System working

Key points:

- People who use services told us they experienced difficulties when transferring between inpatient care and crisis care into community care, and services did not always ensure continuity of care when people were being transferred.
- Communication between services was also an issue, with people expressing frustration at the lack of communication between inpatient services and the community mental health teams.
- Due to ongoing concerns with the quality of care provided by NHFT, the integrated care board and NHS England have a range of processes in place to oversee and improve care provided. However, we were concerned that change was not happening quickly enough.

Continuity of care between services

Care that is person-centred and coordinated across healthcare services can improve outcomes for people and reduce:

- confusion
- repetition

- delay
- duplication and gaps in service delivery
- people getting lost in the system.

Responses to the 2023 Community mental health survey and other feedback from people who use services highlighted difficulties in transitions of care for people discharged from inpatient services or the crisis team into community care. We heard that community mental health referrals were not always followed up in a timely way, which affected people's mental health and left them feeling unsupported. Some people told us that moving between services felt fragmented and that it was difficult to move from one service to another. This was also the case when people had to move from one geographical area to another, either from other services to Nottinghamshire or within Nottinghamshire.

This feedback was supported by the findings of 4 prevention of future deaths reports where the HM coroner raised that individuals with complex mental health conditions, including psychosis and suicidal intent, had been unable to access mental health services.

We found that services did not always ensure continuity of care, including when people moved between different services. While some staff told us there were close working relationships between teams, others were less positive about being able to contact other services internally.

As highlighted in our section on access to care, we found that complex pathways and systems did not ensure that people were not able to fall through the cracks into being unsupported or unsafe. However, a small number of respondents to the 2023 Community mental health survey were positive about the support they received from occupational therapists, particularly while they were on the waiting list for talking therapies.

Communication between services was also an issue, with people expressing frustration at the apparent lack of communication between inpatient services and the community mental health teams. This created problems including:

- issues with medication
- care plans not being followed through
- individuals being left unsupported for significant periods of time.

Again, this was supported by findings of our review of HM coroners' prevention of future deaths reports which raised concerns about a lack of coordination and information sharing between services. This had contributed to poor decision making and had put people in the community at risk. Issues included gaps between the crisis home resolution treatment team and GPs, and/or the LMHT.

GP services

One of the most common routes of discharge from community mental health services was to a patient's GP. Due to their involvement with VC, we reviewed mental health care processes at the University of Nottingham Health Service.

Our inspector and national professional advisor spoke with the lead GP and the lead advanced nurse practitioner for mental health care. We also spoke with 6 other members of staff, reviewed 4 sets of medical records and reviewed a range of policies and procedures in place at the practice in relation to the care of patients with mental health needs.

We found that the GP practice had a number of safe processes and systems in place to support the care of people with mental health needs which met national best practice guidance.

Feedback from the GP reflected our concerns around coordination of care and sharing of information. The GP practice told us they were concerned that if people are discharged back to the care of the GP from the mental health teams, it can take 4 weeks or more to receive the information.

The practice also told us that they struggle to access the right contact details for trust staff. They gave an example of an individual who came to see the GP/mental health practitioner and the person reported they had seen the psychiatrist, but there was no evidence available to know what had been discussed or when the person had been seen.

The practice told us that people who use services describe being 'passed around' services, moved from team to team as the right path hadn't been found, because they didn't meet the criteria or were not suitable for the services provided. This causes a lot of frustration for people.

Integrated care board oversight of NHFT

Nottinghamshire Healthcare Foundation NHS Trust (NHFT) is part of the Nottingham and Nottinghamshire Integrated Care System (ICS). The Nottingham and Nottinghamshire Integrated Care Board (NHS Nottingham and Nottinghamshire ICB), was established in July 2022 and its partners include:

- Nottingham City Council
- Nottinghamshire County Council
- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- East Midlands Ambulance NHS Trust

The ICB is responsible for overseeing the provision and quality of healthcare services at the NHFT.

The ICB is aware of the challenges facing the trust. Key concerns shared with us by the ICB, which we have also found on our review, include:

- Quality, including high levels of ongoing serious incident investigations, not meeting requirements of the duty of candour legislation, lack of learning from incidents and the speed of implementing the new NHS England Patient Safety Incident Response Framework (PSIRF). There are also concerns about the trust's quality team who carry out visits to teams/services internally and also to any provider that NHFT commission to provide services on its behalf.
- Performance, including gaps in services, declined referrals, out of area placements, long lengths of stay in hospital, CQUIN achievement (NHS England's Commissioning for Quality and Innovation standards).
- Issues raised in HM Coroner prevention of future death reports including a lack of learning, repeated themes, poor quality of serious incident reports, lack of candour and lack of external information sharing.
- Number of services in rapid improvement boards and/or intensive and enhanced improvement groups, including adult mental health wards, and wards for older people and Lings Bar Hospital. Rampton High Secure Hospital, HMP Lowdham Grange and HMP Nottingham.
- Long waiting lists in adult mental health, child and adolescent mental health and neurodevelopmental assessment.
- Issues with management of the trust 'limited' internal assurance, financial deficit, poor staff survey results, high sickness absence and turnover rates, the level of violence and hate crime incidents reported by staff.

Due to the level of concern related to the NHFT, there are a range of quality oversight arrangements in place between the ICB and the trust, which include support from the ICB quality team. This oversight feeds into the ICB quality and people committee, which in turn reports to the ICS system quality group.

As a result, the trust remains on segment 3 of the NHS system oversight framework. This means that the trust has significant support needs against one or more of the 5 national oversight themes and is in actual or suspected breach of their NHS provider licence. The trust is monitored by NHS England at level 2 'enhanced' national quality board. This is the level at which NHS England has determined it must be monitored.