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.