Care planning and engagement

As part of our review of VC's care and treatment, and the 10 cases we reviewed for benchmarking purposes, we looked at:

- the care plans of each patient
- how the trust responded to their referral into services
- how care plans were developed and the involvement of the patient and their family or carers and the patients' care pathway.

Access to care

People experiencing a mental health crisis should be able to access the right help at the right time. Not being able to access this care can cause a crisis to escalate, leading to greater mental distress or physical harm.

Following his initial contact with police, VC received a mental health assessment, which found that he needed mental health crisis care and treatment. In response, and with VC's consent, he was referred to the Crisis Resolution and Home Treatment (CRHT) team.

As described in our first report, the CRHT team in Nottingham is a 24-hour, 7 day-a-week service for adults with a serious mental illness who are in an acute crisis which is so severe that, without intervention from this service, patients would need to be admitted to hospital. CRHT teams aim to act to prevent hospital admission by providing intensive interventions in the community.

We found that the CRHT team picked up VC's referral quickly and had planned to visit him at home on the same day after he had left custody. This reflects the findings of our review of safety and quality of care at Nottinghamshire Healthcare NHS Foundation Trust (NHFT) and our review of the 10 benchmarking cases, which found referral into the service was good. It was also in line with Royal College of Psychiatrists (RCPsych) best practice guidelines to see very urgent referrals within 4 hours, and urgent referrals within 24 hours. However, before the CRHT team could carry out their initial visit, VC was re-arrested 1 hour after being released.

VC's referral to the CRHT team can be seen to have been appropriate and following Mental Health Act (MHA)1983 Code of Practice guidelines to provide person-centred care that offers the least restrictive intervention. However, the fact that he was re-arrested so quickly after leaving custody from his first arrest raises questions about the quality of the initial mental health assessment and the assessment of risk that took place. VC had presented with a clear description of psychosis with paranoid delusions, which he had acted on.

Following his second arrest, a Mental Health Act assessment was carried out that led to VC being detained in hospital under section 2 of the MHA. Section 2 allows for a person to be admitted to hospital, for up to 28 days, to assess whether they are suffering from a mental disorder, the type of mental disorder and/or how the person responds to treatment. (See also Admission to hospital.)

On his first admission to hospital, it was known from the Mental Health Act assessment that VC was psychotic. However, no psychological assessment or interventions related to psychoeducation and relapse were offered despite the new diagnosis and VC and his mother expressing his difficulties in coming to terms with it. This was a missed opportunity in VC's care and goes against NICE (National Institute for Clinical Excellence) guidelines on first-episode psychosis.

In our first report, we highlighted our concerns about access to psychologists, and the volume of vacancies for these posts across NHFT. In some teams, including CRHT, we were concerned that all psychology posts were vacant at the time of the review. This is not in line with NHS England guidance or NICE guidance on access to psychological therapies, and means that people may not be able to access psychological treatments in a timely way.

In the community, the appropriate care pathway for people with a diagnosis of psychosis is referral into an early intervention in psychosis (EIP) team. These community-based, multidisciplinary teams provide a full range of evidence-based treatment including pharmacological, psychological, social, occupation and educational interventions. Guidelines from NICE state that adults with a first episode of psychosis should start treatment by EIP services within 2 weeks of referral.

In line with Royal College of Psychiatrists (RCPsych) best practice guidelines, VC was placed under the care of the CRHT team following his discharge from his first hospital admission. At this point, the CRHT team monitored VC for an extended period to check that he was taking his medicine. After 15 days, VC was then moved to the care of the EIP team.

Our benchmarking identified that the EIP teams were dealing with very complicated cases, involving patients with a range of mental health needs. In some cases, the referral was screened on the same day and then accepted onto the caseload. We saw that triage assessments were completed within 0 to 7 days, and full assessments were completed, where required, alongside the CRHT. Similarly to the 10 benchmarking cases, we found that VC was taken on quickly after the referral was made, and triage assessments were completed appropriately and in line with best practice guidance.

After initial referral to mental health services, people should have a care co-ordinator allocated to them to keep in regular contact with them, as well as help to plan and co-ordinate their care and treatment. Although our wider review of NHFT found some issues with allocating a care co-ordinator to people in a timely way, we found that VC was allocated a care co-ordinator from the EIP team promptly, who remained his primary care co-ordinator until April 2022 when his care was transferred to 2 community psychiatric nurses.

Care planning

Effective care planning is vital for patient wellbeing, and patients must be as fully involved in their care planning as possible. The Mental Health Act (MHA) 1983 Code of Practice is clear that care planning should take into consideration the wishes, feelings, beliefs and values of the individual, but it must also consider what is in the person's best interests.

Under the Mental Capacity Act 2005, providers must assume that a person has the capacity to make a decision themselves, unless it is proven otherwise. Where there are concerns, a capacity assessment should be carried out. There was no evidence of a structured approach or explanation of capacity assessments for VC.

Our review of VC's records showed that, in line with the MHA Code of Practice, his care plans followed national guidance in respecting his wishes and, where possible, involving him in developing his care plans. This reflects the findings of our review of 10 other cases. In these, we found that the EIP teams worked to engage both patients and their families in care planning. The teams offered a range of treatment options to patients. For example, we saw evidence of where a decision to change a patient's medicine to depot ensured that the patient took their medicine, which in turn improved their mental wellbeing and quality of life.

However, VC's psychosis meant he was often guarded or provided misleading information. To provide a full and accurate picture, 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. As highlighted in the section on risk assessments, this was a particular issue for VC.

While the care plans included information about his treatment and how to respond to side effects of medicine, they did not include information about:

- how to manage ongoing issues with VC not taking his medicine
- VC's limited engagement with services
- plans for preventing a relapse.

Based on the information available to staff in his care plans at the time, the approach to managing VC's condition could have been seen to have met his needs. However, it is clear that poor record keeping and the lack of a holistic approach to care planning led to decisions around his care that did not meet his needs and did not take into account the potential risk that he presented to others.

The majority of benchmarking cases we looked at showed that patients did receive comprehensive assessments and packages of support that met their needs. However, in one example the patient's first language was not English and no independent translator was provided. This prevented the EIP team from creating a detailed assessment and history for the patient, and in turn hampered their ability to identify risk factors and create a person-centred care plan that met their needs.

These findings echo those from our wider review of NHFT which, found that the quality of care planning was inconsistent, care plans were not always holistic and that patients, their families and carers were not always involved. In particular, we highlighted issues with person-centred care planning, and the need to focus on people as individuals instead of the diagnosis.

In line with RCPsych guidelines, VC's care co-ordinator and the wider EIP team employed a range of methods throughout the time he was in their care to try and maintain contact with VC and ensure he could access the care he needed. This mirrored the findings of our review of the 10 benchmarking cases, which showed that EIP services sent pre-appointment reminders and used creative solutions to maintain contact and enable face-to-face meetings during the COVID-19 pandemic. This included, for example, using outside spaces such as local parks and open markets.

However, throughout the time he was under the care of the EIP team VC showed little understanding or acceptance of his condition. As a result, he consistently declined offers of cognitive behavioural therapy for psychosis (CBTp) and other treatment options, and was hard to engage. CBTp is a key tenet of the EIP model and an accepted evidence-based treatment. It can be used either in conjunction with antipsychotic medicine, or on its own if medicine is declined, and can improve outcomes such as psychotic symptoms as outlined in NICE guidance. CBTp is a structured intervention to review symptoms of serious mental illness. It focuses on a range of interpersonal problems including medicine compliance. Like other forms of cognitive behavioural therapy, CBTp involves establishing a therapeutic relationship, developing an understanding and insight, setting goals and educating a person in techniques and behavioural coping strategies to reduce and manage symptoms.

From our review of VC's records, we found that his engagement with CRHT and EIP teams fluctuated throughout the 2 years and deteriorated towards the end of this period as he became increasingly disengaged.

Engagement with VC and his family

The MHA Code of Practice is clear that patients and, if appropriate, the views of families, carers and others, should be fully considered when taking decisions about their care.

Following discharge to the community from his first admission to hospital in June 2020, VC's records suggest that CHRT and EIP teams engaged well with him. For example, on the day of his discharge to the EIP team in June 2020, the EIP and CRHT teams held a joint visit to VC. The EIP team kept in contact with VC in the immediate days after discharge and took over prescribing and delivering his medicine to ensure he had a supply.

However, VC's 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.

Three days after the family contacted the EIP team, VC was detained in hospital for the second time under section 3 of the MHA. Section 3 allows for a person who is already well known to psychiatric services to be admitted to hospital for up to 6 months in the first instance for their health, their safety or for the protection of other people.

Following discharge from his second admission in July 2020, VC was cared for in the community until August 2021. We found that during this time, the EIP team and his care co-ordinator made every effort to engage with VC and, as far as possible, maintained contact with him.

During this period of his care, we noted a pattern of VC not always engaging with the EIP team and not always attending appointments at the EIP base. In response, records show that the team carried out home visits and took steps to ensure he had received his medicine. However, there was evidence to suggest that he was still unwell. At some appointments he stated he was still hearing voices, but coping.

As part of our review we spoke with VC's family who expressed that they did not feel engaged by VC's care team. 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 NHFT.

There were a number of occasions between July 2020 and August 2021 when VC's family told EIP services that they were worried that his mental state was deteriorating. While we saw evidence to suggest that the EIP team had sometimes acted on the information from VC's family, there were times this did not always work well.

For example, in October 2020 following concerns raised by VC's family, the EIP team attempted to contact him by phone but there was no response and there is no record of additional attempts to contact him. Similarly in May 2021, the family raised concerns with the CRHT team that VC was unwell. The team contacted VC by phone and VC told them he was taking his medicine. As a result, the CRHT team concluded that there was no role for them at that time as there were no obvious signs of deterioration. As highlighted in the section on Care planning, we are concerned that in this instance the team did not adequately consider what VC was telling them with other information they may have held.

By the middle of August 2021, VC told the EIP team he had stopped taking his medicine and did not believe he was unwell. The EIP team believed that he was relapsing. However, an MHA assessment was not arranged until 2 weeks after this, which VC did not attend. As a result, the police were called to carry out a section 135. This allows the police to enter a person's home and take a person to (or keep them at) a place of safety so that a mental health assessment can be carried out. At this time, medicine dating back to February 2021 was found at his flat, suggesting that he wasn't taking it.

Following his detention, VC was taken to a section 136 suite, also known as a place of safety, and detained under section 2 of the MHA. Places of safety are meant to be used for short periods (24 hours) to keep people in crisis safe and to allow for a mental health assessment to be carried out. However, due to issues finding a bed, it was over a week before VC was admitted for the third time to an independent hospital, under section 2 of the MHA. After 3 weeks, VC was transferred to an independent hospital in Nottingham where he was held under section 3 of the MHA. (See Admission to hospital.)

As part of their ongoing engagement with VC, during this admission NHFT records show that a member of the EIP team contacted the independent hospital in Nottingham as they were due to attend VC's ward round, but they were informed that VC had been discharged that morning. Our review of records from the independent hospital show that they had contacted the EIP team before his discharge. The discharge summary was still to be completed and forwarded to the EIP team. (See section on Discharge planning.)

Following his discharge back into the community in October 2021, VC had limited contact with the EIP team, appearing confrontational and missing appointments. The team tried to contact VC by phone and carry out 'cold call' (unannounced) home visits with limited success. The EIP team was able to provide VC with prescribed medicine during this period when he did engage, but he missed multiple appointments.

Disengagement with services is common for people with mental health problems. Through our benchmarking review, we saw examples in most of the records reviewed where patients did not attend appointments with the EIP team. In the majority of cases, the teams followed up with patients who did not attend appointments in a variety of ways, such as by text, email, telephone calls and home visits, which had led in most cases to the patients re-engaging with services.

However, the EIP team did not have specific guidance within the standard operating procedures about how to manage patients who had disengaged from services. There were no frameworks in place about what should happen if a patient missed a certain number of appointments, and what steps care co-ordinators should follow depending on the number of appointments missed.

We identified issues with engagement, particularly with people who had disengaged from mental health services, in 3 out of the 10 benchmarking cases we reviewed. These records showed large gaps in visits from several weeks to over 2 months in one case. There was no explanation provided for these periods of non-contact. In another case, there was no evidence of attempts to engage or contact a patient for up to 2 weeks. In this case, when the patient reengaged with services, no review was carried out so services could prevent future disengagement. When the patient did disengage again, the same approaches were adopted with no lessons learned.

These findings reflect concerns raised in our first report around a lack of time for reflective practice, as well as a lack of learning from serious incidents and problems with the trust not making rapid changes to services to improve safety and reduce the chance of them recurring.

In December 2021, VC contacted the EIP team and told them that he no longer wanted them to contact his family or tell them aspects about his care and treatment. Efforts to liaise with his family reduced notably after this time.

The MHA Code of Practice is clear that carers cannot be given confidential patient information without the consent of the patient. In these cases, NICE guideline CG136, Service user experience in adult mental health, provides guidance on the approach to take and states that whether the person wants their family involved should be reviewed on a regular basis.

In VC's case it could be argued that the trust could have continued to engage with the family while still maintaining his confidentiality.

In January 2022, VC was admitted back into hospital for lack of engagement with community services. During this fourth admission to hospital, VC continued to only engage minimally with staff and therapeutic activities. By this stage, VC was known to have a diagnosis of paranoid schizophrenia, that he continued to lack insight into his mental state and frequently disengaged with community teams. In addition, it was known that he was not taking his medicine in the community, and that he posed a risk to others during periods of relapse.

NICE guidance states that people with severe mental illness, including paranoid schizophrenia and psychosis, should receive "treatment and care in the least restrictive and stigmatising environment possible and in an atmosphere of hope and optimism". In line with this, VC was discharged in February 2022.

Following this fourth and final discharge, VC's engagement with the EIP team was inconsistent. When he did engage he was described as guarded, which is a symptom of psychosis. EIP teams continued to try to contact VC by phone or text and to encourage him to attend the team base.

In April 2022, after a discussion at an EIP multidisciplinary team meeting, it was agreed to transfer VC's care from the long-standing care co-ordinator to 2 EIP team community psychiatric nurses. From his medical records, we can see that efforts to engage him assertively and to liaise with his family reduced notably at this time.

After the change of care co-ordinator in April 2022, contact with VC was limited. As well as missing appointments with his new care co-ordinators, VC frequently missed appointments to collect medicine from the EIP base or only engaged briefly with EIP staff when he did attend.

The RCPsych guidance, Quality Standards for Early Intervention Services recommends that staff should follow up with patients who have not attended an appointment or assessment. There is evidence that the EIP team continued to try to contact VC by phone, text and letters over the next few months. However, records show that the team did not hold the correct address for VC on file.

In July 2022, VC told the EIP team that he was out of the country. In August 2022, the community psychiatric nurses tried to visit VC at home as a cold call, but were told nobody of VC's name lived at the address they visited. Records show another home visit was planned, but there is no evidence that this took place.

We found similar issues in some of the benchmarking cases with address details not being up to date, particularly with people who had disengaged from mental health services. In one case, the EIP team attempted to visit the patient, but at the address of a family member. There was no evidence of the staff member then re-routing to the correct home address and no further follow up.

The RCPsych quality standards state that if patients are unable to be engaged, the assessor or team should make a decision, based on patient need and risk, as to how long to continue to follow up with the patient. It also states that carers (with patient consent) should be involved in discussions and decisions about the patient's care, treatment and discharge planning.

In our wider review of NHFT, we found that the trust had a 'did not attend' (DNA) policy, which acknowledged that failure to attend appointments or the cancellation of appointments can indicate a risk or safety concern for the individual. However, the policy did not have a discharge flowchart for teams to follow. A flowchart was not added to the policy until June 2023.

In September 2022, the EIP team made the decision to discharge VC 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 was the final contact any trust service had with VC.

Lack of GP involvement in discharge planning was an issue we identified in our wider review of NHFT. In our first report, we noted that the University of Nottingham Health Service told us that their GPs have never been invited to be involved in assessment planning. We also highlighted findings from the February 2024 report from the Parliamentary and Health Service Ombudsman (PHSO), which found that unsafe discharge potentially leads to poorer outcomes for people and risks repeated cycles of re-admission.

It can be seen that the plan to discharge VC when he disengaged from EIP services, before liaising with other agencies or doing a welfare check or cold call to his home address, did not adequately consider or mitigate the risks. Evidence over the course of VC's illness and contact with services and police indicated beyond any real doubt that he would relapse into distressing symptoms and potentially aggressive or intrusive behaviour if he did not receive antipsychotic medicine and was not monitored.

It is clear that after 4 admissions in 2 years, and repeated disengagement and refusal to take medicine, VC required a much more robust package of care that included consistent and assertive interventions. More assertive engagement and restrictive measures were crucial to managing his illness and the risk he posed to others when unwell.

NICE guidelines recommend the use of depot antipsychotic medicine for people who do not comply with taking oral medicines. In addition, community treatment orders (CTOs) are designed to support people in the community to maintain stable mental health outside of hospital and promote recovery. These would have been important components in a more robust package of care for VC (see section on Discharge planning).

Admission to hospital

Being admitted to hospital is not the least restrictive option for people experiencing a mental health crisis and should always be used as a last resort. However, when people need treatment in hospital, they should be able to access the inpatient services they need, for the shortest time possible, in a therapeutic environment close to home.

Between May 2020 and February 2022, VC had 6 Mental Health Act assessments, which led to his 4 hospital detentions. Each of these admissions involved instances of threatening and assaultive behaviour as a result of his psychosis. During this period, there were 2 assessments where it was decided not to detain him.

The first, second and fourth of VC's admissions to hospital were arranged quickly and a bed was available in the trust once it was decided that he needed to be admitted to hospital. However, the third admission was less timely and led to VC being cared for in a section 136 suite while a bed was sought at a psychiatric intensive care unit (PICU) (see also Engagement with VC and his family). For this admission, VC was initially admitted to an out-of-area PICU bed at an independent mental health provider in the North East in September 2021. He was then transferred to an independent hospital in Nottingham, from which he was discharged in October 2021.

The use of out-of-area beds was an issue we identified in our wider review of mental health services at NHFT. Our report found that problems with patient flow through the trust's acute and PICU inpatient beds was leading to a high number of people being admitted to services out of the local area. Our report also highlighted how poor access to inpatient beds meant that community teams were having to manage caseloads with higher levels of complexity and acuity.

For his fourth admission to hospital, VC was detained under section 2 of the MHA. While section 2 is usually used if the person is not known to mental health services, or has not been assessed in hospital before, it can also be used in cases where they are known to services but have not been assessed for a considerable time.

By this point, VC was known to have a diagnosis of paranoid schizophrenia, as well as being non-compliant with medicine in the community and that he was a risk to others when he was relapsing. Given this information, it could be considered a missed opportunity not to detain him under section 3. 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. (See also section on Discharge planning.)