Parliamentary and Health Service Ombudsman

Maintaining momentum: driving improvements in mental health care

HC 906

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and Health Service
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Foreword

I am publishing this report, which documents cases of serious failings in NHS mental health services, because we are at a significant moment for mental health care. Long regarded as a 'Cinderella' service within the NHS, it is now a Government priority. The *Five Year Forward View for Mental Health*, published in 2016, sets out an ambitious vision for transforming mental health care in England. The big challenge facing system leaders is how to realise these ambitions at a time when acute mental health trusts are facing unprecedented financial and workforce pressures.

The cases highlighted in this report starkly illustrate the human cost of service failures.[1] These cases are not isolated examples. They are symptomatic of persistent problems we see time and again in our complaints casework and, moreover, they represent failings throughout the care pathway.

In the most severe cases, mistakes can lead to avoidable deaths. The cases of Ms J and Mr O illustrate the potentially tragic consequences of misdiagnosis. Ms J died because doctors failed to diagnose Neuroleptic Malignant Syndrome (NMS), a reaction to the antipsychotic drugs that she was being treated with. Mr O took his own life after clinical staff failed to diagnose Post-Traumatic Stress Disorder (PTSD) and, as a consequence, failed to anticipate the risk of self-harm or suicide.

Even where mistakes do not lead to avoidable death, they can still cause harm or considerable distress to the patient. The case of Ms R, a woman with bipolar disorder, illustrates the damaging consequences of inadequate risk assessment and poor communication. After Ms R gave birth, her baby was taken into care without a full assessment of the risk she posed to her baby or any explanation of why her child was taken away.

This caused Ms R considerable stress which in turn affected her sleep, appetite and ability to breastfeed.

Patients who use specialist mental health services are among the most vulnerable in our society. As a result, any serious failings on the part of the organisations providing these services can have catastrophic consequences for them. I'm encouraged by the scale of ambition in the *Five Year Forward View for Mental Health*. However, the challenge to NHS leaders is to make those ambitions a reality and ensure that the kind of incidents described in this report become a thing of the past.

Rob Behrens, CBE
Parliamentary and Health Service Ombudsman

[1] This is when there has been a failing or failings in the NHS care/treatment someone has received. Service failure can also include an NHS organisation failing to provide care/treatment or a service.

Introduction

This report aims to highlight failings that have occurred, and continue to occur, in specialist mental health services in England, and the devastating toll this takes on patients and their families. Not only are the examples of injustice shown here shocking and tragic, they also show a failure by local NHS organisations to investigate complaints effectively. We do not expect any service that deals with the complex issues presented in this report to run flawlessly. But it is vital that, when someone raises concerns, an effective and robust investigation is carried out to find out what happened, acknowledge their mistakes, put things right and make sure these failings are not repeated.

The complaints in this report predate the *Five Year Forward View for Mental Health*, the much needed national strategy to improve mental health services in England, which was published in February 2016. Nevertheless, the serious errors we highlight are typical of the complaints we continue to receive. Moreover, they echo the concerns flagged by the Care Quality Commission (CQC) in its 2017 report on the state of mental health care.[2]

We recognise that NHS England has started to address these issues in its implementation plan for the *Five Year Forward View for Mental Health*. For that reason we are not making systemic recommendations in this report. We expect the number and severity of complaints about the systemic failings highlighted in this report to reduce over time if the plan brings about the step change in service provision that is its ambition.

Although this report highlights cases that demonstrate some significant failings, these only scratch the surface of the challenge to improve our mental health services. In 2016-17 there were 14,106 complaints made to NHS mental health trusts, with around 65% being upheld or partly upheld by the local organisation.[3] In 2016-17, we completed a further 352 investigations into NHS mental health trusts and found failings in 130 (37%) of these cases.[4] We also saw failings in a further 37 complaints which were either already accepted by the organisation, or where we were able to resolve the complaint without completing a full investigation.

As the final stage in the NHS complaints process, we only see examples of when things go badly wrong. There is, of course, a lot of excellent practice in mental health services. The CQC inspects all healthcare providers and has rated 68% of NHS core mental health services as good and a further 6% as outstanding.[5]

Even so, we have a unique view into what happens when failures occur. We see some of the worst injustices and the resulting human impact on patients and their families. It is our role to ensure NHS organisations learn from these mistakes and take the necessary steps to prevent those mistakes from happening again.

[2] http://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf
[3] https://digital.nhs.uk/catalogue/PUB30080
[4] There are other NHS organisations providing mental health care, but which also provide other services including acute physical health services, as well as independent providers. These are not included in these statistics.
[5] http://www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf

About us

The Parliamentary and Health Service Ombudsman was set up by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS in England and UK government departments. Our investigations look at the difference between what happened and what should have happened. If we find something went wrong we will make recommendations to put things right, both for the people directly affected and to ensure the service improves to prevent the same mistakes happening again.

We make recommendations to put things right for the individual, taking account of the scale of the injustice and what the individual wants. These remedies can include acknowledging and apologising for mistakes. We also aim to put the complainant in the position they would have been in had the mistakes not happened. This can be difficult and in some cases we recommend that a financial payment should be made to achieve this, although complainants often do not want a payment and we will take this into consideration.

We also ask organisations to show how they will prevent the same mistakes happening again. In all the complaints included in this report, we recommended the organisation produce an action plan to make changes. This was to ensure the organisation learned from the complaint by looking again at what went wrong and actively identifying how they could improve their service.

We have produced guidance for how organisations can produce an action plan.[6] We also ask them to share their action plans with the CQC to inform their inspections and, where relevant, NHS Improvement, which works with NHS trusts to help improve their services.

We will shortly be publishing our own new three-year strategy, in which we will commit to publishing more information about the outcomes of our casework, including the recommendations we make and what organisations have done to comply with our recommendations. Publishing more about what we have found will help public services learn from what went wrong and help them to restore trust among patients while ensuring that future patients do not face similar experiences.

Meanwhile, we use reports like this to highlight key themes from our casework so that those working in, leading and scrutinising public services can improve.

[6] https://www.ombudsman.org.uk/organisations-we-investigate/putting-things-right/writing-action-plans

The state of mental health provision in the 21st century

'For too long mental illness has been something of a hidden injustice in our country, shrouded in a completely unacceptable stigma and dangerously disregarded as a secondary issue to physical health.' Prime Minister Theresa May, 9 January 2017.[7]

Mental health care has come a long way from the institutionalisation of patients in psychiatric hospitals. However, it still does not enjoy parity of esteem with physical healthcare in our health system. Mental health care accounts for nearly a quarter of NHS activity, but receives only 11% of spending. According to The King's Fund, 40% of mental health trusts in England received a real terms decrease in their operating income in 2015-16.[8] More recently, The King's Fund found that, despite 85% of mental health trusts receiving increases to their income in 2016-17, funding for acute and specialist physical healthcare continued to grow more quickly, increasing the gap in funding between physical and mental health services.[9]

Non-consultant led mental health services are exempt from the 18-week 'referral to treatment' waiting time rule, enshrined in the NHS Constitution. This means people with mental health problems can be left without treatment or support when they most need it. The CQC recently reported how one child had been waiting 18 months for treatment.[10]

It is therefore welcome that NHS leaders have recognised the need for a radical upgrade in mental health services. In 2016, the independent Mental Health Taskforce published the *Five Year Forward View for Mental Health*, a strategy for improving mental health services.

The Taskforce identified three strategic priorities:

- **A seven-day NHS:** making sure that mental health crisis care is available 24 hours a day, seven days a week.
- **An integrated physical and mental health approach:** making sure that care for people with both physical and mental health needs is joined up and that one is not treated in isolation or to the detriment of the other.
- **Improving prevention:** enabling people to lead fulfilled and productive lives and providing support at key moments in life, for example, during childhood or when people are out of work.

As we publish this report, NHS England is two years into its implementation plan for the *Five Year Forward View for Mental Health*.[11] This plan sets out an ambitious programme of work to improve mental health services, with the aim of ensuring one million more patients are receiving high quality mental health care. However, the recent CQC report, *The state of care in mental health services 2014 to 2017*,[12] based on evidence from its inspections, shows the challenge the NHS has

[7] https://www.gov.uk/government/news/prime-minister-unveils-plans-to-transform-mental-health-support
[8] https://www.kingsfund.org.uk/blog/2016/10/trust-finances-mental-health-taskforce
[9] https://www.kingsfund.org.uk/publications/funding-staffing-mental-health-providers
[10] http://www.cqc.org.uk/sites/default/files/20171103_cypmhphase1_report.pdf
[11] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf
[12] http://www.cqc.org.uk/publications/major-report/state-care-mental-health-services-2014-2017

to overcome in order to deliver the strategy. This report reinforces the CQC's findings. While 74% of NHS services were rated as good or outstanding, 25% required improvement and a further 1% were rated inadequate.

CQC identified several areas of concern from their inspections:

- Safety concerns over antiquated premises, unsafe staffing levels and poor management of medicines.
- Persistence of restrictive practices, including locked mental health wards, staff on acute wards lacking the skills to anticipate and de-escalate violent situations, and the over-use of physical restraint.
- Poor access and lengthy waiting times for specialist services and a lack of 24-hour crisis care.
- Poor clinical information systems which hinder care co-ordination and information about risk not being available to all staff involved in a patient's care.

The CQC also monitor how NHS organisations use the *Mental Health Act 1983*. Its most recent report[13] showed there has been no improvement in respect of problems it had identified in previous years including:

- Patient involvement in care plans.
- Taking the patient's views into consideration.
- Consideration of patient need or the least restrictive option for care.
- Discharge planning.
- Patients not being informed of their legal rights.

These concerns are additionally worrying given the increasing use of detention under the *Mental Health Act 1983.* 63,622 people were detained under the Act in 2015-16, a 9% increase on the previous year.

In 2017, the government appointed an independent review,[14] led by Professor Sir Simon Wessely, to examine the way providers currently use the *Mental Health Act 1983*, and how it affects patients, professionals and the public. The review is looking at the reasons behind the rising use of the Act, the disproportionate number of people from black and minority ethnic groups detained under the Act, and processes that are out of step with a modern health system. The review is due to publish its findings in autumn 2018.

A common thread running through both the *Five Year Forward View for Mental Health* and CQC's state of care report is workforce challenges. The scale of the problem is underlined by The King's Fund report on staffing in NHS mental health services, which found there has been a 13% reduction in mental health nurses between 2009 and 2017, with inpatient care losing nearly 25%. Almost 10% of all posts in specialist mental health services in England are vacant.[15]

[13] http://www.cqc.org.uk/sites/default/files/20180227_mhareport_web.pdf
[14] https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act
[15] https://www.kingsfund.org.uk/publications/funding-staffing-mental-health-providers

The *Five Year Forward View for Mental Health* set out the need for a costed, multi-disciplinary workforce strategy[16] to ensure the workforce has the right number of people with the right skills.

The complaints we have included in this report demonstrate how patient care and safety is jeopardised by these workforce challenges. They show clinical staff ill-equipped with the skills to manage potentially violent situations, being expected to work double shifts leading to exhaustion, and clinicians having to treat conditions they have no experience of. Unless these workforce challenges are addressed it is difficult to see how the transformation of mental health care, envisioned in the *Five Year Forward View for Mental Health*, can be realised.

How we chose these complaints

We chose the cases in this report after following a rigorous process to identify the common themes in the hundreds of complaints we have received about mental health services in recent years. They cover decisions we made between 2014-15 and 2017-18.

The first step we took was to gain a preliminary understanding of the issues in our casework. We looked at a sample of 150 complaints made by or on behalf of people with mental ill health, which we either upheld or partly upheld, over a two-year period from April 2014 to March 2016.

This report focuses on specialist mental health services because complaints in this area account for a significant majority of our mental health investigations - 71% of the initial sample.

This analysis of our casework data showed that the most common failings were:

- **Failure to treat:** Failures in diagnosing and treating illness, either mental or physical, were present in 16% of the sample.
- **Inadequate assessments (including risk assessments):** Failings in assessments of symptoms, as well as risk assessments for patient safety and the safety of others, were present in 21% of the sample.
- **Treatment or care plans:** This included incomplete treatment or care plans, not involving the patient in developing a plan and not following a care plan. These issues were present in 17% of the sample.
- **Communication:** Problems in communication with patients and their families about care arrangements were present in 33% of the sample.
- **Co-ordination of services:** Problems in communication between services and co-ordination of care, as well as discharge arrangements where responsibility transferred from one service to another, were present in 15% of the sample.

Following this initial exercise, we carried out further qualitative and contextual analysis.

We read 200 of our investigation reports, including those from the original sample,

[16] This strategy, *Stepping forward to 2020/21: The mental health workforce plan for England*, was published in July 2017: https://hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%20202021%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf

spanning decisions we made between 2014-15 and 2017-18 and considered information from external sources, including CQC, the *Five Year Forward View for Mental Health* and mental health charities, such as Mind and Rethink Mental Illness.

Five key themes emerged from this work in respect of the persistent failings we see:

- Diagnosis and failure to treat
- Risk assessment and safety
- Dignity and human rights
- Communication
- Inappropriate discharge and provision of aftercare.

We selected the cases in this report because they illustrate these recurrent themes and because the injustice and harm caused by the failings was severe. Not all the complaints we look into are so serious. However, it is important to show the damaging consequences for patients and their families when mental health services get it seriously wrong. These cases reinforce the concerns highlighted by the CQC and underline why it is so vital the recommendations in the *Five Year Forward View for Mental Health* are fully implemented.

Complaint handling

The other common factor in the cases we examined is far too frequent substandard complaint handling by the NHS organisations. We can only uphold a complaint if there has been a failing that has not been acknowledged and put right by the organisation. While the focus of this report is to highlight where mental health services are failing patients, poor complaint handling compounds the impact of these failings. In the course of speaking to complainants for this report, a common theme was that poor complaint handling 'added insult to injury', and showed a lack of respect.

In 2009, we published the *Ombudsman's Principles for Good Complaint Handling*,[17] which set out what organisations should do to manage complaints properly so customers' concerns are dealt with appropriately. Good complaint handling is integral to good patient experience. Responding quickly and honestly, acknowledging mistakes and putting things right means that, even when something serious has gone wrong, people still feel they are treated with respect and empathy.

Finally, complaints are an opportunity for organisations to learn and improve. This can enhance the organisation's reputation and increase trust among people using the service. Showing how a complaint has made a difference and made improvements so others do not experience the same mistake is an opportunity to rebuild trust and confidence in public services that is too often missed.

[17] https://www.ombudsman.org.uk/about-us/our-principles/principles-good-complaint-handling

The complaints we see

The case summaries in this report are listed under the five thematic headings identified above.

However, complaints that come to us can rarely be distilled to a single theme. We have, therefore, chosen the most relevant theme under which to categorise each case, but they also raise issues relevant to the others we have identified and some broader issues.

What should not be forgotten is that at the heart of each summary is the story of someone failed by the mental health system. This was then compounded by a further failure to properly deal with the complaint that was raised to draw the system's attention to the injustice that had occurred.

In our view, if the *Five Year Forward View for Mental Health* implementation plan is to be considered successful, we would expect to see far fewer of these types of complaints come to us.

Diagnosis and failure to treat

The complaints below are representative of the failings we see connected to diagnosing mental illness and the subsequent impact of not providing the treatment or support for the individual's needs.

The case of Ms J shows the importance of considering and treating a physical illness when someone is in a mental health setting and the terrible consequences that can occur when this does not happen. The *Five Year Forward View for Mental Health* recognises this, committing to both improving staff awareness of mental health in physical health settings, as well as funding physical health checks for people with severe mental illness.

The case of Mr O shows the importance of fully exploring the issues an individual raises when assessing them. Not doing so can lead to a missed diagnosis and a failure to provide someone with the appropriate support and treatment. As Mr O's case illustrates, this can lead to the most tragic of outcomes. Suicide prevention is highlighted as a priority in the *Five Year Forward View for Mental Health*, as is the need for additional skills and capacity in the workforce. We welcome this focus.

Ms J

What happened

Ms J was diagnosed with bipolar affective disorder during a period travelling in Australia. On her return to the UK, her GP referred her to the Trust, which allocated her a care co-ordinator. She was seen by her care co-ordinator and other staff from the Trust and the medication she had been prescribed in Australia was gradually reduced then stopped. Some months later, Ms J had a further psychotic episode, was admitted to hospital and prescribed antipsychotic medication, which she refused. This medication was then administered by injection.

Over the next few days, Ms J continued to be treated with antipsychotic medication and her condition appeared to improve. She reported some physical symptoms to staff, including high pulse rate, stiffness and a sore back. She was later found to be disoriented and confused, glazed in expression and stiff. Her mental state deteriorated again. Doctors put the increased confusion down to infection and treated it with antibiotics. A CT scan[18] was also taken.

Ms J's physical symptoms persisted, and doctors continued to treat her for an infection. Ms J was later found dead. The coroner recorded that Ms J died from Neuroleptic Malignant Syndrome (NMS), a rare but potentially life-threatening reaction to the use of a group of antipsychotic drugs or major tranquilisers called neuroleptics.

What we found

Early on in Ms J's care, when she had a temperature and high pulse rate, it was recorded that NMS was unlikely. When, after a few days of improvement, Ms J's mental state deteriorated and she reported further physical symptoms, the doctors responded by testing for a urine infection and treating this with pain relief and antibiotics. The doctors treating Ms J also looked at other possible causes for the change in her condition, and ordered a CT scan, but did not consider NMS.

As doctors were struggling to determine the cause of Ms J's symptoms, they should have referred her for a physical medical opinion, but did not. Staff did not carry out a creatine phosphokinase (CPK) blood test, which would have identified NMS.[19] This was contrary to Good Medical Practice,[20] which advises that good clinical care must include adequately assessing a patient's condition and providing or arranging the advice, investigations and treatment that are needed. Had doctors identified NMS, it is likely that Ms J would have received the appropriate treatment and survived. As such, we concluded that Ms J's death was avoidable.

Furthermore, we found that the Trust was not open and accountable or customer focused in its response to Ms J's mother's complaint, adding to the distress felt by the family.

[18] Computerised tomography scan, which produces detailed images of internal body structures, including internal organs, blood vessels and bones.
[19] Creatinine phosphokinase (CPK) is an enzyme in the body. It is found mainly in the heart, brain and skeletal muscle. In NMS the level of CPK in the blood will be raised.
[20] https://www.gmc-uk.org/guidance/good_medical_practice.asp

Our recommendations

We recommended the Trust write to Ms J's mother to fully acknowledge and apologise for the failings we identified and to outline the lessons learnt and the actions that would be taken as a result of our findings.

The Trust, in its response, said it had:

- Ensured all medics receive peer supervision to discuss challenging clinical cases, monitored through audit reports.
- Sent a high profile alert to its staff raising awareness of NMS and started including information about the condition in inductions for trainee medics.

Mr O

What happened

Mr O's GP referred him to the Trust's community mental health team following concerns about his mental health. Mr O had not shown any previous signs of mental ill health. His case was triaged and a recommendation made that he be seen with two workers due to the paranoid nature of his presentation. Mr O was only seen by one Approved Mental Health Professional (AMHP)[21] who decided he did not meet the criteria for referral to secondary care, but that he might benefit from short-term support to assess whether his symptoms were indicative of a developing illness.

At his next appointment, the AMHP recorded that Mr O was not suffering from a major mental disorder and discharged him to his GP. A little over a month later, Mr O took his own life. Mr O's father, Mr E, complained about the care his son received.

What we found

The AMHP assessed Mr O as having 'first episode psychosis'. The National Institute for Health and Care Excellence (NICE) guideline for psychosis[22] states that healthcare professionals should assess for Post-Traumatic Stress Disorder (PTSD) because people suffering psychosis are likely to have experienced previous trauma. Mr O had referred to childhood sexual abuse in his assessment, meaning it would have been appropriate to explore PTSD.

The AMHP did not explore the possibility that Mr O was suffering from PTSD or use any recognised assessment tools, such as the Impact of Event Scale, which measures the distress caused by traumatic events. Therefore, we found the Trust had failed to follow clinical guidelines and recognised practice when assessing Mr O and failed to explore a potential diagnosis for PTSD.

As a result, the risk assessment conducted by the Trust was too brief and inadequate because there had been no consideration of the risk posed by PTSD. Mr O was then referred for Cognitive Behavioural Therapy, which was inappropriate for his symptoms and not in line with the treatment options for psychosis as set out in the Mental Health Clustering Tool.[23] The Trust also failed to seek advice from a psychiatrist.

We found that Mr O should have been assessed for and given specialist treatment for PTSD. While we cannot say that he would have engaged with this treatment, or that this treatment would have prevented his death, missing this potential diagnosis meant that Mr O did not get the support he needed.

Our recommendations

We recommended the Trust acknowledge and apologise for the failings we identified, and develop an action plan to address those failings. We are still to close this case as the Trust has failed to provide a sufficiently robust action plan which meets the requirements we set out. As well as continuing to press the Trust for a more rigorous action plan, we have shared this information with the Care Quality Commission so that they can consider it as part of their regulatory and inspection processes.

[21] AMHPs exercise functions under the *Mental Health Act 1983*. Those functions relate to decisions made about individuals with mental disorders, including the decision to apply for compulsory admission to hospital. Social workers, mental health and learning disabilities nurses, occupational therapists and practitioner psychologists, registered with their respective regulator, may train to become AMHPs. http://www.hcpc-uk.co.uk/assets/documents/1000414DApprovalcriteriaforapprovedmentalhealthprofessional(AMHP)programmes.pdf

[22] NICE Guideline 178 Psychosis and schizophrenia in adults: prevention and management https://www.nice.org.uk/guidance/cg178

[23] The Mental Health Clustering Tool allows clinicians to identify appropriate treatment options for a patient based on their presentation.

Risk assessment and safety

Risk assessment in mental health settings is crucial for understanding patient needs and ensuring the safety both of the individual and of others. Decisions around risk need to be based on knowledge of the individual, their social context and experience, relevant research evidence and clinical judgement.

The complaints we see related to risk assessment and patient safety reinforce concerns expressed by the CQC about patient safety. This includes unsafe staffing levels and poor reporting practices and systems, which can mean that risk assessments are not seen by all staff involved in a patient's care and, consequently, inappropriate decisions are taken.

The cases below are examples of the impact of poor risk assessment – caused by poor knowledge of illness and the individual context – and the consequences of an unsafe care environment. They are representative of the failings we see in relation to risk assessments, where either a too stringent or too lax approach results in an injustice to the individual and their freedom or safety is compromised.

Mr D

What happened

Mr D had a history of mental ill health, and had recently been an inpatient with the Trust. He had a history of risky behaviour and excessive alcohol intake, and had previously self-harmed. Following his discharge from hospital, he was being cared for by the Trust's Acute Home Treatment Team (AHTT).

Mr D contacted the AHTT crisis line ten days after his discharge from hospital. He reported having consumed a large amount of alcohol and that he had cut himself. The AHTT asked if he needed an ambulance, and advised him to get some sleep as he was due to be seen the following day. A short time later, Mr D called the crisis line again, asking, 'What should I do?' The AHTT reiterated their previous advice. Mr D suggested he might take an overdose, before denying this and ending the call.

Mr D went on to take an insulin overdose and started a fire in his flat. He was later jailed for three years for this offence.

What we found

We found the Trust had not put effective plans in place to manage Mr D's risk after his discharge from hospital.

Mr D's recent inpatient stay meant he was at heightened risk of suicide. The Trust should have produced an action plan to manage this risk, in accordance with *Preventing suicide: A toolkit for mental health services*,[24] but did not.

The Trust had assessed Mr D's risk while he was an inpatient and identified alcohol as a risk factor. The Crisis Resolution Home Treatment Plan referred to alcohol misuse as a risk. However, it had not formally assessed the risks to his safety, or provided guidance for staff to manage and support him, in the event of alcohol misuse in the period following his discharge from hospital. This meant that the decisions taken when Mr D contacted the crisis line were unreasonable.

Mr D had consumed a large amount of alcohol and said he had cut himself. He hinted at further attempts to harm himself. Alcohol was one of the main risks to Mr D, and can also mean that a person lacks the capacity to make decisions about their own welfare. Given this, the AHTT should have assessed his mental capacity to make decisions, in line with the *Mental Health Act Code of Practice*. It should not have relied on his own assessment that he did not need medical assistance or that he would not attempt further self-harm.

The Home Treatment Plan also suggested that a welfare check was considered appropriate in certain circumstances. We found that the risk factors in Mr D's case should have triggered a visit either from the AHTT or the police.

Mr D contacted the AHTT at a time of crisis. He had recently been an inpatient with the Trust, had consumed a large amount of alcohol, and had a history of self-harm and attempts to take his own life. These risks were not fully acknowledged or planned for by the Trust. This was compounded by poor and inconsistent decision making around Mr D's capacity to

[24] http://www.nrls.npsa.nhs.uk/resources/?entryid45=65297

assess his own condition and decisions. Staff therefore did not judge his risk appropriately and take action to keep him safe.

The Trust missed opportunities to support Mr D effectively when he contacted them in crisis. Had appropriate action been identified and taken, there may have been a different outcome for Mr D, his further self-harm might have been prevented and he might have avoided prosecution.

Our recommendations

We recommended the Trust write to Mr D to acknowledge and apologise for these failings and the distress these mistakes caused. We also recommended the Trust review its policies and procedures around risk assessment by the AHTT, welfare checks for people in crisis, and managing patients with dynamic risk factors. We recommended the Trust produce an action plan on the back of these reviews, detailing what had been learnt from the complaint and the action taken to prevent repetition.

The Trust's action plan showed it had:

- Established a process to ensure all patients have an initial assessment to help identify a dual diagnosis (mental illness and substance misuse), which is then updated on the first home visit. This action helps identify the additional risks for people with dual diagnosis and the actions to be taken to mitigate and respond to these risks.
- Implemented 'safety plans' as part of the risk assessment process, developed with patients and available online. This ensures all staff are able to access and refer to this information when contacted by a person in crisis.
- Reinforced the policy for 'safe and well' checks to all AHTT staff and developed a collaborative standard operating procedure with local police for these checks.
- Shared learning from the complaint with AHTT staff, and held a reflective learning session to ensure all staff are aware of the appropriate policies and guidance for when they are contacted by a person in crisis.

Mr L

What happened

Mr L was a young person with autism and mental health issues. Following a gradual deterioration in his mental health, he was referred to a centre for severe mental illness as a voluntary inpatient. He was discharged a month later. Some months later, Mr L was detained for a month under section 2 of the *Mental Health Act 1983*. He was discharged, and then readmitted the next day. Finally, he was moved to a permanent residential placement. Following this move he was diagnosed with bipolar disorder.

During Mr L's first voluntary stay at the centre, he was assaulted by another patient, causing a deep cut to his lip which required stitches and several loose teeth which needed a form of splint to be attached to prevent further movement. The Trust agreed to a care plan for Mr L to support both him and his family following his discharge, but this was never implemented.

Mr L's mother, Ms Y, complained about the care provided to Mr L.

What we found

Mr L was a very vulnerable young person who, as his own risk assessment noted, was susceptible to being bullied. The Trust was also aware of the risk posed by the patient who went on to assault Mr L and they had increased staffing levels to mitigate the danger. However, we found that the risk assessment for the second patient was completed three days after his admission and two days after the assault. This was not in line with good practice.

We found that some of the staff had worked double shifts, again falling foul of good practice because of the risk of tiredness. There was a lack of specific experience of child mental health or learning disability.

We found that, while the Trust was aware of the risk posed by the other patient, it did not follow good practice in assessing that risk and it did not ensure staffing arrangements were adequate to mitigate the risk posed to others. The assault was avoidable.

We also found that, despite the Trust agreeing to a care package to support Mr L on his discharge, this mental health and social care support, which he and his family needed, did not take place.

Our recommendations

We recommended the Trust acknowledge and apologise for the failings we identified, and pay Mr L £1,000 and Ms Y £500 for the injury and distress caused. We also recommended the Trust produce an action plan.

The Trust's action plan showed it had:

- Introduced daily multi-disciplinary team (MDT) handover meetings on wards to enable early risk identification and a checklist to ensure risk assessments are completed within 24 hours of admission, together with ongoing audits to ensure compliance.
- Provided training to staff working in child and adolescent services, with an overview of the key issues related to inpatient services, such as child and family development and behavioural skills specific to child and adolescent services.
- Held meetings between the inpatient and community teams to agree ownership of care plans on discharge.

Dignity and human rights

The NHS Constitution states that patients *'have the right to be treated with dignity and respect, in accordance with [their] human rights'*.[25] Our casework shows that an individual's human rights can be infringed as a result of poor care. For this reason, we consider the core human rights values of fairness, respect, equality, dignity and autonomy when applying the *Ombudsman's Principles for Good Administration*.[26]

Patients who use mental health services should be treated with dignity at all times, particularly so in times of crisis, when an individual's illness may compromise their ability to understand their own actions. It is vital to the trust we place in mental health services that they protect and respect our human rights when we cannot do so ourselves.

The *Five Year Forward View for Mental Health* reinforces how important it is for commissioners, providers and the CQC to protect human rights at times when a person's capacity, autonomy, choice and control might be compromised. The strategy aims to ensure that a person's rights to be treated in the least restricted setting, to give or withhold consent, to use advance decisions and to maintain family life, are respected.

[25] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#nhs-values
[26] https://www.ombudsman.org.uk/about-us/our-principles/ombudsmans-introduction-principles

Ms G

What happened

Ms G had a history of bipolar disorder and was detained under section 2 of the *Mental Health Act 1983* after her family became concerned about her behaviour. On arrival at the ward, she was held in seclusion for 50 minutes before being reviewed by a doctor and joining the main ward. She was then returned to seclusion.

Staff later observed Ms G eating a sandwich that had menstrual blood on it and there was blood smeared on the walls. It was later reported she had inserted a plastic cup into her vagina. She was reviewed by a doctor, and the seclusion continued before she accepted antipsychotic medication.

What we found

Ms G was in acute mental health crisis. She had been assessed as being at an increased risk of harm to herself and others. The Trust recorded a clear and reasonable rationale for keeping her in seclusion. However, we found no evidence that Ms G was provided with sanitary products, which resulted in blood ending up on her food and Ms G using a plastic cup to collect menstrual blood.

We found the Trust's Seclusion Policy states *'patients will be treated with dignity and respect at all times'* and Ms G's seclusion care plan states that her personal hygiene and toileting facilities should be considered, under the heading *'dignity and respect'*. However, there was no mention that Ms G was menstruating and no care plan around this. Additionally, food was placed on the floor without consideration of Ms G's circumstances.

We found that not providing Ms G with the sanitary products she needed compromised her dignity and hygiene. This was not in line with the *Mental Health Act Code of Practice*[27] which states that seclusion arrangements should include an environment that takes account of a patient's dignity and physical well-being.

We also found the Trust did not, on every occasion, fully explain what they were doing when administering medication by injection, which was not in keeping with established good practice or the Nursing and Midwifery Council's *Standards for medicines management*.[28]

These failures caused Ms G distress and humiliation, which were compounded by the Trust's failure to fully respond to her initial verbal complaint.

[27] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
[28] https://www.nmc.org.uk/standards/additional-standards/standards-for-medicines-management/

Our recommendations

We recommended the Trust write to Ms G to acknowledge and apologise specifically for the failings we identified. Additionally, we recommended the Trust prepare an action plan to describe what they would do to prevent a recurrence of these failings, and send this to the CQC.

The action plan produced by the Trust showed it had:

- Raised awareness with staff of the need to maintain personal hygiene in seclusion, with discussions in team meetings.
- Discussed privacy and dignity issues at the Trust's learning lessons group and seclusion steering group.
- Highlighted the need for explanation of administering medication by injection within the learning lessons group and seclusion steering group for all clinical teams.

Human rights in mental health care

All public bodies and their employees have, under the *Human Rights Act 1998,* a duty to protect, respect and fulfil people's human rights. This includes NHS services and staff, as well as services provided by third parties on behalf of the NHS. The NHS Constitution clearly states: *'You have the right to be treated with dignity and respect, in accordance with your human rights.'*

There are many aspects of mental health care where human rights are particularly relevant, such as detention under the *Mental Health Act 1983*. The British Institute of Human Rights has produced a series of practitioner toolkits that put human rights into the context of mental health care, showing examples of how taking a human rights based approach leads to better services and care.

The toolkits are available at https://www.bihr.org.uk/human-rights-on-the-frontline-resources

Communication

Communication is critical to good care in all health settings, and particularly so in mental health services, where an individual's decision making and understanding may be impaired. The NHS Constitution pledges to *'make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered'*.[29]

The two complaints below show the potentially harmful impact of poor communication with patients. In both cases, the complainants were caused considerable distress because actions by the people caring for them were not explained to them. This lack of communication meant the actions that followed were disproportionate and unreasonable, and the injustice avoidable.

Equally important is communication between services. In mental health care, there is often interaction between services, including GP, acute physical health providers and social services. We often see poor communication and a lack of co-ordination between services – including on risk, need, treatment plans and discharge – and this can have a massive impact on patients and their families.

[29] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

Mr P

What happened

Mr P was detained in hospital under section 2 of the *Mental Health Act 1983*, for assessment and treatment. Section 2 is for people whose mental health has not previously been assessed in hospital. A nurse visited Mr P to explain his rights while detained, but recorded that he was not able to understand them at that time. Mr P then started refusing his oral medication and a doctor authorised the forcible administration of the medication by injection.

What we found

Although there was an initial attempt to explain Mr P's rights to him, further attempts should have been made at regular intervals. We found the Trust did not inform Mr P of his rights as a detained patient, or the Trust's powers to force medication, as required by the *Mental Health Act Code of Practice*.[30] This meant that he did not fully understand the consequences of his decision.

Furthermore, the decision to forcibly administer Mr P's medication was carried out without a full assessment by a doctor or adequate information about his physical health. There was no discussion between medical staff and Mr P about his proposed treatment and possible alternatives. Mr P therefore was not given the opportunity to reconsider withholding his consent. Because the Trust did not communicate with Mr P in the way it should have, it did not minimise the need for force, meaning the level of restraint used was excessive.

Mr P was also denied a blanket for sleeping and was regularly woken at night by staff shining a light in his face. This was a serious failing of nursing care and has had a lasting effect on Mr P. The ward routine was dominated by the needs of smokers while Mr P, a non-smoker, was denied access to the fresh air. He was prevented from leaving a room when a false fire alarm went off, even though he was on the ward as a voluntary patient at that time.

Our recommendations

We recommended the Trust apologise to Mr P, and pay £2,000 in recognition of the distress, anxiety, discomfort and frustration he experienced. We also asked the Trust to develop an action plan to ensure they had learned from their mistakes. This showed the Trust had:

- Provided training for staff on giving information on their rights to detained patients.
- Revised and updated a Rapid Tranquillisation Policy to provide guidance on best practice on treatment in an emergency.
- Provided training for doctors and nurses emphasising the importance of physical evaluation before administering medication in an emergency.

[30] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

Ms R

What happened

Ms R had a past diagnosis of bipolar disorder, having suffered a manic episode after an earlier miscarriage. She suffered further manic episodes in the following years and took medication to help manage her condition.

Ms R became pregnant again and, during her pregnancy, sought support from the Trust. Because of her history of bipolar disorder, the Trust decided that Ms R was at high risk of relapse and placed her on the vulnerable list for admission to the mother and baby unit. She was visited a number of times by the Rapid Assessment, Interface and Discharge (RAID) team. When she gave birth, her baby was taken from her while she received a full assessment under the provisions of the *Mental Health Act 1983*. She was later reunited with her baby.

What we found

The Trust engaged well with Ms R during her pregnancy and took appropriate steps to support her. However, following the birth of her baby, Ms R told staff that she did not want to see her community psychiatric nurse or the Home Treatment Team when she returned home. She was reviewed by a psychiatrist who was concerned about the potential for a relapse, and arranged for a full assessment under the *Mental Health Act 1983*. At this point, Ms R's baby was taken away as staff were concerned about how she would react to the assessment and any risk to her baby.

We found that the Trust did not carry out an assessment of the risk Ms R posed to her baby before the decision was made to separate them. A full risk assessment should have been carried out and documented. Furthermore, the decision seemed at odds with earlier statements that she had been bonding well with her baby and there were no other indications of risk.

Compounding this poor decision making was a lack of communication with Ms R. At no point was the reason for removing her baby explained to her. The decision to remove a baby from its mother is a significant one and doing so without explanation would have been hugely distressing. It was not in accordance with established good practice. Additionally, Ms R was not informed about the frequency of visits from the RAID team while she was in hospital.

As a result, Ms R lost her appetite, which prevented her from breastfeeding, suffered sleepless nights and became increasingly stressed. She also became worried about having another baby.

Our recommendations

We recommended the Trust acknowledge and apologise for the failings we found, as well as pay Ms R a total of £500 in recognition of the upset and distress caused. We also recommended the Trust prepare an action plan to prevent repetition of the failings.

This action plan demonstrated the Trust had:

- Emphasised to staff the need to be clear with patients on care plans and decisions, ensuring discussions and decisions are documented and a copy given to the patient.
- Provided additional training for RAID teams on safeguarding and reminded them of risk assessment requirements.
- Discussed the complaint at the Trust's Governance Committee meeting and communicated key messages to all services.

Inappropriate discharge and provision of aftercare

We have previously reported on the problem of unsafe discharge from hospital in physical healthcare.[31] We see similar issues in mental health services.

Being discharged from hospital, particularly after having been detained under the *Mental Health Act 1983*, can be the most vulnerable time for patients. Moving from intense, round the clock supervision and support back into the community, with more limited options can be very challenging. There is a heightened risk of suicide in the first three months after discharge.[32] Often people require support from a number of services, such as community mental health teams, GPs, and social services. Discharge planning is crucial to ensure the safety of patients during the transition.

The aim in the *Five Year Forward View for Mental Health* is to ensure people have the right care at the right time and the support to lead active and independent lives. NHS England's implementation plan identifies the need to improve and promote the use of personalised, recovery-focused care planning in secure inpatient services. This is in line with the requirements of section 117 of the *Mental Health Act 1983*, making sure discharge planning starts while the patient is still in hospital and engaging with other services early.

Evidence from complaints to us shows a huge disconnect between the ambitions set out in the *Five Year Forward View for Mental Health* and the reality of discharge. The complaint below is typical of the failings we see in discharge planning: it can be rushed, with the patient and their family not involved and little thought given to the support needed in the period after leaving hospital.

[31] https://www.ombudsman.org.uk/publications/report-investigations-unsafe-discharge-hospital-0
[32] http://www.nrls.npsa.nhs.uk/resources/?entryid45=65297

Mr C

What happened

Mr C had a complex history of mental health problems, including bipolar disorder and emotionally unstable personality disorder. As a child, he had special educational needs, including attention deficit hyperactivity disorder, dyslexia and dyspraxia. Mr C had difficulty engaging with mental health services, had been sectioned under the *Mental Health Act 1983* several times, and had been a voluntary inpatient. He had been put on the waiting list for a care co-ordinator several times, though one was never allocated.

Mr C had been detained under the *Mental Health Act 1983,* before being discharged with support from the Community Treatment Team (CTT). He was discharged from the CTT having missed an appointment.

Mr C died shortly after from a drug overdose.

The Trust instigated a Critical Incident Review following Mr C's death. Mr C's father, Mr F, then brought a complaint to the Ombudsman covering many issues over a long period of time.

What we found

Immediately before his death, Mr C was discharged from the CTT because he missed a single appointment. At the time he was not registered with a GP, but there was no discharge plan and no offer of access to a crisis service if Mr C needed to re-engage with support.

Mr C was not told of the decision to discharge him. That decision contravened the Trust's own policy, which states discharge should be discussed with the multi-disciplinary team (MDT) in order to mitigate risk, and also went against good practice for people with Mr C's difficulties.

Throughout his time engaging with the Trust, Mr C had not been allocated a care co-ordinator. When discharged from the CTT, his psychiatrist felt a care co-ordinator would not have been helpful because of Mr C's history of not engaging with services. We found that Mr C's complex needs meant he did require a care co-ordinator and that not having someone to address his mental health, substance misuse and housing needs contributed to his death.

Mr C was detained under the *Mental Health Act 1983* before being discharged to the CTT. Mr C's responsible clinician did not initiate an aftercare assessment as required under section 117 of the Act, which would have triggered involvement from the Clinical Commissioning Group and social services. There was little formal planning and there was poor communication between the inpatient and community services. Mr C's responsible clinician did not ensure his aftercare needs had been assessed or covered in his care plan, and nor was this discussed with Mr C.

While Mr C had many complex issues, the Trust and mental health professionals should have done more to support and treat him. As a result, opportunities were missed to treat his illness and limit his deterioration.

The Trust also failed to investigate all the concerns raised by his father, Mr F, as part of his complaint. And, despite commissioning an independent review of Mr C's care, the Trust failed to explain the inconsistencies between their own conclusions and those in the independent review. This added to Mr F's distress and uncertainty about what happened to his son.

Our recommendations

We recommended the Trust write to Mr F to acknowledge and apologise for the failings we found and pay £2,500 for the injustice suffered. We also recommended the Trust produce an action plan to prevent a repeat of the failings, and explain how improvements in its service and complaint handling are being monitored.

This action plan showed the Trust had:

- Arranged learning meetings with staff and Mr F to ensure the experience of Mr F and his son is shared and learned from.
- Developed a new procedure to review all deaths and share learning across the Trust.
- Added section 117 aftercare needs to the MDT paperwork.
- Fully reviewed and updated serious incident procedures, with director-led quality assurance.
- Fully reviewed complaints procedures and established a working group, comprising staff and members of the public, to implement the recommendations.

Section 117 aftercare

Section 117 of the *Mental Health Act 1983* imposes a duty on health and social services to provide aftercare to patients who have been detained for treatment under section 3 of the *Mental Health Act 1983*. The services provided must meet the person's needs as a result of their mental illness and reduce the chances of them having to go back to hospital.

The planning for aftercare should begin while a patient is still in hospital. Before deciding to discharge, the responsible clinician should ensure that the patient's needs have been fully assessed, discussed with the patient and addressed in their care plan. Aftercare can include almost anything arising from or related to the person's mental health disorder that helps someone live in the community. It may include, for example, help with specialised accommodation, social care support, day centre facilities or recreational activities.

Next steps

We publish this report at a time when there is significant work being conducted to improve mental health services, both by the NHS itself and policy makers.

In addition to the implementation plan for the *Five Year Forward View for Mental Health,* there is Professor Sir Simon Wessely's Independent Review of the Mental Health Act,[33] due to report later this year, which follows on from the Government's recent Green Paper on children and young people's mental health service provision.[34]

Given this, we are not making system-wide recommendations for change at this time. Instead this report highlights the human impact of service failure to make sure there is no loss of momentum in the implementation of the *Five Year Forward View for Mental Health.*

We challenge those working in and scrutinising the system to consider whether the type of issues we have documented in this report are declining. If not, we urge NHS leaders to consider whether further work or investment is needed to make sure the ambitions set out in the *Five Year Forward View for Mental Health* are achieved.

Our new three-year strategy will set out our ambition to begin publishing the majority of our casework online, including complaints about mental health services, which will help to further understanding of how services can be improved and the impact of failings when they happen. In the meantime, we will continue to monitor the evidence from our complaints casework and if there are no signs of progress, we will consider what further action is required from policy makers and NHS leaders.

The ambition set out in NHS England's plan for delivering the *Five Year Forward View for Mental Health* to *'improve access and outcomes, deliver seven-day services, reduce inequality and realise efficiencies across the local health and care economy and wider society'* is laudable.

It is important that it is achieved.

[33] https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act
[34] https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

Further resources

There are a large number of resources to support mental health services and practitioners to deliver safe and effective services. The list below is not comprehensive, but includes some useful resources and further reading:

Mental Health Act Code of Practice:
https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

NHS England resources for commissioners:
https://www.england.nhs.uk/mental-health/resources/

Mental Health Taskforce:
https://www.england.nhs.uk/mental-health/taskforce/

Mind briefing on discharge:
https://www.mind.org.uk/media/18839049/leaving-hospital-minds-good-practice-briefing.pdf

National Collaborating Centre for Mental Health (NCCMH):
http://www.rcpsych.ac.uk/workinpsychiatry/nccmh.aspx

The NCCMH works together with a variety of stakeholders, including world leading academics, clinicians and people with lived experience, to produce a variety of products.

These products include:

- national guidance and pathways for commissioners and providers of mental health services
- independent systematic reviews
- competence frameworks
- service evaluations.

NICE mental health guidelines:
https://www.nice.org.uk/guidance/lifestyle-and-wellbeing/mental-health-and-wellbeing

CQC approach to human rights:
http://www.cqc.org.uk/guidance-providers/all-services/our-human-rights-approach

CQC Equally outstanding: Equality and human rights - good practice resource:
http://www.cqc.org.uk/publications/equally-outstanding-equality-human-rights-good-practice-resource

British Institute of Human Rights: Mental Health, Mental Capacity and Human Rights - practitioner toolkits:
https://www.bihr.org.uk/human-rights-on-the-frontline-resources

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