Background

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 us to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT), where VC was treated for paranoid schizophrenia.

As part of our review, which is complimentary to the Independent Mental Health Homicide Review by NHS England, we were asked to look at 3 specific areas:

1. **A rapid review of the available evidence related to the care of Valdo Calocane**, alongside a small number of other cases (to enable benchmarking), to determine whether this evidence highlights wider patient safety concerns or systemic issues with the provision of mental health services in Nottinghamshire.
2. **An assessment of patient safety and quality of care provided by NHFT**, drawing on our latest inspection findings and other available intelligence. This includes our recent inspections of Rampton High Secure Hospital and acute wards for adults of working age and wards for older people with mental health problems at NHFT. We will also assess care for patients in the community who are presenting with risk to public safety, and the extent to which there is sufficient oversight from the provider. This includes the trust's discharge processes and approaches, including its assessment of patient risk and engagement and working with other local partners.

3. **An assessment of progress made at Rampton Hospital since the most recent CQC inspection activity** to offer an up-to-date assessment of care provided at the hospital.

In this report, we detail the findings of parts 2 and 3: our assessment of patient safety and quality of care provided by NHFT, and our assessment of progress made at Rampton Hospital since our last inspection in July 2023.

We will publish a separate report on part 1 in relation to the care of VC in summer 2024.

Nottinghamshire Healthcare NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust (NHFT) provides learning disability, mental health, community health, forensic and offender healthcare services across Nottinghamshire, Leicestershire, Lincolnshire, and South Yorkshire. The trust delivers services from over 257 locations in the community, in hospital settings and across low, medium and high secure environments, including prisons.

NHFT also provides specialist national and regional services such as the National High Secure Deaf Service, the National High Secure Learning Disability Service and the Nottingham Centre for Transgender Health.

NHFT is part of the Nottingham and Nottinghamshire Integrated Care System, and serves a population of 1,226,000 people. Each year, the trust provides care to more than 2 million people.

As well as serving a large number of people, NHFT cares for a diverse population across a wide geographical area:

- over half (55%) of people who live in the city of Nottingham live in the most deprived areas nationally, but this drops to just over 15% in the wider Nottinghamshire area
- 43% of people who live in the city of Nottingham are from ethnic minority groups, while 88% of the population in the wider Nottinghamshire area are White British.

Community mental health services for adults of working age

NHFT's community mental health service is made up of 12 local mental health teams (LMHT), plus bed management, administrative and psychological services. LMHTs provide mental health services for people aged 18 to 65 years across Nottingham City, Nottinghamshire county and Bassetlaw.

Community mental health teams (including early intervention teams and crisis teams) provide short and long-term support in the community for people with mental health needs. The teams may include a community psychiatric nurse, a psychologist, an occupational therapist, a counsellor and a community support worker, as well as a social worker. As part of the support offered, once they have had an assessment, guidance from the Royal College of Psychiatrists is clear that people should be allocated a care coordinator to keep in regular contact with them and help plan and coordinate their care and treatment.

Following assessment, individuals will be placed on a care pathway. Care pathways define what happens and who does what in terms of diagnosis, treatment and follow up in a healthcare setting. Put simply they are used to inform providers of care, and patients, their families and carers about what to expect during that period of treatment. They define:

- what patients are being seen for
- what assessment or diagnosis tools should be used

- who carries that out, for example, nurse, psychologist, doctor or care coordinator
- what treatment is indicated.

The trust has a separate specialist service for early intervention in psychosis. Psychosis is characterised by hallucinations and delusions, and affects people's perception of reality, with the potential to cause considerable distress and disability for the person and their family or carers. National Institute for Health and Care Excellence (NICE) clinical guideline CG178 states that treatment can begin as soon as a first episode of psychosis has been identified – it does not have to wait for a final diagnosis and services are encouraged to embrace diagnostic uncertainty.

Treatment should be provided by a service capable of providing a full and effective early intervention in psychosis package of NICE recommended care. This is normally a specialist early intervention in psychosis team. People who experience psychosis can and do recover. The time from onset of psychosis to the provision of evidence-based treatment has a significant influence on long-term outcomes. The sooner treatment is started the better the outcome.

At NHFT, the early intervention in psychosis teams work with people for up to 3 years from their first episode of psychosis, and work towards discharge for 6 months before the person is due to be discharged from the service. Patients may be discharged to another LMHT.

High secure hospitals

NHFT runs Rampton Hospital, one of 3 high secure hospitals in England. The other 2 high secure hospitals are Ashworth Hospital in Liverpool and Broadmoor Hospital in Berkshire.

As a high secure service, each hospital has to go through a rigorous relicensing process every 5 years. The current licence for all 3 high secure hospitals expires in March 2024, with new licenses required from April 2024.

As part of the relicensing process, all 3 hospitals have to go through a series of assessments (provider, regional and national) by a relicensing panel to ensure they meet the criteria set by NHS England. Each hospital is reviewed by a dedicated regional relicensing panel, which is made up of regional NHSE staff, CQC and some national specialised commissioning staff. The panels review the hospitals independently of each other and then submit their proposals to the National Oversight Group for High Secure Psychiatric Services for ratification. Following the panels' assessments, the Department of Health and Social Care will recommend to the Secretary of State whether the hospitals should be relicensed, and how long for.

The current assessment process began in January 2023 and is due to finish at the end of March 2024. While the panels for Ashworth and Broadmoor have recommended the hospitals should be relicensed for 5 years from April 2024, this has not yet been agreed for Rampton Hospital as 2 specific criteria have not been met. These are:

- **High secure hospital criteria 5a –** the hospital must be rated good across all areas in their latest CQC inspection, or there is assurance that any ratings below good are being addressed.
- **Provider criteria 7 –** the provider must be rated good across all areas in their latest CQC inspection, or there is assurance that any ratings below good are being addressed.

At the beginning of the process, the panel (including CQC) felt that Rampton Hospital met the high secure hospital criteria 5a. The panel was assured that although Rampton Hospital was rated below the required good, these issues were being addressed. However, as the relicensing process progressed, concerns emerged about deterioration across the trust, and we were no longer assured that issues were being addressed.

In addition, throughout the process the panel could not be assured that provider criteria 7 had been met. While Rampton Hospital appeared to be making improvements, other parts of NHFT continued to deteriorate. The panel felt that a full 5-year licence for Rampton Hospital would not be suitable, but that a 12-month licence should be offered with conditions added to ensure improvement. This would then result in further monitoring at Rampton Hospital for a 12-month period, ensuring that the appropriate improvements were being made. If the improvements at both hospital and trust level continued, a further license for 4 years could be awarded at the end of 12 months bringing the hospital back in line with the other 2 high secure hospitals. The 12-month period would also allow NHS England to consider and identify alternative high secure provision within another Trust should improvements not be made or be sustained.

Evidence used in this report

In this report, we use information gathered from our onsite visits, reviews of the trust's services, data from previous inspections and ratings, along with other information and personal experiences, including those from people who use services, their families and carers, to inform our judgements about the quality of care within the trust.

We reviewed data, reports and policies, drew on findings from surveys, and analysed publicly available datasets to assess the patient safety and quality of care provided by the trust.

Where possible in the report, we have compared data from NHFT with other trusts or national data. However, in many places this has not been possible due to a lack of standardised data collection.

Conclusions we draw in our report are not solely based on the findings of our rapid review, but take into account findings from our previous inspection activity at NHFT and Rampton Hospital over the last 5 years. We have then looked at these findings within the context of our wider understanding and evidence around the challenges facing mental health services. This includes drawing on evidence from our statutory State of Care and Mental Health Act annual reports, and other thematic reviews.

Feedback to CQC

To inform our view of quality and safety we reviewed information that has been shared with us from people who use services, families and carers, feedback from staff and from partner organisations. This feedback is collected through our Give feedback on care webform, as well as phone calls and emails to our National Customer Service Centre.

Between 18 July 2023 and 5 February 2024 there were 247 records referring to Nottinghamshire Healthcare NHS Foundation Trust (NHFT), of which 173 provided information on quality and safety of care to support the report.

Some cases concerned the trust as a whole, while others related to the service. Analysis is presented at trust or 'setting' level (for example, inpatient, secure setting), except for Rampton Hospital, which was included in trust level analysis as well as reported separately.

Surveys

To better understand the experiences of people who use services, as part of this review we carried out quantitative and qualitative analysis of responses to 2023 Community Mental Health Survey for Nottinghamshire Healthcare NHS Foundation Trust (NHFT). Our analysis does not include national figures or compare results with other participating trusts. National survey results, including trust level results for NHFT, will be published in Spring 2024.

Unless otherwise stated, people's experiences used in this report are based on a combined analysis of qualitative comments from the community mental health survey analysis and all other feedback received by us.

The feedback we received from people who use services, families and carers, and staff, is from individuals who have chosen to contact us directly to share their experience. This means we may be more likely to receive feedback on less favourable or more extreme experiences. We analysed survey responses in response to both what was good, and what could be improved about care. However, as with all feedback to CQC, responses detailing positive experiences tend to be general in nature, and as a result have limited scope for analysis. Negative experiences are commonly more detailed and provide more opportunity for actionable insight. As a result, our analysis focuses on experiences of poorer care, while acknowledging it may not be representative of every experience.

Prevention of future death reports

We analysed 15 prevention of future death reports for NHFT, which were sourced from both the courts and tribunals judiciary websites. These reports highlight the most serious concerns relevant to a service. The sample contained reports published after 1 January 2021, but some dates of death pre-date this, owing to the time taken to conduct an inquest. Reports such as those relating to acute healthcare provision not relevant to the review and some of historic concern were not included in the analysis.

Healthwatch

In November 2023, Healthwatch produced a report on specialist mental health services in Nottingham and Nottinghamshire. We reviewed this report and summarised the key points in order to corroborate findings from this rapid review. The response from NHFT to the report has not been reviewed or included in this summary.

Mental Health Act reviews

CQC has a duty under the Mental Health Act 1983 (MHA) to monitor how services exercise their powers and discharge their duties when patients are detained in hospital, subject to community treatment orders or guardianship under this legislation.

Following MHA reviewer visits to locations, a letter is sent to report on findings. There were 20 letters from MHA reviewers relating to different locations in Nottinghamshire, issued between July 2023 and November 2023.

Each of the MHA reviewers' letters ends with any actions that the provider must carry out (under Section 120B of the MHA). MHA reviewers raise these actions when they have some concerns about the use of the MHA, compliance with the Code of Practice and/or the experience of detained patients. Each action is linked to the MHA Code of Practice – one of the 5 guiding principles, and often also the relevant chapter/section.

There was one MHA reviewer visit to Rampton Hospital (Evans ward) in this time period.

Analysis of these letters focused on the actions raised by MHA Reviewers to give us an overview of issues raised.

Data sources

We used data and insight gained through our routine monitoring of and engagement with NHFT. Where data was sent directly to CQC from NHFT this was analysed and, where possible, benchmarking analysis is referenced in the report.

Staffing data was analysed for staffing levels (fill rates), staffing sickness and staff training requirements for NHFT. When relevant, NHS Staff Survey 2022 data was analysed as supporting information on findings.

This report also provided an analysis of data within bed occupancy rates, discharge information and out of area placements data. In addition, a review of data, policies and papers relating to the overall running of the trust supports findings in the report.

To assess patient safety and the quality of care at NHFT, we visited and assessed a number of services in the trust, including community health services for adults of working age, crisis services and the University of Nottingham Health Service, due to their involvement with VC.

During these visits we spoke with 37 members of staff including doctors, nurses, care assistants and allied health professionals.

We were able to observe the care that patients receive, and directly speak to 34 people using services, 10 carers, relatives and loved ones. In addition, we were able to review 30 records of care and treatment provided to people using these services.

We reviewed and incorporated findings from our inspections of the trust's acute wards and psychiatric intensive care units (October 2023) and wards for older people with mental health needs (November 2023).

Rampton Hospital

We visited and assessed Rampton Hospital on multiple occasions to review what progress had been made since our last inspection. These visits included 4 out of hours visits. All visits allowed us to observe the care that patients receive. We spoke directly to 50 patients currently being treated at Rampton Hospital.

In addition, we reviewed 34 records of care and treatment, 40 records regarding consent to treatment, and 21 records regarding medicine administration provided by the trust for patients.

We spoke with 50 members of staff currently employed in the hospital including doctors, nurses, health care assistants and allied health professionals.

We used the data and insight gained through our routine monitoring of Rampton Hospital and engagement with NHFT. Where data was sent directly to us from the trust, this was analysed and where possible, benchmarking analysis is referenced in the report.