25 November 2013

Dear Colleague,

As you may be aware the organisers of the Campaign to Save Mental Health Services are planning a public meeting in Norwich this evening. In preparation for this, they have raised several concerns in the media recently and have distributed an open letter to staff, service users, and members of the public regarding the state of mental health services in Norfolk and Suffolk.

The campaign organisers are undoubtedly passionate about the counties' mental health service provision in which they play an integral part. The Trust Board welcomes such passion and fully supports their view that more investment is required in mental health services. However, the Trust also feels that some of the statements made are not accurate and that in the interests of an open and honest debate, we should respond on these issues. We know that this is a difficult time for all concerned, not only in the Trust, but also from changes being made elsewhere in public funding and we welcome an open and honest debate about such issues.

The campaign has claimed that:

1. The Trust is accelerating £20m reductions over two years instead of four.

All NHS providers are required to make efficiency savings year on year and, in common with most other organisations, this is achieved through service and workforce redesign. Our plans have been developed with staff and other stakeholders, including trades union representatives.

We anticipate making efficiency savings of £28.86m between 2012 and 2016. We are not accelerating the savings over two years.

2. The Trust is closing or reducing inpatient units including Meadowlands secure unit and either Northgate or Carlton Court acute units.

As secure services are commissioned in a different way from our other services, they are not included in the Trust Service Strategy. Due to low bed occupancy, we decided (with the agreement of commissioners) to temporarily close the low secure unit Meadowlands in Thorpe St Andrew, Norwich. With only five out of 11 beds occupied, and space to accommodate these service users elsewhere, it was a logical step to take. Service users have been moved to beds available in other secure units in Norwich. The temporary closure has been completed and we are already working closely with commissioners to review the future of Meadowlands.

Carlton Court and Northgate Hospital will not be closed. A public consultation into these services will be launched by Great Yarmouth and Waveney Clinical Commissioning Group (HealthEast) in 2014.

3. The Trust has no inpatient Older Person Mental Health units in the King's Lynn area and we are planning to the reduce bed count at the Julian Hospital, Norwich

Our adult services, including the inpatient unit in King's Lynn, will serve all adults irrespective of age. However people with dementia and older people with mental health problems and very complex needs will be admitted to our specialist units at the Julian Hospital in Norwich. We anticipate that, at any one time, about five or six patients (out of many hundreds) from west Norfolk will have needs so specialist that they require admission to our services in Norwich. In an ideal world, we would like to provide smaller specialist units closer to where people live, but it is not practical for our doctors and nurses to provide highly specialist inpatient care in a variety of small units.

We are currently trialling alternatives to admission in west Norfolk because many people previously admitted to our hospital beds in King's Lynn did not in fact need to be in hospital - but they do need an alternative to living at home, at least for a short period.

Another new initiative is the Dementia Intensive Support Team (DIST), which provides intensive support for people with dementia and other age-related mental health conditions and works to keep people at home, or to prevent their care home placement from breaking down.

Because we have reorganised the way in which we use our resources, we now have the capacity to diagnose more people with dementia in west Norfolk and start people on new dementia medication.

4. The Trust is making staff redundant or downgrading their posts.

The Trust employs approximately 4,000 members of staff and, since the launch of the Service Strategy in October 2012, has made 61 redundancies, of which 41 have been compulsory and 20 voluntary.

We have additional funding for providing a west Norfolk for Psychiatric Liaison service at Queen Elizabeth Hospital in King's Lynn; in Suffolk, we have additional funding for Psychiatric Liaison with West Suffolk Hospital and Ipswich, as well as autism and eating disorder services.

These new services may provide an opportunity for some staff at risk of redundancy to secure another job. As an alternative to redundancy, some employees have been redeployed to a lower banded post with pay protection. In such cases we support these staff to find higher banded posts at the earliest opportunity.

5. The Trust has disbanded certain community teams.

Throughout the development of the Service Strategy, we have been clear that service models will need to change and that the services may need to be provided in a different way. We have disbanded certain community teams in line with the clinically-led redesign plans, but the services originally provided by multiple small teams are now being provided by larger, multi-disciplinary teams.

Having a critical mass removes the need for multiple handovers between small teams, something which the Trust has been criticised for by commissioners and offers a more flexible service. The Trust has created a new service line for adults with mental health problems that will continue to offer assertive outreach and homelessness services. The Trust acknowledges that this involves moving away from a dedicated assertive outreach team and that caseloads will change. There will be no reduction in the service or the numbers of people seen.

6. There are almost 200 unallocated referrals in Norwich community mental health teams.

This figure refers to people who have not been allocated a care coordinator. The Trust acknowledges that there is a backlog in agreeing the care coordinator and this situation is being monitored closely by the Executive Team.

For central Norfolk (a population of about 500,000) the Trust has about 2,000 open cases in adult services at any one time. The numbers are closely monitored and the most recent report (from this week) showed that there were 135 cases waiting to be allocated a named care coordinator. Our community teams are working through the cases in a systematic way and all of our service users are in touch with our services and are being monitored regularly.

7. The Norfolk Access and Assessment team is poorly resourced and struggles to cope with the high number of referrals.

We deployed the Access and Assessment Service (AAS) because our Link Worker service was struggling with the demand for new assessments. In some areas, Link Workers were holding caseloads of 50 people waiting to be assessed and to have a brief intervention (up to three sessions). There were no standards at that time for how long someone would have to wait for their first assessment and, in some cases, people waited for many weeks. Deployment of the AAS has resolved this.

AAS receives approximately 100 referrals a day across Norfolk; the service standard is that referrals are triaged within one day and, if necessary that person receives a face-to-face assessment within four hours, 72 hours or 28 days, depending on urgency. The Trust has achieved its 100% target in providing face-to-face assessment within four hours across Norfolk and Suffolk. We are one of the few Trusts who are trying to meet a new 72 hours target; our performance in Norfolk is currently 90% and 70% in Suffolk; we want to improve on that and are now providing additional out-of-hours' clinics to meet demand. We will be working with staff in the AAS to identify where the pressures lie and consider how they can be helped in meeting the demands on the service.

For the first time, GP referrers can specify how quickly they would like someone to be seen. Waiting times and workload are monitored daily, but we acknowledge there are shortcomings in some areas and we are working hard to meet GPs' expectations. Where there are problems, unlike the Link Worker model, we know immediately and we can make adjustments. Training and supervision is consistent across the service. The AAS model is a standard approach found across the NHS and social care that allows us to link with partner services, including 111, A&E and social services.

8. The Norfolk Crisis Resolution Home Treatment (CRHT) team is no longer able to provide a safe alternative to hospital admission and is operating at 25% below capacity.

The Crisis Resolution Home Treatment team is not operating below capacity. Under the Service Strategy, the Trust is increasing the size of the Crisis Resolution and Home Treatment Teams and these changes will take place early next year for Norfolk.

In Norfolk, we are experiencing considerable pressure from A&E departments at acute hospitals. We are working with hospitals and commissioners to put in place specialist mental health liaison services to help acute hospitals meet the four-hour A&E target. This will free up our crisis teams to support people in the community who would otherwise be admitted to our acute beds.

9. Patients are being prematurely discharged from our services.

Staff work with every patient to develop a suitable discharge plan prior leaving our services. National benchmarking with other mental health trusts shows we have a low re-admission rate, an indication that service users are not discharged too early.

10. Wards are operating at over 100% capacity.

Our acute wards are usually full, and, on occasion we struggle with over capacity. The acute inpatient services compare favourably with national benchmarks for quality and efficiency. We have low lengths of stay and very low re-admission rates.

We are working on alternatives to admittance and to improve timely discharge from our wards to help alleviate these pressures. We are looking to speed up this work as we recognise that sending patients out-of-area is not ideal.

11. Patients are admitted to hospitals out-of-area at a huge cost and disruption to any form of continuity of care.

In common with all mental health trusts, we use out-of-area placements for people who require highly specialised treatments that are only available regionally or nationally, for example specialist mother and baby units or brain injury units.

In common with many mental health trusts in England, we have seen increase in 2012-13 and 2013-14 in the demand for acute beds and the number of out-of-area acute placements.

Out-of-area placements represent a small proportion (less than 5%) of our admissions but it is something we are working to avoid by implementing increased community services, including those mentioned above.

In the last year we placed 51 people out of area at a total cost of less than £500,000. We are working to reduce the numbers of out-of-area placements, recognising they are not in the best interests of our service users or staff. In Suffolk out-of-area placements are very rare.

12. There are often delays in voluntary and compulsory admissions.

There are often delays in essential admissions – both voluntary admissions and compulsory admissions under the Mental Health Act – when at times an assistant mental health practitioner (AMHP) is unable to make an application for detention because the papers cannot be completed for lack of a named hospital.

13. Care coordinator caseloads will treble in size.

*Care coordinators have **not** been told their caseloads have trebled in size. Caseloads for care coordinators are typically between 25 to 35, depending on the complexity of the cases. Some care coordinators do have larger caseloads, such as those who review people living in residential care.*

The Trust monitors staffing levels and caseloads across our localities and service lines (this is now reviewed by the Executive Team as well) and we always take action if we see an increase in activity in a particular team.

14. The Trust is complacent in its response to a reported increase in alleged suicides over the last five months.

The Board supported the establishment of a working party in August, chaired by Dr Peter Jefferys MD, a consultant psychiatrist who has experience of unexpected death audits. The working party reports to the Board in December and we will report publicly; it would not be appropriate to comment before the review is completed. The themes within the review are: risk assessment and risk management, case allocation issues, clinical supervision and transfer of care and discharge.

Earlier this year there was a spike in Serious Incidents (SI) in Norfolk. In November this year, the Trust's Service Governance Sub-Committee reviewed all SIs in Norfolk (including deaths) for the previous 18 months. The Sub-Committee concluded that overall there had been no increase in levels of unexpected deaths compared with last year. We continue to review every case by conducting a prescribed internal investigation, including liaising with the family or carer, the relevant CCG, coroner and, in some cases, the police. The Board is intending to put in place a process where a non-executive director and an executive director lead investigations into the most serious incidents.

Only over the course of a year, as we fully understand the causes of death (as some of these will be by natural causes) will we be able to see whether we are looking at a pattern. We will continue to work closely with West Norfolk CCG to review every case and monitor the situation carefully.

We would like to emphasise the importance of a cohesive, honest, and transparent response to such allegations in the media, and in the wider community, and to express our thanks for your continued support of the Trust and its constituent teams during these challenging times.

Yours sincerely

Andrew Hopkins
Acting Chief Executive

Gary Page
Chair