so communication and information can be provided in a way that meets individual needs. • Implementation of DIALOG/DIALOG+ in MH services to enable a structured conversation between a health professional that is patient centred with a focus on change. • Shared Decision - making principles should be applied when creating care plans with patients, their families, carers and advocates. • Shared decision - making tools should be developed with service users, families and carers to ensure that informed decision making can take place. • Service Users should have access to interpretation and translation support as early as possible to enable meaningful engagement in care planning.

Care plans and engagement

Family, Carer and Advocate Involvement

Theme from Report	Learning for LPT
Families feeling excluded, not listened to or that staff weren't communicating effectively was an issue we identified in our wider review of care at Notts HC. The family contacted the hospital to say they were worried that his illness was getting worse, but this was not always acted on well. This happened to other families too. The family contacted the EIP team shortly after discharge saying they were concerned that VC's mental state was deteriorating. While records show that the family's concerns were documented and emailed to the care co-ordinator, there does not appear to have been any attempt to contact VC following the concerns raised. This raises questions about how well the team engaged with VC's family, as well as questions over the quality of record keeping.	• Structure to be put in place to ensure discussions with service users and if and how they want their family or carers to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances and should not happen only once. • The involvement of families and carers can be quite complex, staff should receive training in the skills needed to negotiate and work with families and carers, and, also in managing issues relating to information sharing and confidentiality. • All inpatient and crisis services are to due to complete their self-assessment against the 6 Triangle of Care standards by September 2024. There are plans to implement within the community. By adopting the Triangle of Care standards services will work to improve therapeutic alliance between service user, staff member and family/ carer that promotes safety, supports recovery and sustains wellbeing. It aims to ensure appropriate carer inclusion - "Carers Included" - throughout the patient's care journey. • Creation of a guide for staff around caring confidentiality has

Action in response to medication non compliance and disengagement

Clinical Decision making

Theme from Report	Learning for LPT
Valdo was known to be non compliant with his medication There was a pattern of non compliance with medication followed by deterioration Detaining individuals under section 3 provides additional powers under the MHA including discharge onto a community treatment order (CTO). This may have provided a practical framework to use depot medicine in the community, although the decision not to use depot medication at this point was also a missed opportunity.	Actions underway • MDT process strengthened to ensure the team have the information to make their decisions, this Includes consideration of different actions • Identification of patients for referral to Assertive Outreach • MDT's are also working in a hub and spoke model this supports safe clinical decision making where patients aren't engaging and compliance with medication is a theme. However, this needs to be strengthened following recent incidents within LPT. DMH has taken learning from a recent incident and this will inform wider working around safe clinical decision making.

Risk Assessments

Clinical Decision making

Theme from Report	Learning for LPT
Risk assessments should take into account information about the patient's history, including any incidents of violence, or self-harm or self-neglect, and should assess how the person using services is feeling, thinking and perceiving others – not just how they are behaving. While some key risks were identified, we found that risk assessments minimised or omitted key details including: • refusing medicine ongoing and • persistent symptoms of psychosis levels of violence against others • when his psychosis was not managed well escalation of violence towards others in the later stages of his care under NHFT • it appears that there was no holistic approach to VC's medicine reviews. These reviews do not appear to have connected his lack of response to treatment with the dose and type of medicine he was prescribed, or his lack of compliance with taking the medicine	We are implementing and strengthening risk assessment process using the following guidance via MH transformation. **Self-harm: assessment, management and preventing recurrence** NICE guideline [NG225] This guidance has been developed and this alongside the findings from The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) One of the significant changes is to not assess risk as Low, medium or high but rather, the management of risk should be personalised. Risk assessment is one part of a whole system approach that should aim to strengthen the standards of care for everyone, ensuring that supervision, delegation and referral pathways are all managed safely.

Capacity to consent to treatment

Clinical Decision making

• Theme from Report	• Learning for LPT
Our review of VC's care also found concerns around his capacity to consent to treatment and whether these were considered in his risk assessments. The Mental Health Act Code of Practice is clear that "a person is 'unable to make a decision' for themselves if they are unable to do any one of the following: • understand information which is relevant to the decision to be made • retain that information in their mind • use or weigh that information as part of the decision-making process, or • communicate their decision (whether by talking, sign language or any other means)."	• Teams/clinicians to learn/share/discuss when to document consideration/assessment of capacity. • Whilst capacity is to be assumed, consideration to be given when patients are not engaging or struggling to comply with medication as a reason to consider assessment of capacity.

Discharge Decision

Clinical Decision making

• Theme from Report	• Learning for LPT
Before he was discharged back to the GP in September 2022 from the early intervention in psychosis team, there does not appear to have been an updated risk summary VC was discharged back to his GP due to non-engagement. However, there was no evidence that VC's family was consulted or that the GP, police or university were consulted. This reflected findings of our wider review where we found a lack of GP involvement in discharge planning. Problems around communicating discharge decisions and difficulties in transitions of care between inpatient and community services were also issues we identified in our wider review of Notts HC. Discharge planning was not robust, and that there was a 'lack of clarity of thinking' in relation to discharge decision The discharge happened on a Friday with no crisis home treatment team input arranged over the weekend. The EIP team attempted to make a referral to the crisis resolution and home treatment team but they were unable to accept VC due to capacity due to an "influx in GP referrals over the weekend"	Actions underway: • LPT does not currently have a trust wide discharge policy that incorporates differences between directorates. This is currently under review. • Following learning from a recent incident, DMH has developed a more robust discharge SOP. This will be used to inform the wider policy development.

Self Assessment of community mental health services

- Following the publication of Part one of the Section 48 review into Nottinghamshire Healthcare NHS Trust a detailed self-assessment was presented at the Executive Management Board in June and July 2024 on the key areas of learning in the Part One Report.
- This section detailed systems and processes in place within adult community mental health teams and the wider DMH directorate to provide assurance of reflection and self assessment against the key learning identified in the report.

Self Assessment

- LPT has worked with the LLR ICBs to complete the NHSE Midlands Self Assessment Tool. This considers current level of service provision and capacity in relation to adequately and safely providing the function of assertive and intensive community support for people with serious mental illness, where engagement is a challenge. This tool considers 14 key domains. The self assessment has been completed and an action plan is in development. The progress of these actions will be governed through the ICB.
- LPT and NHFT executive and compliance teams engaged in a reflection and learning session on the Section 48 reports as part of their joint CQC programme on the 6th September. This was to provide an opportunity for shared learning and approaches to improvements and will form part of an ongoing programme of work.

Further Self Assessment

- The compliance team have commenced a series of mock inspections alongside the Valuing High Standards Programme for the Crisis teams, Community Mental Health & LD Teams and CAMHS Services to provide additional assessment and support for improvement aligned to the learning from this review.
- A further self-assessment using the AMAT tool was conducted across the wider adult and children's community mental health services in September 2024 to provide intelligence on the learning from Part one and Part two of the review. This data will be used to inform the development of improvement actions which are not currently in place through already established programmes of work.

Self assessment

- 25 services across DMH and FYPC/LD were asked to completed the self assessment process with a response rate of 100%.
- The Community Mental Health Service for working age adults completed this in June 2024 following the publication of part one with a review of the additional questions from part 2 in September.
- All other services submitted their responses via AMAT.
- The services are listed in table 1.
- Some aspects of the Section 48 learning were more applicable to some areas than others however we took a broad approach to enable teams the opportunity to reflect across the wider service.

Table 1 Services completing self-assessment

DMH	FYPC/LD
• Community Mental Health Team Adults • Community Enhanced Rehabilitation Team • Mental health facilitator service • PIER Team • Therapy Services for People with Personality Disorder • Perinatal and Maternal Mental Health Team. • Homeless Mental Health Service • Assertive Outreach • Mental Health Liaison Service and Mental Health Urgent Care Hub • Crisis Resolution Home Treatment Team • Community Forensic Mental Health Team • PAUSE Team • MHSOP Community	• Crisis and home resolution team/ crisis plus/ CYP mental health urgent hub • CAMHS Outpatients & Group Work • Intensive community support team • Young people's team • Eating Disorders Team CAMHS • Learning Disabilities Team CAMHS • Paediatric Psychology • Specialist Autism Team • LD Crisis Response and Intensive Support Team • LD Forensic Team • LD Access & Community LD Team • Adult Eating Disorder- Outpatients

Initial priority areas of improvement identified from self assessment:

- Continued work on reducing waiting times and processes for ensuring people are kept safe while waiting in some community teams as part of ongoing improvement work underway.
- Delivery of the Crisis improvement programme to ensure consistent timely access.
- Working with system partners to ensure services, including GP practices, are integrated and use shared systems to provide patients with seamless transitions in care and treatment.
- Working with system partners to ensure that joint working protocols are in place with GP practices, which ensure that patients with complex mental health needs have joined up care.
- Development of a robust discharge policy which should include how patients, families and carers are involved in the discharge planning process and shared decision making.
- Ensuring Local SOPs for DNA reference the Trust wide DNA/Was not brought policy.
- Review of systems and processes in place to ensure safe caseload sizes are managed and ensure these are effective.
- Review of local SOPs to ensure they include what to do where a person does not have capacity and does not consent to the involvement of the team.
- Ensure that all incidents are reported (and escalated where appropriate) in a timely way.
- Ensure that, where applicable, safeguarding advice is sought and acted upon in a timely way.
- Strengthen co-production and collaborative working with staff, patients, families, carers and partners.
- Continue to strengthen MDT working to enable a collaborative approach to delivering safe and quality care.
- The above priority areas will be monitored and reported via the MH Q&S meeting.

Improvements already underway

- *A template for patients being transferred between teams has been developed for use across planned treatment to ensure that all relevant information is shared clear and up to date*
- Risk training has been updated to include discussions surrounding discharge due to ‘Did-Not-Attend’ (DNA) being needs-led decision making. The current Clinical Risk Assessment Training slides will have been amended to ensure staff are aware that any decision to discharge a patient due to non-attendance must be needs-led rather than a blanket approach due to non-attendance. The slides have been updated and will now be used in any current Clinical Assessment Training that is delivered to staff across the clinical teams.
- Update to the Trust Policy in relation to ensuring decisions are needs led and that all risk assessments must be updated prior to patients being discharged to evidence that it is safe to discharge under the management of non-attendance policy.
- The Head Of Nursing and Head of Psychological Therapies have worked together to implement scenario-based sessions to support change in thinking in relation to patients who have difficulty engaging. As part of this, the Practice Development Nurse has developed some scenarios which will be included in the clinical risks assessment policy which allow for facilitated discussions about how we can support patients where engagement is a limiting factor.
- An audit of record-keeping was completed by the Matron in June 2024. The community matron and team manager carried out triadic supervision with all individual team members with the City Central CMHT to feedback the findings of the audit and discuss any improvement plans. All individual staff were sent copies of their own action plans and the team members have been given protected time to focus on the actions of the audit. The Matron will continue to audit the record keeping on regular occasions and the findings of these audits will be shared with the individual staff members and via the Quality and Safety meetings, where there are any themes identified then the Matron and Practice Development Nurse will support with any actions across the whole team.

Improvements already underway

- The MH Directorate already had an ongoing programme set up to look at improving the MDT process with clearly identified roles and responsibilities and to develop guidance which would support MDT working. The first part of this has been to send the SOP out for comments. There has also been the introduction of a specific MDT template and guidance introduced on the electronic patient record. This template is to be completed during the MDT meetings and the Community Mental Health Team SOP has been updated to include guidance around the completion of this template. The SOP has been shared with the clinical teams and is being updated based on any feedback received and the final version is due to be signed off in September. The Practice Development Nurse is attending MDT meetings to support with embedding the new template across the clinical teams. All the CMHT's have confirmed that the template is now being used in practice. There will be regular audits of the MDT documentation commencing in October.
- Training and review of real-life scenarios will be used to foster discussion and learning for all registered disciplines across all services within the Directorate of DMH. In addition to this as part of the ongoing transformation work, the Assertive Outreach team and now working closely with the CMHT's (including attending MDT discussions) to ensure where there are complex patients where engagement is a factor that they are available to provide support and expertise and to consider if an onward referral to Assertive Outreach is required, this is supporting with timely onward referrals for a more assertive approach.
- We are adding a discharge checklist to SystmOne.
- Developing a discharge audit to ensure all processes are being followed and for an improvement plan to be developed to ensure compliance and process for ongoing monitoring in place. The discharge checklist is currently being used within MDT's in its paper format, which ensures that the clinical discussions are being captured and recorded as part of the MDT discussion. There is a plan to have the discharge form as part of the electronic clinical record and this is being developed with support from the IM&T team. A discharge audit was added to the Trusts electronic audit system (AMaT) in August and the first audit has been completed. The results have been presented at Community Quality and Safety meeting on the 27th of August 2024 and team managers have been asked to write action plans which identify how the audit results will be improved and to ensure this is shared with clinical teams. A specific discharge audit for the City Central discharges were completed in September 2024. The action plans are due to be presented in September's Community Quality and Safety meeting and will be reviewed at regular meetings moving forward.

Next steps

- Following the phases of self-assessment it is identified that LPT has a number of improvement programmes already in train both within LPT and at System level which have already addressed or are addressing the learning from the review. It was proposed at the Strategic Executive Board in September 2024 that there is a mapping exercise conducted on the current plans in place and ensure all improvements identified through this self assessment process are captured within a clear action plan with timescales. This will be presented at SEB in October 2024.
- To note there is already a detailed programme of mental health transformation across LLR. This includes actions and timescales. The key community transformation actions are namely, establishing the new Integrated Neighbourhood Community Mental Health Teams, the new front door and MDT process, and the Community Clinical Framework. These continue to be progressed and are reviewed and monitored through the DMH Transformation DMT and the LPT Transformation and QI Committee. The Directorate also have a detailed improvement plan for the Crisis Service.

Next steps continued

- A series of Community of Practice style meetings are planned across the Trust to involve and engage with staff and patients on the wider learning.
- LPT is proactively engaged in the NHSE ICB self assessment of community mental health services. The self assessment process has been completed and is within the analysis and action planning phase which is to be completed by the end of September 2024.
- The Compliance team are planning an ongoing series of mock inspections/quality visits across LPT Community MH, LD, CAMHS services in preparation for impending CQC activity. This will dovetail with the Joint CQC programme Board with NHFT and be reported to SEB.
- Respond to the CQC survey by the 30th September 2024.

Action to identify gaps in work already underway and collaboratively agree actions with clinical teams

- Workshop planned for PM 8th October (face to face)
- DMH and FYPCLDA clinical teams
- ICB Patient Safety specialist invited
- Format will be four stations to consider the key areas against the staff's experience:
  - Management of Non Engagement
  - Listening and hearing from Families
  - Decision to discharge
  - Assessment of Risk

Summary

- This slide pack provides a summary of the learning from the Section 48 Review of Nottinghamshire Health Care Foundation Trust.
- It details the self-assessment processes that have been undertaken alongside opportunities for reflection and learning at organisation, system and group level.
- The next phase of this work is to further analyse and map the self-assessment to current improvement programmes in place and ensure these are captured within a clear improvement plan alongside community of practice sessions. This will be presented to SEB in October 2024.