Access to care

Key points:

- High demand and long waiting times at NHFT meant that people were not able to access care when they need it.
- People's mental health was not monitored for signs of deterioration while waiting for support.
- Too many people did not have an allocated care coordinator, putting them and the public at the risk of harm.
- The crisis teams did not always respond to people's immediate needs to minimise any discomfort, concern, or distress, and did not always provide care and treatment to people quickly.
- The flow to inpatient beds was ineffective and people could not access a bed when needed for their mental health needs.

Referrals and waiting times for community services

As reported in our 2022/23 State of Care report and 2021/22 Mental Health Act (MHA) annual report, access to mental health care continues to be an area of concern nationally. In these reports we highlighted how unavailability of community care is putting pressure on mental health inpatient services, with many services struggling to provide a bed.

While we found no issues with referrals into community mental health services at NHFT, declined referrals was a concern flagged by the integrated care board (see section on system working). We found that high demand and lengthy waiting lists meant that people were not able to get the care they needed when they needed it. Many people told us that they were unhappy with access to community mental health and crisis services at NHFT. This was reflected in their feedback with many people reporting that they felt frustrated by "immense" or "extraordinary" waiting times:

> "I have now been on it [waiting list] over 1 year, and was told when I first asked for help, that it would be 3 to 4 months. I was totally forgotten after my initial assessment, which was traumatic… I have had to chase numerous times to get feedback, updates etc, I have gone backwards on the waiting list."

> "Accessing crisis team has always been poor for both myself and brother during the acute stages of psychosis. Emergency services too. It is only the police that have ever responded and then I get treatment."

This was supported by a November 2023 Healthwatch review of specialist and community mental health services at NHFT, which found significant issues with people accessing care. The process to access specialist mental health support was described as difficult, fraught, or impossible to navigate. Many criticised the long waiting lists, which led some people's conditions to deteriorate and added further strain on crisis services.

Each of the local mental health teams (LMHTs) had a waiting list, with 1,233 people in total on a waiting list at the time of the review. A further 39 people were waiting for treatment on the urgent LMHT pathway. We found that the number of people waiting for treatment and the length of time they were waiting varied significantly between the teams and across geographical areas. For example, there were 3 people on the family intervention and medical follow-up pathway, compared to 347 people on the care coordination pathway. The longest wait was 135 weeks in the Broxtowe and Hucknall team, compared to 2 weeks for the Mansfield team.

A lack of clear standards in waiting times for community mental health services meant that we were unable to compare NHFT waiting times against other trusts. However, we were concerned that variation in waiting times at NHFT meant access to services was not equitable. The makeup of teams also meant that some teams worked in silo and caseloads were not shared by urgency or need, but by locality.

The trust did not have a policy in place on how to manage people who were on the waiting list for mental health services. Staff told us they were worried about the length of the waiting lists and unsure of how to manage these. It was also unclear how teams managed people whose symptoms were getting worse. This seemed to be managed differently across the teams we visited. We raised this with the trust at the time of our review as we were concerned about the risk to people using the service. The trust took immediate action and they informed us that the adult community mental health service had subsequently reviewed everyone waiting for a service. This included calling people to check how they are and that they have support around them, explaining the current position regarding waiting times, when they were likely to be offered an appointment and where necessary, escalating support via the duty system or in exceptional circumstances via crisis resolution home treatment team.

As well as long waiting lists, we were concerned that too many people did not have an allocated care coordinator at the time of our review. The Royal College of Psychiatry Standards for Community Mental Health Services is clear that patients should know who is coordinating their care and how to contact them if they have any questions. However, we found that 724 patients (7% of the LMHT caseload) did not have a care coordinator. This varied across the trust ranging from 7 people in the early intervention in psychosis team without a care coordinator, to 158 people in Newark and Sherwood LMHT. Without the oversight of a care coordinator, staff and services cannot monitor any deterioration of people's condition, putting them at risk of harm.

We were also concerned that this put other people and the public at risk of harm. Through our review we heard of a few examples where a person known to NHFT community mental health services not assigned a care coordinator despite increasing risk to them and to the public. At the time of publication, we were reviewing these incidents in line with our specific incident guidance.

Crisis care

In our 2022/23 State of Care report, we highlighted ongoing concerns around community mental health care and people not getting the help they need when they need it, which can lead to people reaching crisis point.

As part of our review, we looked at the care provided by the crisis teams at NHFT. We found that the crisis teams at NHFT do not always respond to people's immediate needs to minimise any discomfort, concern, or distress, and do not always treat people quickly. This was supported by feedback from people who use services.

Almost all respondents to the 2023 Community mental health survey who provided additional comments, and had used the crisis care service at NHFT, said they felt the service was inadequate for people's needs. People were particularly negative about the crisis helpline, with comments ranging from the helpline being "useless" to being actively detrimental to their care. Some people reported that they were told simply to distract themselves when experiencing suicidal ideation. Advice like this made them feel unheard in moments of acute distress, amplifying feelings of loneliness and isolation.

> "No – the crisis team and the mental health team. If I leave a message, mostly they'll get back but once I rang at midnight and they didn't get back to me till 4am. That was the crisis team."

> "The crisis team response to any crisis was uninformed and disinterested."

NHFT's Crisis Resolution and Home Treatment (CRHT) 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, the patient would need to be admitted to hospital. The team aims to act to prevent hospital admission by providing intensive interventions in the community. In cases where it is necessary to admit the person to hospital, the CRHT will consider a package of care aimed at speeding up the date of discharge and reducing the length of the admission.

The crisis resolution and home treatment team are also responsible for the management of, and flow to, inpatient acute and psychiatric intensive care beds for people needing an admission from the community to hospital.

The trust's crisis service was in high demand. Between February 2023 and January 2024, the crisis service received 9,210 referrals. It may be that this demand was being exacerbated by the waiting times for people who need longer term support from the LMHTs.

The crisis team aims to see very urgent referrals within 4 hours, and urgent referrals within 24 hours, in line with Royal College of Psychiatrist best practice guidelines. However, how well they met these standards varied. On average:

- Between February 2023 and January 2024, the team saw 72% of very urgent patients within 4 hours, but in December 2023 only 54% of patients were seen in this time
- Between February 2023 and January 2024, the team saw 69% of urgent patients within 24 hours, but in December 2023 only 56% of urgent referrals were seen in this time.

The team's crisis line is run with a third-party provider. People calling the line will initially speak to a call handler who can provide an initial non-medical response. These calls can be transferred to crisis team staff as required. Between February 2023 and January 2024, 130,103 calls were made to the crisis line. Of these, 88,887 (68%) were answered and 35,210 calls were abandoned or the call cut out.

Staff we spoke with told us that they received a high level of complaints in relation to failed calls to the crisis line. However, data from NHFT showed that there were only 5 complaints about the crisis service since November 2023, and none of these related to call wait times or response times. As a result, we were unclear about how these concerns were being escalated and reported.

When we raised this issue with the trust, they told us, "We had previously established that the telephone system used by the crisis line was not meeting the needs of the patient group and presented an organisational risk and was not a stable platform. A working group was implemented to oversee the development of a new platform, which would also accommodate the NHS 111 option 2, mental health calls and as such would require increased capacity. This is now well advanced and expected to be launched in April 2024. Recruitment has also started to support this increased function. The new system will also provide more detailed reports on callers and abandoned calls than we are currently able to undertake."

Access to inpatient beds

Admission to hospital is not the least restrictive option for people experiencing a mental health crisis and remains a last resort. As a result, there are strict criteria for admitting people to hospital, either as an informal patient or when detained under the Mental Health Act 1983.

As highlighted in our 2021/22 Mental Health Act annual report, demand for inpatient mental health services nationally is continuing to increase, with gaps in community care and issues with bed availability adding to this pressure. As well as increasing pressure on inpatient services, gaps in community and social care services can also lead to delays in discharging patients from hospital. While admitting people with mental health needs to hospital remains a clinical decision, there is evidence to suggest that pressures on inpatient beds have had, and continue to have, an impact on decisions about whether to admit them.

We found that issues with bed management and NHFT's ability to admit people to hospital had a knock-on effect on mental health care in the community. Poor access to inpatient beds meant that community teams were having to manage caseloads with higher levels of complexity and acuity. This created greater risk and pressure on community teams, whose therapeutic input lessens as they manage increasing levels of crisis.

After our review, the trust told us that, "As a trust, we prioritise patient safety and acknowledge this causes significant pressure on our services, which at times requires the use of out of area beds. We have invested heavily in bed management support in the form of a bed management team. The team sits outside of the crisis resolution and home treatment team, which provides the clinical gatekeeping function. We have a clinical oversight lead of all patients cited on out of area hospitals with their responsibility being to link in with the respective clinical teams and support the transition back to Nottingham. There is also a quality lead that supports the oversight of our subcontracted out of area placements."

High levels of bed occupancy in mental health hospitals are a known indicator of pressure in other parts of the system. The Royal College of Psychiatrists recommends a maximum bed occupancy of 85%. While we did not see high bed occupancy levels across NHFT, the trust had difficulties with people staying in hospital for long periods and delayed discharges, which affected the flow of patients through adult mental health services. Leaders at NHFT recognised this as an issue and were monitoring it as part of their Board performance reports.

The wards for working age adults and psychiatric intensive care units had a high number of patients (26) clinically ready for discharge, but where transfers were delayed because of the complexity and risk of individual patients. Delayed transfers rose to 11.1% in November across the mental health care group, with mental health services for older people reporting 13.8%. As a result, the trust was not meeting the aims of the NHS Mental Health Implementation Plan 2019/20 to 2023/4, which aims to reduce length of inpatient psychiatric stays to a maximum of 32 days.

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. However, due to issues with patient flow through NHFT's acute and psychiatric intensive care unit inpatient beds, we found that a high number of people were being admitted to services out of the local area.

We have been reporting on our wider concerns about out of area placements for a number of years. As we highlighted in our 2022/23 State of Care and 2021/22 MHA annual reports, out of area placements are not beneficial to patients, they impact on consistency and quality of care people receive, limit the opportunities to work with a person's local care coordinator and reduce the likelihood of people being able to stay in close contact with their loved ones throughout their admission. People being placed in hospitals far from home and away from friends and family can also increase the risk of closed cultures developing.

Between 1 January 2022 and 31 November 2023, NHFT reported 190 inappropriate out of area placements to the Mental Health Services Data Set (MHSDS). In total, this meant that patients were out of area for 6,450 days. Between 2022 and 2023, the monthly average number of days that NHFT patients were placed in inappropriate out of area placements nearly doubled from 152 to 420.

The January 2024 NHFT board report highlighted that there were 846 out of area placements days reported for November 2023, the highest for 24 months. The farthest distance travelled by individuals was 301 kilometres (187 miles) between March to May 2023. This was on the trust's risk register and was being monitored.

From 2022 to 2023, the Midlands region saw an increase of 23% in inappropriate out of area placements. NHFT accounted for 15% of all inappropriate out of area placed patients in the Midlands in 2023.