Quality of care

Key points:

- When in contact with community mental health services, most people said staff had treated them with kindness, compassion and dignity. However, people in inpatient services were less positive and described concerns around the attitudes of staff, and restrictions.
- The quality of care planning and risk assessment was inconsistent, and we saw limited evidence of patients and their families and carers being involved in their care plans. In addition, assessments were not always personalised and holistic.
- NHFT had redesigned and reorganised its community mental health teams in line with national guidance, but pathways of care were not clear and the make-up and size of teams did not meet the needs of the local populations.
- Care and treatment provided by NHFT was not always in line with the Mental Health Act 1983 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and current evidence-based good practice and standards.
- Discharge planning across community mental health and crisis services was not robust, with people describing concerns around being discharged too soon or leaving inpatient services in a worse state than when they arrived.

Compassion, kindness and dignity

Whether people were treated with kindness, compassion, and dignity varied across services at NHFT.

As part of our review, we looked at the trust level responses to the 2023 Community mental health survey for NHFT. Overall, respondents to the survey were positive about staff interactions, with staff described as “compassionate”, “kind”, “caring”, “professional”, “friendly”, and “supportive”.

During our site visits of LMHTs and crisis services, we observed 5 direct sessions of care between staff and people using the service, and found staff to be kind, compassionate and understanding. We also found that staff understood individuals’ needs and supported people to understand and manage their care, treatment, or condition.

As part of our review, our Experts by Experience also spoke with 27 people using community mental health and crisis services and 10 of their carers, friends and family. Most said that staff were kind, compassionate and treated people with dignity. Some people described staff going “above and beyond”. People who used the crisis services described it as a “fantastic service” and told us that staff were kind and treated people who use services and their carers with dignity and respect. People told us:

> “They were so kind to me when I was crying in appointments, the psychiatrist had a great bedside manner, eye contact, her face shows she cares. I don’t feel belittled, she discusses options with me openly and honestly. The Community Support Worker is really compassionate, empathetic, a warm human being. I have a wonderful rapport with them and I feel I am respected and treated with dignity.”

> “The Community Psychiatric Nurse’s approach is that he is very compassionate,

> professional and competent, he doesn't promise what he can't give, he gives explanations, builds on trust, communication is clear, direct and professional. I have limited responses to certain things, with them for the first time I have trust and respect for everything he has helped me with. I have achieved more in the last 6 months than in the last 14 years."

> "I was always treated with kindness, they were always willing to listen, they would remember lots of details about me, my children's names, they were interested in me as a person. If I didn't have the courage say to ring the doctor, she has done that for me, has got the doctor to ring me, she wrote a letter to help me get my current home, she got on to the council, so kind."

However, we also received negative feedback from people using services. Most negative feedback we received came from people using inpatient services. They described not being listened to and that staff were "rude", "unprofessional" and "dismissive".

Between July 2023 and February 2024 our Mental Health Act reviewers carried out 20 visits to different parts of the trust. During these visits, reviewers found evidence of blanket restrictions being used and that, as a result, staff did not always ensure they protected people's privacy, dignity, and human rights.

The findings of these MHA reviewer visits triggered our October 2023 inspection of wards for adults of working age and November 2023 inspection of wards for older people.

Other feedback we received from people who used services, their friends, family and staff from July 2023 highlighted concerns around basic needs not being met in inpatient settings. Issues often included the cleanliness of rooms, issues with pests, lack of bedding or a mattress, lack of suitable clothes, and the hospital not providing personal care assistance.

Care planning and involvement

The Royal College of Psychiatry Standards for Community Mental Health Services is clear that every patient should have a written care plan that reflects their individual needs. It states that when developing the care plan, staff members should collaborate with patients and their carers (with patient consent) and offer the patient a copy of their care plan.

Feedback from people who used services, their friends and family and staff showed repeated concerns about a lack of person-centred care, including people not feeling involved in creating their care plans or with changes to their medication, feeling dismissed, and not listened to. There were also recurring reports of care plans not being shared, or individuals not being updated about any changes to them. One person told us:

> "I didn't know who my named nurse was until week 3, I didn't see a care plan until a week ago. When I did see it, it was full of errors and not worth the paper that it was written on."

Families also felt excluded, for example, we heard reports of staff refusing to speak with family and not allowing them to attend ward rounds or meetings despite the person wanting their family's involvement and for them to advocate on their behalf.

This was supported by findings of the November 2023 Healthwatch report which found issues with professionals not listening and/or not communicating effectively, as well as feelings that services revolved around 'tick-box' exercises.

In general, people identified the need for more person-centred care that considers people as individuals instead of focusing solely on the diagnosis. Some also suggested that family and loved ones need to be involved more in the treatment plan.

As part of our review, we looked at more than 30 care records of people who use services to assess the quality of care planning and involvement of people and their carers and families. We saw that the approach to care planning and risk assessment was inconsistent and there was limited evidence of people being involved in their care plans. Training for staff in the writing of holistic and person-centred care plans was not mandatory. This was not in line with Royal College of Psychiatry Standards for Community Mental Health Services, which require that people have a risk assessment and management plan that is co-produced where possible, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality).

The people we spoke with who used community mental health and crisis services and their carers agreed that care planning was inconsistent. While some people we spoke with said that they had a care plan and risk assessment, which they had been involved in writing and updating, 4 other people we spoke with did not know whether they had a care plan.

These findings reflect the findings of our November 2023 inspection of wards for older people with mental health problems. On this inspection we found that care plans were not always personalised and holistic and they did not give a holistic viewpoint of the patient as a whole.

Quality of care and treatment

How services are structured has an impact on the quality of care people receive. To support the delivery of the NHS Long Term Plan, NHS England commissioned the Royal College of Psychiatrists to develop a new place-based community mental health model that provides more effective support, care and treatment for adults. The Royal College of Psychiatrists Community Mental Health Framework for Adults and Older Adults suggests that at the centre of the new model, should be an integrated, single core community mental health service that delivers:

1. assessment and advice or brief treatments

2. specific psychological and pharmacological interventions and care planning and coordination
3. support to access community assets.

NHFT had redesigned and reorganised its community mental health teams in line with the Royal College of Psychiatrists' framework. However, we found that teams were not well structured and the make-up and size of teams was not standardised and did not meet the needs of the local populations.

The Royal College of Psychiatrists' framework outlines that, to give people the best chance to get better and to stay well, it is critical that in the new community based offer, adults and older adults with severe mental illness can access evidence-based NICE recommended psychological therapies in a timely manner.

We found that the approach to psychological therapies in community mental health and crisis services was inconsistent. In addition, care and treatment provided by the trust was not always in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Mental Health Act 1983, and current evidence-based good practice and standards, such as the community mental health framework. The length of waiting lists also meant that the trust was not able to deliver care and treatment in a safe and consistent manner.

At the time of our review there were 724 people who were not allocated to a care coordinator, and whose needs were complex and high risk. The Royal College of Psychiatrists' framework highlights the important role of care coordinators for people with more complex needs:

> "Interventions for people with more complex problems are likely to be multi-professional in nature with one person having responsibility for coordinating the care and treatment. This coordination role can be provided by workers from different professional backgrounds."

Our review found that the structure of pathways for assessment and treatment for people with complex mental health problems (other than to early intervention in psychosis) was unclear. This meant that staff felt their specialist skills were diluted, and that people were not able to access specialist care and advice in a timely manner, with clear access to those services.

The Royal College of Psychiatrists' guidance acknowledges that, as part of the new community mental health model, there need to be services that have the expertise and capacity to care for people with complex needs. This includes:

- specialist community mental health teams to provide care and treatment for people with more complex needs, such as those with an associated personality disorder.
- rehabilitation teams to provide support for people with long-term complex needs who may need additional support with activities of daily living and community support. This includes, for example, support with accommodation, care coordination, and additional support and planning tailored to meet specific rehabilitation needs.
- specialist treatment services for people whose needs cannot be effectively met by core community mental health services. This includes, for example, perinatal mental health services, eating disorder services or community forensic mental health services.
- support for those who may be at risk of being excluded from their community, such as rough sleepers, and people leaving the criminal justice system or people who are frequently in contact with the police.

While it may be the case that professionals with these skills were in place at the NHFT, the pathways to receive treatment from them were complex, unclear and waiting times were lengthy. This meant that some people with complex needs who presented with high risks were lost in the system and were not receiving appropriate support.

In February 2023, NHS England produced guidance on Implementing the early intervention in psychosis access and waiting time standard. This defines the standard as:

> "At least 60% of people with a first episode psychosis would start treatment with a NICE-recommended package of care with a specialist early intervention in psychosis service within 2 weeks of referral."

As of January 2024, NHFT's early intervention in psychosis service was seeing 86% of referrals in less than 2 weeks. This had improved from 80% in August 2023.

Discharge

We found that the discharge planning process across the community mental health and crisis services was not robust, with little evidence of discharge planning in care plans.

As part of our review, we looked at a sample of prevention of future death reports. Several of these reports raised concerns about the quality of care provided by NHFT and individuals' discharges. Issues included a 'lack of clarity of thinking' in the multidisciplinary team in relation to the decision to discharge, and people not being involved or notified in this decision. In one report, the coroner noted that:

> "[X] was called and invited to agree to the withdrawal of services. Such a practice runs the significant risk that patients who are less assertive or who have poor insight into their mental health needs will be said to have 'agreed' that a service is no longer required."

This mirrors feedback from the Community mental health survey and people who use services. People described issues including being discharged "too soon" or leaving inpatient services in a "worse state" than when they arrived. Some people felt they were not ready to be discharged, especially if they had been receiving support for a long time, or there was no emergency plan or community support in place before being discharged. This could lead to people being readmitted to services very soon after discharge or rapidly deteriorating in the community.

Responses to the community mental health survey highlighted multiple incidents of people being discharged from inpatient services without the support of community mental health teams in place, or a lack of timely follow-ups from the community mental health team. Feedback included comments as follows:

> "Stop pushing for patients to be discharged against their will. I have been in the system a long time, that is because my illness has proved treatment resistant… Removing me from services is as good as a death sentence."

> "Doctors shrug and said 'don't really know what to do'. Had an episode in front of [the] mental health worker and was discharged next day. No support put in place afterwards. Locum doctor said, 'We can't help unless you actually want to kill yourself.'"

As part of our review, we looked at how GPs were involved in discharge planning from inpatient mental health wards, but found no evidence of them being involved in this. University of Nottingham Health Service, who we assessed as part of our review, told us that their GPs have never been invited to be involved in assessment planning.

Of all people discharged from community mental health, crisis and early intervention in psychosis teams between 1 January 2023 to 31 December 2023, 12,712 (96%) were discharged back to their GP. Of the discharges back to GPs, only 3,657 (29%) were recognised as needing ongoing mental health care and treatment.

In February 2024, the Parliamentary and Health Service Ombudsman (PHSO) published its report Discharge from mental health care: making it safe and patient-centred, which looked at failings in discharge and transitions from mental health settings from their casework. The report highlighted that unsafe discharge potentially leads to poorer outcomes for people and risks repeated cycles of readmission, and that discharge experiences and outcomes are impacted by:

- poor record keeping
- failings in carer and family involvement
- poor communication between clinical professionals and teams in planning transfers of care.

Staff in the early intervention in psychosis services told us that historically there was not a discharge flow chart in place. However, one had been created in June 2023 following the deaths of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber. In one of the local mental health teams, they had developed a project to consider which patients may be ready for discharge from the team. Leaders talked of some team members' reluctance to discharge patients due to the complexities of their caseload, as well as team members' anxiety about working with new people.

The PHSO supports the view that the community mental health framework:

> "... refers to the ambition of 'maximising continuity of care' to make sure there is no care 'cliff-edge'. It aims to end a system that is centred around 'referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support'. Instead, it represents a 'move towards a flexible system that proactively responds to ongoing care needs'."

However, the discharge and transition processes at NHFT were not yet in line with the community mental health framework and affected the outcomes of people who use services.