Dialogue with the Governors

Plan

- Introduction
- Presentations 1hr
- Please hold questions to the end
- Q&A chaired by Ian Gibson 1hr
- “Chatham House Rules”

Who are “The Campaign”?

- Volunteers who feel passionately about mental health provision in Norfolk and Suffolk, including:
  - People who use NSFT services
  - Carers and family
  - Staff
  - Members of the general public
- Over 300 on mailing list; 1,700 followers on FB; 3,500 unique website visitors every month

What are we here to do today?

- To open a dialogue
- Mental health provision and change is a complex subject
- Provide a few external observations
- Four specific areas……..

Agenda

- Changes
- Obligations
- Resources
- Confidence

Changes

Background

- Institutional care
- Care in the community
- National service framework for mental health

Pre-service redesign

- Specialist community services
  - Community mental health teams
  - Crisis resolution home treatment teams
  - Assertive outreach teams
  - Early Intervention in psychosis teams

  - Older adults community teams
  - Child and adolescent mental health teams

Pre-service redesign
What did we learn?

- Nationally since NSF suicide rate reduced
- Early Intervention in psychosis saves £14,500 per service user over 3 years
- Specialist workers embedded in generic teams do not get the same outcomes.
- Some evidence from 'National Confidential Enquiry into Suicide and Homicide in the Mentally Ill' that Assertive Outreach reduces suicide
- Investing in community services reduces costs by reducing need for hospital beds whilst effectively managing risk

Post redesign

- Access & Assessment
- Generic teams based on geography (Suffolk) or age (Norfolk) with specialists embedded in the teams.
- Exception – early intervention in psychosis still exists as separate teams in central Norfolk and Yarmouth and Waveney
- Youth

Post service redesign
What is the evidence?

- Youth pilot commissioned to explore effectiveness of alternative model for subgroup.
- However – full implementation occurred before the pilot was complete.
- What is the evidence that the new service models will be:
  - Safe?
  - Effective?
  - Able to make the necessary savings?
- When will this evidence be available?

Obligations

Experience

- Worked in mental health services since 1997
  - Assertive Outreach team
  - Community Mental Health teams
  - Primary Care
  - Crisis teams
  - Criminal Justice team
  - Last six years as a social worker in the Crisis Resolution and Home Treatment (CRHT)
- Approved Mental Health Professional (AMHP)
  - carries out these duties every week
  - duty rota covering the whole of the Central Cluster area: North Norfolk, Norwich and South Norfolk.

What is a Crisis Team?

- The Crisis Resolution and Home Treatment (CRHT) team
  - responds to urgent referrals
  - decides whether patients can be treated at home or require hospital admission
  - facilitates discharge from hospital
  - offers treatment/support at home following admission, especially where there is no allocated Care Coordinator or an agreed after-care plan
  - Often responsible for visiting within seven days of discharge from hospital, which is recognized as a high risk of suicide period.

Rising referrals

- Referrals to crisis teams have risen dramatically over recent years
  - Those referred suffering from
    - severe and acute psychosis
    - severe depression and anxiety leading to self neglect
    - people with personality difficulties in distress
    - others in severe social crisis at risk of suicide.
  - For the first time, the suicide rate of people under CRHT care has exceeded that of people under inpatient care.
- If people at risk refuse home treatment or admission, or do not have the capacity to consent, they are often referred for an assessment under the Mental Health Act.

Role of the AMHP

- An AMHP is a social worker or nurse who has completed six months post-qualifying training in work under the 1983 Mental Health Act.
- The AMHP is responsible for:
  - Taking into consideration the referral
  - Arranging a formal Mental Health Act assessment, if appropriate
  - Making an application to a named hospital for detention under the Act, based on two doctors' recommendations
  - Ensuring the legality of the process is fully complied with, including the Code of Practice
  - Conveying the patient to hospital in a safe, dignified manner, ensuring human rights are respected
- An AMHP is individually legally responsible for his or her actions.

Cannot detain without *named* hospital

- A patient becomes liable for detention only once the AMHP's application has been completed and signed, naming the receiving hospital, and when two doctors' recommendations have been completed.
- Under Section 3 (Mental Health Act 1983) both doctors have to specify the name of the hospital where treatment is available.
- Unless these legal documents are completed, a patient cannot be detained and cannot be safeguarded.
- The current situation, where no hospital is available at the time of assessment, is placing patients at risk (see examples) and forcing AMHPs to act illegally and breach regulations and codes of practice (Section 13, 1983 Mental Health Act).

Failure to comply with Section 140

- The Clinical Commissioning Groups and NSFT (by proxy) are not fulfilling their statutory duty under Section 140, 1983 Mental Health Act, to
  - "… give notice to every local social services authority for an area wholly or partly comprised within the area of the clinical commissioning group … specifying the hospital or hospitals administered by (or otherwise available) to the clinical commissioning group … in which arrangements are from time to time in force:
    - For the reception of patients in cases of special urgency;
    - For the provision of accommodation or facilities designed so as to be specially suitable for patients who have not attained the age of 18 years."
- (see also DOH Reference Guide, paragraph 2.20)

Admissions to Out-of-Area Beds

- Last week there were 21 patients in out-of-area beds: ‘out of area’
  - Bradford, Weston-Super-Mare, Hastings, Dorking, London.
- Not ‘specialist placements’
  - patients who could be treated on an open acute ward
    - such as Waveney Ward, Glaven Ward , or the now-closed Thurne Ward at Hellesdon Hospital.
- Other patients ‘not out of area’, but are not in their correct locality
  - patient from Norwich may well be placed in Bury St Edmunds
    - many miles away from his/her care team, and family and friends
- Requests for assessments under the Mental Health Act have increased significantly, both locally and nationally, over the last two years
- Last year – for the first time ever – the number of people detained under the Act exceeded 50,000
- Locally, the number of assessments rose by 10%.

Consequences of lack of beds

- Patients who would agree to a local admission as a voluntary patient, but refuse an admission to a hospital many miles away from family, end up being detained – unnecessarily – under the Mental Health Act
- Breach of Section 131.1, 1983 Mental Health Act
- Breach of Code of Practice Principles 1.2, 1.3,1.4,1.5
- see also Department of Health Reference Guide, paragraph 37.2, page 293.

Consequences of lack of beds

- Patients detained under the Act are given priority for admission over voluntary patients, even when the clinical need is equal
  - voluntary patients can then end up waiting days or even weeks, for an admission to hospital
- Patients who require urgent admission under the Act cannot be detained because an admitting hospital cannot be identified
  - this means that – following an assessment – the patient has to be left to his or her own devices
- In other cases, the assessment itself is delayed
  - sometimes patients are then kept overnight in police custody or in a place of safety, on dubious legal authority, while a bed is found.
- Following admission, no proper after-care planning can take place because the patient is being treated often hundreds of miles from the responsible care team.
- AMHPs have been informing NSFT management of the implications of the lack of beds within the Trust since the beginning of 2012
  - meetings with the Chief Executive and through correspondence informing them of numerous critical incidents

Problems of Coordination & Conveyance

- The NHS ambulance service will not convey patients out of area
  - private ambulances have to be commissioned, at great cost, and are often not available
  - AMHP is often forced to use an ambulance service based in Essex, but
    - until the admission is confirmed, the ambulance cannot be requested
    - It then takes two hours for the Essex ambulance service to arrive in Norfolk.
- NSFT makes frequent use of the Priory Group private hospitals, scattered across the country
  - Now cherry-picking the easiest patients to manage, after great delay and requests for comprehensive information, which has to be supplied by the AMHP
  - The hospital then frequently refuses to accept our patient, leaving the AMHP high and dry.
- The AMHP is often stuck out in an isolated rural area, trying to identify a bed, coordinate ambulance and police, and at the same time having to cope with a disturbed patient and sometimes distressed relatives
  - The task is at times an impossible one, leading to huge stress levels and absences through sickness.

Resources

Allocation of resources in three areas worthy exploration today

- Redundancies
- External placements
- Access & Assessment

Redundancies

Does NSFT have enough money?

- £7.3m spent on redundancies
- 79 voluntary redundancies
- Many recent departures
- £4.8m in specific provisions
- Where is the other £2.5m?

Why redundancies?

- 361 vacancies across NSFT
- Problems recruiting throughout NSFT
- Recruitment is slow & expensive
- Services at risk due to VR
- Average of £1.5m per month on temporary staff
- Approx. £18 million per year
- Using non-NHSP agency staff
- Recruitment overseas?

All areas, all services, all professions, all levels

If only 25% redundancies unnecessary the programme has wasted £1.8 million – probably more

External placements

- End of February 2014, Month 11, NSFT £2.18m *over* budget on external placements
- Extrapolates to £2.38m for 2013/4 year
- Annual cost of 20 bed ward is £2 million
- From where is the money coming?

Why isn't the 'radical redesign' working for beds?

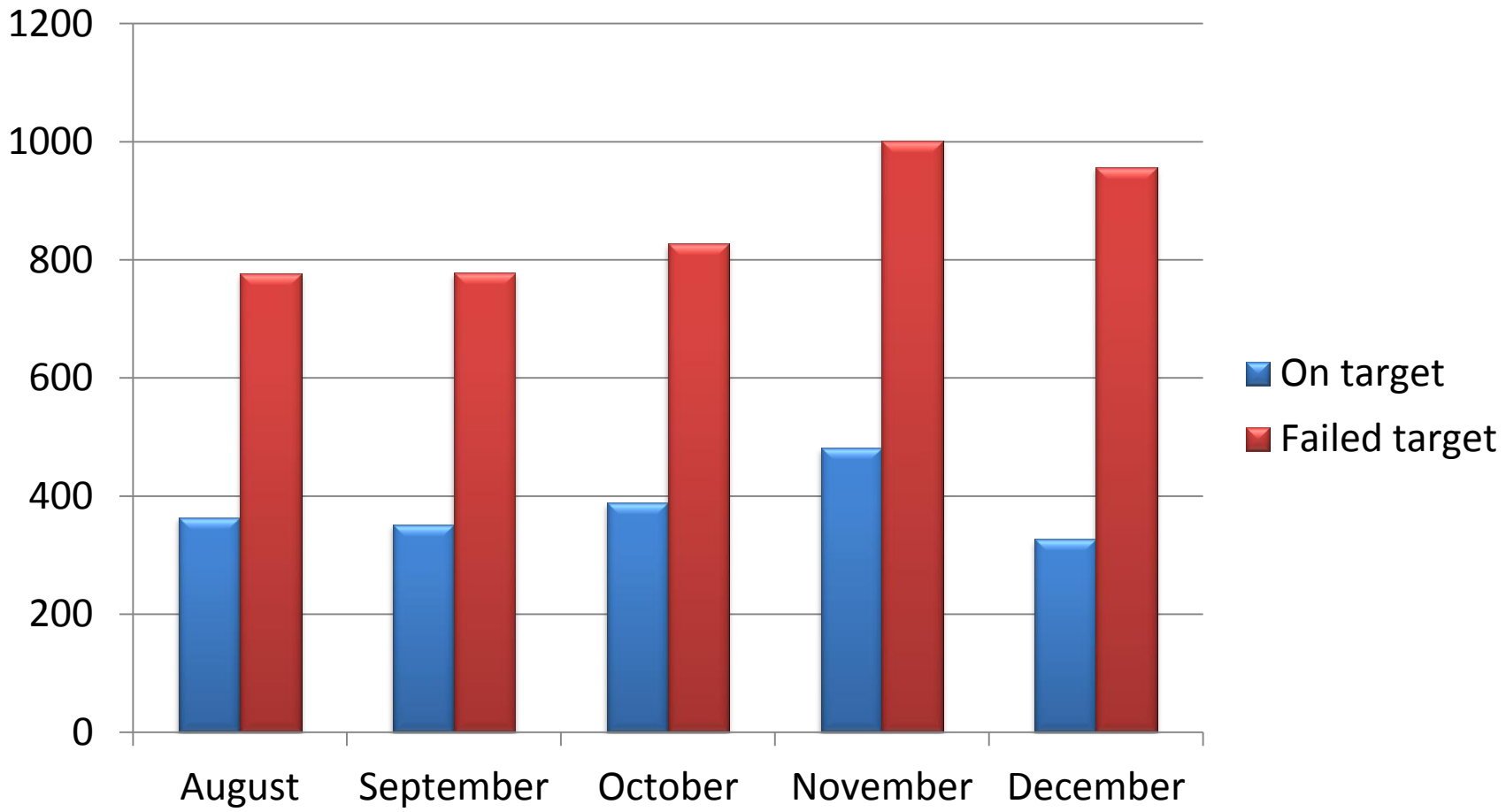
- Are 'cheaper providers' a viable solution?
  - nursing homes and B&Bs?
  - Are they genuinely cheaper?
  - Impact on quality and safety
  - Is capacity available now?
- Re-opening hostel beds only appears to have provided a temporary respite
- Need a solution that genuinely addresses the problem of vicious circle

Access & Assessment

Assessment Standards		Aug-2013	Sep-2013	Oct-2013	Nov-2013	Dec-2013
4 hr	Number triaged to Assessment within 4 hours of referral actually receiving assessment in 4 hours	29	36	27	79	84
	Number of Assessments within 4 hours made by telephone	23	32	25	69	70
	Number of Assessments within 4 hours made face to face	6	4	2	10	14
	% triaged to Assessment within 4 hours of referral actually receiving assessment in 4 hours	67%	71%	46%	53%	65%
72 hours	Number triaged to Assessment within 72 hours of referral actually receiving assessment in 72 hours	25	7	23	98	53
	Number of Assessments within 72 hours made by telephone	18	2	14	70	32
	Number of Assessments within 72 hours made face to face	7	5	9	28	21
	% triaged to Assessment within 72 hours of referral actually receiving assessment in 72 hours	25%	9%	21%	23%	17%
28 days	Number triaged to this category actually receiving assessment in 28 days	310	309	339	305	190
	% triaged to this category actually receiving assessment in 28 days	31%	31%	32%	33%	23%
Notes: Exception Report to accompany this report for those not assessed within priority allocated by triage		777	778	827	1002	957

- £3.93m spent which delivers no treatment
- £.624m *over* budget
- Routine referrals from January being called in April

Access & Assessment Performance 2013



Finally

- Redundancies
  - Where is **£2.5m** without specific provision coming from?
  - Appears at least **£1.8m** wasted on needless redundancies
    - Probably much higher
- Out of area placements
  - Where is the **£2.4m** overspend coming from?
- Access & Assessment
  - Where is the **£600K** coming from?
  - Is it a good idea to spend nearly £4m on a service which delivers no treatment and fails to meet targets?
- Total across three areas is at least **£7.3m**

Confidence

picker Institute Europe

NHS

Focused on staff experience

National NHS Staff Survey Co-ordination Centre

2013 Results

Results for the 2013 NHS staff survey are now available to view.

Briefing note: Issues highlighted by the 2013 NHS staff survey

Agenda

- Changes
- Obligations
- Resources
- Confidence

Any Questions?