Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2

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.

Download an easy read version of this report

Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2 (easy read)
20240902_nottinghamshire-healthcare-nhsft-special-review-part2_easy-read.pdf

File title
Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2 (easy read)

Keywords
Mental Health Act

In March 2024, we published the first part of our review on the findings of our assessment of patient safety and quality of care provided by NHFT, and progress made at Rampton Hospital since our last inspection in July 2023.

For this part of the review, we were asked to carry out:

> "A rapid review of the available relevant evidence related to the care of Valdo Calocane, including available evidence made public during the criminal trial, alongside a small number of other cases (to enable benchmarking), to determine whether this evidence indicates wider patient safety concerns or systemic issues with the provision of mental health services in Nottinghamshire. 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."

Foreword

This report identifies points where poor decision-making, omissions and errors of judgement contributed to a situation where a patient with very serious mental health issues did not receive the support and follow up that he needed.

While it is not possible to say that the devastating events of 13 June 2023 would not have happened if Valdo Calocane had received that 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.

For the individuals involved, their families and loved ones, the damage cannot be undone. However, there is action that can, and must, be taken to better support people with serious mental health issues and provide better protection for the public in the future.

It is important to recognise that treatment for people with serious mental health issues is not straightforward – either for those providing it or those receiving it. This report highlights a clear need for improved oversight and guidance at both a provider and a national level.

We have made recommendations for Nottinghamshire Healthcare NHS Foundation Trust that relate specifically to the failings we identified with the care provided to Valdo Calocane. We have also made recommendations for NHS England around the development of new guidance setting out national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia.

NHS England will be conducting a more detailed scrutiny of Valdo Calocane's wider interaction with mental health services in its Independent Homicide Review. This has a broader scope than this review, and may well identify other areas of his care that fell short.

This review has focused on one NHS trust but, as highlighted in part 1 of our review, 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.

Chris Dzikiti
Interim Chief Inspector of Healthcare

Summary

Throughout the 2 years he was under the care of Nottinghamshire Healthcare NHS Foundation Trust (NHFT), it is clear from Valdo Calocane (VC's) records that he was acutely unwell. VC showed symptoms of psychosis, including presenting as guarded, and having little understanding or acceptance of his condition throughout his care under NHFT. Problems with him not taking his medicine were also recorded from early on.

Our review found:

- If the decision had been made to treat VC under section 3 of the Mental Health Act (MHA) 1983, during his fourth admission to hospital, further options would have been available for his care and treatment in the community
- There was a series of errors, omissions and misjudgements, all of which were compounded by the symptoms of VC's illness.

  Key among these were:

  - the decision to discharge VC back to his GP in September 2022
  - inconsistent approaches to risk assessment for VC
  - poor care planning and engagement with VC and his family.

A core part of our review was to consider whether the evidence we gathered from VC's care records indicated wider patient safety concerns or systemic issues in Nottingham. While we did not find any widespread patterns with 10 other cases that we reviewed as a benchmark, many of the issues we have identified are consistent with the problems we found in our wider review of the quality of care and safety of services at NHFT.

NHS England's Independent Homicide Review will provide a more detailed scrutiny of VC's wider interaction with mental health services. The scope of NHS England's review is broader than this review, and may well identify other areas of VC's care that fell short.

Key findings

Risk assessment and record keeping

- Inconsistent approaches to risk assessment was an issue in both VC's case and the 10 benchmarking cases, and reflected findings from our wider review of NHFT. As well as minimising or omitting key details, there were other issues particular to VC's case, including:
    - While some key risks were identified, risk assessments minimised or omitted key details and did not outline the seriousness and the immediate threat of the risks and the known issues that would increase the risk to himself and others.
    - Risks around his capacity to consent may not have been managed adequately as, in light of his symptoms, not all opportunities to assess his capacity to consent to treatment in the community were taken.
    - 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.

Care planning and engagement

- In line with the findings from our wider review of NHFT, VC received a timely referral into mental health services after his first arrest. While our first report highlighted issues with people being allocated a care co-ordinator in a timely way, we found that VC was allocated a care co-ordinator from the early intervention in psychosis (EIP) team promptly. This person remained his primary care co-ordinator until April 2022 when his care was transferred to 2 community psychiatric nurses.
- Care plans for VC and the 10 benchmarking cases we looked at followed national guidance. However, teams did not always take a holistic approach, which hampered their ability to identify risk factors and create person-centred care plans. This reflected concerns raised in our first report around inconsistent care planning.
- There were issues with VC's engagement with services throughout the 2 years he was under the care of NHFT. We found similar issues in 3 out of the 10 benchmarking cases. While teams took steps to follow up and re-engage people, we found large gaps between visits in the records for both VC and the 3 benchmarking cases.
- While VC's family contacted NHFT services to raise their concerns, the information they provided was not consistently acted on and did not always work well. We also identified issues of families feeling excluded, not listened to or that staff weren't communicating effectively in our wider review of care at NHFT.
- While VC received timely admission to hospital in most cases, delays around his third admission led to VC being admitted to an out-of-area PICU (psychiatric intensive care unit) bed. Concerns over the use of out-of-area beds was also a wider issue that we identified in our first report.
- In September 2022, 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.

Medicines management and optimisation

- In line with the Mental Health Act Code of Practice, VC's preferences were at the forefront in decisions around the choice of medicine and treatment regime. However, his decisions and wishes were not always balanced with other information.
- From the beginning of the 2 years, there was an obvious pattern of VC not taking his medicine while in the community. Records also show that medicine had been found in his flat, suggesting that he wasn't taking it. This is similar to 3 of the 10 benchmarking cases we looked at, where we found issues with medicines monitoring.
- Despite multiple hospital admissions and evidence that VC was still symptomatic on the treatment prescribed, there was no real change to his care and treatment. NICE guidelines are clear that people with schizophrenia whose illness has not responded adequately to treatment, should have their diagnosis and treatment reviewed to ensure it is at an adequate dosage and for the correct duration.

Discharge planning

- No problems were identified for the first 2 discharges between local NHS hospitals and community services for VC. This reflects some of the findings from our review of 10 benchmarking cases, which found that, of the 4 patients discharged from NHFT, 3 were handled well.
- There were differences between the records we reviewed from the trust and the independent hospital in relation to the third discharge in October 2021. At this discharge, VC was unable to access specialist crisis team care. 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 NHFT.

- There is no evidence of discussion around the value of depot medicine or a community treatment order (CTO) until his fourth admission. NICE guidelines recommend the use of depot antipsychotic medicine for people who do not comply with taking oral medicines. Giving VC a depot injection and placing him on CTO would have allowed for recall to hospital, but as he was being held under section 2 of the MHA it was not legally possible to discharge him using a CTO.
- The evidence over the course of VC's illness and contact with services and police indicated beyond any real doubt that VC would relapse into distressing symptoms and potentially aggressive and/or intrusive behaviour. The decision to discharge VC back to his GP in September 2022 did not adequately consider or mitigate the risks of relapse and violence or his lack of engagement with services. This reflects the findings from our wider review of NHFT, which found that discharge planning was not robust, and that there was a 'lack of clarity of thinking' in relation to discharge decisions.

Background

Scope of our report

Under section 48 of the Health and Social Care Act 2008, we have the power to carry out a thematic review of the care provided by NHS and adult care services. As a result, the scope of our review was limited to the care Valdo Calocane (VC) received from NHFT mental health services, from his first point of contact in May 2020 to his discharge back to his GP in September 2022.

It does not look more widely at how services across the system, including for example the police or social care services, worked together. In addition, it does not comment on VC's interactions with the police, other than where this intersects with the care provided by NHFT.

In order to identify any failings in care, as well as wider issues with mental health services in Nottinghamshire, we have reviewed VC's care records alongside 10 other cases receiving care from NHFT (to enable benchmarking) and evidence from our wider review of NHFT. While we have reviewed VC's care records, our report focuses on the quality of care provided by the trust.

As part of our review, we have engaged with the families of VC and the victims, but we have not interviewed or spoken with any members of NHFT staff involved in VC's care as part of the review.

Methodology

For this part of our section 48 review, we commissioned 2 consultant psychiatrists with experience of community mental health teams and early intervention in psychosis services to review VC's medical records for the entire duration he was under the care of the trust, including the records from the time he spent under the care of the independent hospital.

We also commissioned 2 senior community mental health nurses, who have experience in early intervention in psychosis teams, to carry out a review of all medical records of 10 cases for benchmarking.

The 10 cases were selected from a list of 2,528 patients who had been patients of the early intervention in psychosis services at NHFT between April 2020 and February 2024. Cases were selected at random to ensure that records reviewed covered a cross section of the entire period. Of the 10 cases selected, 6 were closed and had been discharged from the trust, and 4 cases were still open to trust services.

For both VC and the benchmarking cases, reviewers looked at all interactions that patients had with the trust including, but not limited to:

- observations

- risk assessments
- care plans
- discharge plans
- Mental Health Act assessments
- multidisciplinary team meeting notes.

Reviews were completed following a template of best practice guidelines, the trust's policies and procedures and national guidance, to form a judgement about the care and treatment delivered. VC's care and treatment and the benchmarking cases were compared against each other to identify if any themes and trends existed between them. These were further compared against the wider review of the trust completed previously to identify any similarities.

Context

VC first came into contact with NHFT mental health services in May 2020. At the time, he was a student at Nottingham University.

VC's first contact with mental health services occurred during the COVID-19 pandemic when the country was in its first lockdown.

It is clear from his records that VC was acutely unwell throughout the 2 years he was under the care of NHFT. Following his first arrest and mental health assessment it was concluded that VC was psychotic and suffering from paranoid delusions. He was later given a diagnosis of paranoid schizophrenia in July 2020. See the timeline for a chronology of his interactions with NHFT mental health services.

The way in which symptoms of psychosis present will be unique to each person and there will be a range of symptoms that differ in both presentation and severity. The 3 main symptoms of psychosis include:

- hallucinations
- delusions
- confused and disturbed thoughts.

People with psychosis can present as hostile and guarded, or demonstrate uneasiness with others. Records indicate that VC showed evidence of these symptoms throughout his care under NHFT.

During his care, VC also showed little understanding or acceptance of his condition. Lack of insight is a common, but not predictable, feature of someone with psychosis or schizophrenia. While some people will have insight, many won't.

People experiencing delusions or hallucinations genuinely believe that what they are experiencing is happening to them. This is exacerbated when someone is paranoid, as their paranoia will increase their suspicions and distrust of people and organisations.

Evidence-based practice has demonstrated that psychoeducation and psychological therapies can help people gain insight into their illness and understand the importance of taking their medicine. However, it cannot always be guaranteed to work. In some cases, people do not engage with other therapies and will only take medicine to help them live with and manage their symptoms.

It is evident that VC's risk of violence, and in turn the risk this posed to others, increased when his psychosis was not managed by medicine. However, it appears that VC did not engage with therapies that could help him manage his condition and problems with him taking his medicine were recorded from early on.

VC's engagement with care services fluctuated throughout the 2 years. While there is evidence that some health professionals were proactive in maintaining contact, VC was consistently hard to engage. Towards the end of the 2-year period VC became more unwell and increasingly disengaged from care services

Timeline of VC's interaction with mental health services in Nottingham

2020

May

- **24 May**
  First arrest/mental health presentation.
  Sent home following mental health assessment
- **24 May**
  Re-arrested (1 hour after discharge)
- **25 May**
  First detention under under section 2 of the Mental Health Act 1983 (MHA) at Highbury Hospital

June

- **17 June**
  Discharged to the crisis resolution home treatment (CRHT) team
- **30 June**
  Care moved to the early intervention in psychosis (EIP) team

July

- **11 July**

  VC's family contacts EIP team with concerns about his mental health

  Concerns recorded but no contact attempted

- **14 July**

  Police incident. Second detention under the MHA (section 3) at Highbury Hospital

- **31 July**

  Discharged from hospital to CRHT

VC engaged with care services until August 2021, but concerns noted throughout the period around VC taking his medicine

August to October

- **15 August 2020**

  Care moved to the EIP team

- **9 and 24 October**

  2x contacts by VC's family

  These were followed up by the EIP team

2021

May

- **29 May 2021**

  Concerns raised by VC's family

  Followed up by crisis team by phone

August

- **19 August**

  VC's condition noted to be deteriorating and increasing lack of engagement from VC

September

- **3 September**

  Taken to a place of safety under section 2 of the MHA

- **11 September**

  Third hospital admission to independent hospital (out of area) under section 2

October

- **1 October**

  VC moved to independent hospital in Nottingham under section 3 of the MHA

VC engagement with care services superficial and sporadic

- **22 October**

  Discharged back into the community

- **22 October**
  VC's family contacted the EIP team expressing dissatisfaction at not being informed that he was being discharged
  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"

2022

January

- **18 January**
  VC detained at a place of safety following alleged assault on fellow student
- **19 January**
  VC assessed for detention under the MHA but not detained as the assessing doctor felt he could be managed in the community and was not detainable

---

VC disengages from mental health services and not taking medication.

- **28 January**
  Fourth hospital admission at Highbury Hospital (due to lack of concordance)

February

- **24 February**
  Discharged back to EIP team

April

- **28 April**
  Care coordination transferred from long standing care coordinator to two community psychiatric nurses due to concerns about risks

September

- **23 September**
  Discharged back to GP due to non-engagement. No further records.

Risk assessment and record keeping

Guidelines from the Department of Health and Social Care (DHSC) on Best practice in managing risk define risk in mental health as relating to a negative event, such as violence, self-harm/suicide or self-neglect. Assessing and managing risk provides an opportunity to engage with patients, and their carers and families, in order to promote the patients' safety, recovery and wellbeing. It is integral to providing safe and effective care and making decisions on transition between services.

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.

As part of our review of VC's care and treatment, and the 10 cases we reviewed for benchmarking purposes, we looked at the risk assessments carried out by Nottinghamshire Healthcare NHS Foundation Trust (NHFT) for each patient, as well as any information relating to risk.

NHFT records risk assessments on its electronic patient records system. This has an in-built tool that prompts for specific information which it then uses to provide an assessment of risk to inform treatment plans.

VC's records showed that 8 risk assessments were completed between May 2020 and February 2022. These appear to have been completed for each of his admissions to hospital, as well as being updated at other times during his care and treatment in the community.

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.

Risks assessments did not provide a suitable analysis of the risks or identify the factors that may reduce his risk of violence and how this would be managed. They also did not outline the seriousness and the immediate threat of the risks and the known issues that would increase his risks, or provide a written outline of the scenarios where the risk of violence would escalate and who may be put at risk. As a result, the extent of the risk did not fully inform his care and treatment planning.

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)."

As described in the background to this report, throughout the period he was under the care of NHFT, as part of the symptoms of his psychosis VC showed little understanding or acceptance of his condition. This is likely to have significantly impaired his ability to weigh up the information regarding the need for antipsychotic treatment and the risks of discontinuing it. On that basis, VC should have had assessments of his capacity to consent to treatment in the community. However, opportunities to assess his capacity to consent to treatment in the community were not taken. (See also section on Medicines management.)

There does not appear to have been an updated risk summary or review of the level of risk before he was discharged from the early intervention in psychosis (EIP) team to the GP in September 2022. This was a missed opportunity in highlighting to the GP the risk of him not taking his medicine, and the possibility of him having a psychotic relapse as a result.

In the cases we reviewed as part of our benchmarking, we also found inconsistency in the risk assessment records. In most cases, we found that the EIP team assertively managed patients' psychosis, with risk assessments reviewed frequently and updated in response to changes in a patient's risk profile. However, there were examples where the 'Risk and Summary Assessment' could have contained more detail and been reviewed more regularly.

For example, in one patient record the reviews of risk were very limited in detail and there was no evidence that the care co-ordinator had reviewed the patient's risks. The only relevant entry across the 9 risk assessments for this patient did not identify any related actions or activity that were associated with the risks identified. There was also uncertainty about the patient's documented diagnosis and whether it was first episode psychosis or drug-induced psychosis.

Findings from our review of VC's case and the benchmarking cases highlight many of the same concerns that we raised in our wider review of NHFT around inconsistent approaches to risk assessment. In our first report, we flagged concerns that there was variation in how well staff assessed and managed risk. Although the trust told us some teams held daily risk assessment meetings (RAM) to 'RAG' rate people in their care according to their level of risk and the severity of their needs, not all teams were using this. We also found that teams did not keep clinical records of RAM meetings to allow audit and learning. Together, these increased the risk of people coming to harm.

Our findings reflect feedback we received from people using services during the first part of our review, which highlighted significant shortcomings in managing risk. For example, people told us about repeated instances of risk to individuals' physical and mental health that were not adequately addressed. This included failing to manage interpersonal conflicts that escalated into violence, improper handling of medicine, and neglecting the mental health needs of individuals in distress.

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.)

Medicines management and optimisation

Medicine is one of the main treatments for people with severe mental illness, including psychosis and schizophrenia. Taking a person-centred approach and ensuring people are taking their medicine in a safe and effective way is essential to achieving the best possible outcome. Poorly treated mental illness, because of non-adherence and/or under-prescribing or over-prescribing, can have devastating consequences for people and increase the risk of relapse and being admitted to hospital.

As part of our review of VC's care and treatment, and the 10 cases we reviewed for benchmarking purposes, we looked at medicines optimisation for patients and how their medicines were managed.

In VC's case, providing consistent and assertive treatment was key to managing his risk of violence as this, and in turn the risk to others, increased when his psychosis was not managed by medicine.

The MHA Code of Practice is clear that people with mental health conditions should be able to express their views and preferences about their care and treatment, including decisions about their medicine. Shared decision making can help people to understand the benefits, harms and possible outcomes of different options, and accommodating patient preference can increase people's willingness to initiate and engage in treatments.

VC's preferences were at the forefront in decisions around the choice of medicine and treatment regime. However, as highlighted in the section on Care planning, VC's decisions and wishes were not always balanced with other information.

Despite the evidence that VC was symptomatic on the treatment prescribed and had been admitted to hospital on multiple occasions over a short period, there was no change in the approach to treatment. NICE guidelines are clear that people with schizophrenia whose illness has not responded adequately to treatment, should have their diagnosis and treatment reviewed to ensure it is at an adequate dosage and for the correct duration.

Similarly to our findings on care planning and discharge planning, 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.

From the beginning of the 2 years, there was an obvious pattern of VC not taking his medicine while in the community. Records also show that medicine had been found in his flat, suggesting that he wasn't taking it.

This element of VC's case has similarities to a small number of cases from our benchmarking review. In 3 of the 10 cases we looked at, we found issues with medicines monitoring. In these instances, teams relied on self-reporting from patients, as there were no robust processes in place to ensure that patients were taking their medicines. We are unable to give a broader view as we did not look at medicines management as part of our wider review of NHFT. However, our benchmarking suggests this could have been a limited issue as the majority of cases showed good examples of CRHT teams ensuring that patients were taking medicine as prescribed.

As highlighted in the section on Engagement with VC and his family, NICE guidelines recommend the use of depot antipsychotic medicine for people who do not comply with taking oral medicines. Due to the challenges of providing consistent treatment for his illness, VC's lack of engagement and poor compliance with medicine, there was evidence to support changing his treatment from oral medicine to a depot injection.

In 3 of VC's inpatient hospital admissions there are references to a depot injection, but VC consistently declined this, stating that he preferred to take oral medicine. As highlighted in the section on Care planning, we are concerned that the team did not adequately balance VC's wishes with other information they may have held and what may have been in his best interests. This could be seen as a missed opportunity, as his detention under the MHA presented the possibility of changing his medicine to be able to treat his symptoms more robustly.

Discharge planning

In January 2024, NHS England introduced statutory guidance on Discharge from mental health inpatient settings. This sets out how organisations across the health system should work together to ensure effective discharge planning and that people who are discharged receive the best outcomes. This guidance emphasises the importance of involving people who use services and their chosen carers. It is clear that discharge planning should start before or on admission, and should be continued throughout a person's stay in hospital. This reflects current guidance in the MHA Code of Practice, which states that discharge planning should begin as soon as a patient is admitted under the MHA.

As part of our review of VC's care and treatment and the 10 cases reviewed for benchmarking purposes, we looked at the discharge plans (where appropriate) for each individual and how discharges were managed by the trust.

Our review showed that discharge planning for VC only really looked at how he was presenting at the point of each discharge, the context of his individual admissions to hospital and how he had recovered during those stays. VC appears to have complied with taking his medicine when he was in hospital, and his symptoms often improved.

In addition, discharge plans did not take a more holistic view of his previous patterns of admission following relapse after he had stopped taking his medicine in the community. They did not also look at what was required for successful recovery in the community.

Three out of 4 of VC's inpatient stays were in NHS hospitals in the Nottingham area, with one admission (his third admission) out of area to an independent hospital in the North East, during which he was transferred back to an independent hospital in Nottingham. We found no issues with the first 2 discharges between local NHS hospitals and community services. This reflects some of the findings from our review of 10 benchmarking cases, which found that, of the 4 patients discharged from NHFT, 3 were handled well.

There were differences between the records we reviewed from the trust and the independent hospital in relation to the third discharge in October 2021. As noted in the section on Engagement with VC and his family, NHFT records show that discharge from the hospital was unexpected and the EIP team were only told he had been discharged when they contacted the hospital about attending his ward round. Records from the independent hospital showed that they had contacted the EIP team before his discharge. VC's family were not told by the hospital that he was being discharged.

We highlighted problems around people not being involved or notified in discharge decisions in our first report on NHFT. In this, we also reported on difficulties in transitions of care for people discharged from inpatient services or the crisis team into community care. For example, we found 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.

In our wider review, some people told us that moving between services felt fragmented while others 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 re-admitted to services very soon after discharge or rapidly deteriorating in the community.

As part of the step down process, VC should have been discharged to the CRHT team, but the discharge occurred on a Friday and no crisis team input had been arranged over the weekend. The EIP team attempted to refer him to the crisis team, but they were unable to accept his case due to capacity issues. In place of any other input being available, the EIP team took on his care and treatment.

Not having access to the CRHT team means that VC did not receive the specialist support required, which may have increased the risk that his transfer of care back into the community may not be successful.

In both his third and fourth admissions to hospital, discharge planning did not address or take into consideration the previous failures to maintain recovery in the community, which had led to him relapsing and becoming violent.

Ahead of his third discharge, a forensic assessment could have helped with understanding the level of risk and supporting a risk management plan, but this was not considered. There was also no risk assessment or multidisciplinary team meeting ahead of this discharge. The multidisciplinary meeting would have enabled the views of the care co-ordinator, EIP consultant and psychologist to be considered together, and supported the community team to identify risk and treatment challenges. This was a missed opportunity to inform decisions about discharge planning, including for example the use of depot antipsychotic medicine and a community treatment order (CTO), for which there was clear indication.

CTOs allow suitable patients to live in the community rather than being detained in hospital, to help prevent relapse and harm. Patients placed on a CTO have to meet certain conditions which may include, for example, living in a certain place, attending appointments with mental health professionals, or not taking drugs and drinking alcohol. If they don't comply, they may be recalled to hospital under the MHA. Decisions around CTOs are made by the responsible clinician, and can be applied to people who are detained under section 3 of the MHA. People under section 2, or who are already discharged from hospital, cannot be placed on a CTO.

Despite known risks around VC not taking his medicine in the community, and the risk he posed when non-compliant, there is no mention of a CTO, combined with the use of depot injection, until his fourth admission. Records show that at this admission, the community team raised it as a potential discharge approach.

As highlighted in the sections in this report on Engagement with VC and his family and Medicines management, NICE guidelines recommend the use of depot antipsychotic medicine for people who do not comply with taking oral medicines. In addition, community treatment orders (CTO) are designed to support people in the community to maintain stable mental health outside of hospital and promote recovery. Giving VC a depot injection and placing him on CTO would have allowed for recall to hospital if he stopped taking his medicine in the community. But as he was being held under section 2 of the MHA it was not legally possible to discharge him using a CTO.

VC's discharge on oral medicine was based on his assurances that he would continue to take his medicine. However, by this time he had a significant history of not taking his medicine after discharge from hospital, which posed a risk to others when not taking his medicine, which should have been considered.

The evidence over the course of VC's illness and contact with services and police indicated beyond any real doubt that VC would relapse into distressing symptoms and potentially aggressive and/or intrusive behaviour if he was not treated with antipsychotic medicine and monitored in the community.

As a result, the decision to discharge VC from community mental health services back to his GP in September 2022 due to non-engagement did not adequately consider or mitigate the risks of relapse and violence due to his persistent poor insight and resistance to treatment, which were symptoms of his illness.

This reflects the findings from our wider review of NHFT, which highlighted that discharge planning across the community mental health and crisis services was not robust, and that there was a 'lack of clarity of thinking' in relation to discharge decisions.

Conclusions

Our review of the evidence related to VC's care and the 10 benchmarking cases supports many of the findings of our wider review of patient safety and quality of care provided by NHFT. We identified concerns with:

- assessing and managing risk in the community
- the quality of care planning, and the engagement and involvement of families
- poor quality discharge planning.

It has also identified additional patient safety concerns at NHFT around:

- medicines management and reviews
- managing people who find it difficult to engage with services
- clinical decision making around detaining patients under the Mental Health Act.

Our review suggests that in VC's case there was no single point of failure, but a series of errors, omissions and misjudgements in all these areas. The scope of our review has not allowed us to explore this further, but we hope our findings provide additional evidence for NHS England's detailed scrutiny of VC's interaction with mental health services through its forthcoming independent homicide review.

While our section 48 review has focused on one trust, as highlighted in our previous report, the issues we have identified at NHFT are not unique. Both parts of our review have highlighted systemic issues with community mental health care which, without immediate action, will continue to pose an inherent risk to patient and public safety.

As an organisation, we are committed to looking in depth at the standard of care in community mental health across the country to fully understand the gaps in quality of care, patient safety, public safety, and staff experience in community mental health services. But there also needs to be national action to ensure that people most in need get the care, treatment and support they need at the right time in the most suitable environments.

As many of the issues we have found in this part of our review are consistent with the gaps we identified in our wider review, the following recommendations should be viewed in conjunction with the recommendations from our first report. These should be actioned immediately to make significant improvements for people under the care of Nottinghamshire Healthcare NHS Foundation Trust and more widely.

Recommendations

1. At a trust level, Nottinghamshire Healthcare NHS Foundation Trust (NHFT) must:

- (a) Review treatment plans on a regular basis to ensure that treatment prescribed is in line with national guidelines, including from NICE (National Institute for Health and Care Excellence), specifically when it relates to treatment of schizophrenia and medicines optimisation.
- (b) Ensure clinical supervision of decisions to detain people under section 2 or section 3 the Mental Health Act (MHA) 1983 and regularly carry out audits of records for people detained under these sections, which are reported to the NHFT board.
- (c) Ensure that regular auditing of medicines monitoring takes place within community mental health teams to identify any themes, trends and required learning.
- (d) Ensure that, in line with national guidance and best practice, staff are aware of the importance of involving and engaging patients' families and carers and that they do so in all aspects of care and treatment, including at the point of discharge, with patient consent. The trust should ensure that where patients do not give consent, this is reviewed on a regular basis in line with best practice and on all the available information available to the multidisciplinary team.
- (e) Have a robust policy and processes for discharge that consider the circumstances surrounding discharge and whether discharge is appropriate.

2. For community mental health services for working age adults, NHFT must:

- (a) Ensure regular medicines monitoring takes place within the community and address any issues quickly where problems are identified.
- (b) Ensure all practicable efforts are made to engage patients who have disengaged from the early intervention in psychosis service. This includes referring people who find it difficult to engage with services to a team that provides assertive and intensive support.
- (c) Ensure there is a standard operating procedure in place for early intervention in psychosis and community teams to follow when a patient does not attend for appointments and follow-up actions are defined for care co-ordinators.

3. We recommend that NHS England:

- (a) Appoints a named individual to take ownership for the delivery of these recommendations.
- (b) Ensures that providers' boards fully understand their role in the oversight of the needs of patients who have a serious mental illness and who find it difficult to engage with services. This includes developing local services in partnership with others to provide intensive support in order to prevent this cohort of patients from falling through the gaps.
- (c) Ensures every provider and commissioner in England undertakes a review of the model of care in place for patients with complex psychosis who typical services struggle to engage and who present with high risk.
- (d) Within the next 12 months, provides evidence-based guidance setting out the national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia.

- (e) Within 3 months of the publication of the national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia, ensures every provider and commissioner develops and delivers an action plan to achieve these.
- (f) Through the providers' boards, ensures delivery of the actions within 12 months of the standards being published.
- (g) Together with the Royal College of Psychiatrists:
    - reviews and strengthens the guidance to clinicians relating to medicines management in a community setting
    - reviews how legislation is used in the community to deliver medication for those patients who have a serious mental illness and where it is known they are non-compliant with medication regimes.