Conclusions

Following our review, we have identified 3 enduring areas of concern at Nottinghamshire Healthcare NHS Foundation Trust (NHFT):

- **Demand for services and access to care:** High demand for services is leading to long waiting times, with a lack of oversight of people's mental health while they are waiting. Limited numbers of inpatient beds mean that patients are not always able to access the care they need in good time, with delays in admissions leading to people seeking care from emergency or crisis services. Once in contact with services, care planning and risk assessment is inconsistent and teams are not meeting the needs of the local populations. In addition, discharge planning across community mental health and crisis services is not robust, with concerns around people being discharged too soon or leaving inpatient services in a worse state than when they arrived.
- **Staffing:** NHFT do not have enough staff to keep patients safe across community mental health and crisis services and some inpatient services. High demand for services, and complex staffing arrangements mean that staffing levels are not equitable to caseload sizes and the number of referrals received.
- **Leadership:** Senior leaders do not appear to have a clear oversight of risks. While there is evidence of the trust taking action to address safety concerns, including those raised by our review, we are concerned that this is predominantly reactive. In addition, leaders are not obviously prioritising engagement with people who use services.

The gaps and challenges we have identified at NHFT are longstanding issues at the trust which need to be addressed. However, we know that other community mental health services across the country are facing many of the same challenges as NHFT.

As highlighted in our 2022/23 State of Care report, many other mental health services across the country are experiencing high and increasing demand. This is being exacerbated by factors such as population growth, aging demographics and societal pressures, which are straining existing resources and services. Current plans, including NHS England's Community Mental Health Transformation Programme aim to provide a solution. However, the high level of unmet need means that more action is needed.

Ensuring consistent, high-quality care across the 42 systems and mental health organisations can be challenging. Lack of integration between mental health services and other healthcare, social care and support services, like the police, is leading to variations in service provision and outcomes for patients.

Workforce shortage of mental health professionals, including psychiatrists, psychologists and community psychiatric nurses, is increasing staff workloads, creating retention challenges, and leading to staff burnout. In turn, this is having a negative impact on the quality of care of community mental health services. These staffing challenges are being made worse by inadequate supervision and support, which can affect the ability of staff to cope with the demands of their roles. This is a particular issue for staff in remote or under-served areas.

Despite training more staff, figures from the King's Fund mental health 360 paper, published in February 2024, show that the number of vacancies in NHS mental health services remains high. In September 2023, there were 28,600 vacancies (19% of the total workforce), including 1,700 medical and 13,300 nursing vacancies. In every region of England, vacancy rates in mental health services are higher than the overall NHS vacancy rate. Addressing these workforce challenges requires investment in recruitment and retention strategies, improving working conditions and career development opportunities, enhancing diversity within the workforce, and providing adequate support and supervision for mental health professionals.

It is clear that challenges in community based mental health services are having an impact on inpatient mental health services. Despite national aims to intervene early, many patients are getting to a state of crisis and being detained in hospital. The King's Fund 360 report shows that between 2005/6 and 2015/16, the number of times the Mental Health Act was used increased by 40%.

While our review focused on the quality and safety of mental health services at NHFT, our findings highlight the need to look more closely at community mental health services nationally to fully understand the gaps in quality of care, patient safety, public safety, and staff experience in community mental health services.