Campaign to Save Mental Health Services in Norfolk & Suffolk

ISSUES FOR CONSIDERATION BY NORFOLK COUNTY COUNCIL'S HEALTH OVERVIEW AND SCRUTINY COMMITTEE'S MEETING ON 7TH DECEMBER 2017

CAN NSFT ADDRESS THE CQC'S CONCERNS AND RECOVER WHEN IT HAS LOST ONE QUARTER OF ITS INPATIENT BEDS AND MORE THAN TWENTY PER CENT OF BOTH ITS DOCTORS AND QUALIFIED NURSES AND HAS A BUDGET THAT IS BROADLY UNCHANGED SINCE ITS FOUNDATION ON 1ST JANUARY 2012?

We believe the answer to this question is no and has been demonstrated by NSFT's repeating inadequate ratings from CQC and it ignominious position of being the only mental health trust to have been put into special measures. And not just once but twice.

ARE NORFOLK COMMISSIONERS DELIVERING ANYTHING LIKE 'PARITY OF ESTEEM'?

We have investigated NHS payroll data supplied by NHS Digital over the last five years (comparing whole time equivalents in post in July 2012 with July 2017). This information formed the basis of a recent article published by the Eastern Daily Press. This showed that while the number of doctors in the acute trusts in Norfolk increased by an average of 2.9 per cent, the number of doctors at NSFT fell by 20.3 per cent. Similarly, while the number of qualified nursing staff at NSFT's acute hospitals fell by 11.9 per cent, the number of qualified nursing staff at NSFT fell by 20.7 per cent. This doesn't look like Parity of Esteem, except for NSFT management, which increased by 52.7 per cent over the five year period, in contrast to a fall of 9.3 per cent in the other NHS trusts in Norfolk.

WHY HAS COMMISSIONER'S MONITORING FAILED TO DETECT AND PRE-EMPT THE REPEATED FAILURE OF NSFT? IS THE RELATIONSHIP BETWEEN COMMISSIONERS AND THE MENTAL HEALTH TRUST TOO 'COSY'?

We have heard the same individuals representing, at various times, local CCGs, NHS England and NSFT. There does not appear to be a customer-provider relationship and we have had serious concerns raised with us about commissioning, most recently concerning the crisis café project.

We believe that the appointment of an external candidate with an excellent track record in mental health outside NHS system in the East of England would be of benefit to the whole system in creating a more realistic relationship between NSFT and its commissioners and delivering a new perspective of Norfolk's problems.

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WHY DID INTERNAL CORPORATE GOVERNANCE AT NSFT (I.E. NON-EXECUTIVE DIRECTORS AND GOVERNORS) FAIL TO DETECT THE PROBLEMS AND FAIL TO TAKE ACTION TO PREVENT THE FIRST AND SECOND CQC INADEQUATE RATINGS AND NSFT'S ENTRY INTO SPECIAL MEASURES?

We believe that the involvement of service users and carers at NSFT is tokenistic and narrow, with co-production extremely limited, as demonstrated by the lack of service user and carer involvement in the beds review. For as long as NSFT continues to fail to engage with its 'customers', it will not deliver good services.

HAS NHSOC BEEN TOO WARY OF USING ITS POWERS OF REFERRAL TO THE SECRETARY OF STATE?

Sometimes kindness can be cruelty.

IS 'SHOULD' GOOD ENOUGH FOR A 'ROBUST' CAPACITY ASSESSMENT, PARTICULARLY WHEN THE MENTAL HEALTH ACUTE CAPACITY REVIEW IS ONE OF THE MAIN DRIVERS OF THE STP'S PLANS FOR MENTAL HEALTH?

Our view is that it is patently not.

Commissioners and NSFT promised NHOSC and the people of Norfolk that beds would not be closed until it was shown that they were no longer needed and that there would be enough beds by May 2014. This was not the case.

HOW ROBUST IS THE BEDS REVIEW'S RECOMMENDATION THE STANDARDISATION OF ADMISSION RATES IN EACH OF THE CCG AREAS TO THE TWO CCGS WITH THE LOWEST RATES OF INPATIENT ADMISSIONS PER 100,000 POPULATION FOR ADULT AND OLDER ADULTS RESPECTIVELY.

The beds review ignores the NHS data on the prevalence of mental illness. Public Health England data indicates that the prevalence of severe mental illness (PMI) is 80.2% higher in Norwich CCG area than in South Norfolk, for instance. Given the variation in demographics, with Norwich tending to have fewer older residents than rural communities, the disparity in working age adult services is likely to be greater still.

Yet the beds review recommends standardisation according to the needs of South Norfolk. Given the disparity in population age and the prevalence of dual diagnosis, clinicians and AMHPs (Approved Mental Health Practitioners) tell us they believe standardisation of admission rates irrespective of local need according to the lowest common denominator is dangerous and impossible given that many current admissions involve severe mental illness, frequently following assessment under the Mental Health Act.

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COULD THE ELIMINATION OF DELAYED TRANSFER OF CARE (DTOC) ADDRESS THE SHORTAGE OF BEDS?

Firstly, NSFT and the CCGs have repeatedly claimed that the elimination of delayed transfers of care is the solution to the beds crisis since 2013. However, despite management focus, the issue of DTOC has proved difficult to resolve and, if anything has worsened given cuts to social care budgets and an ageing population.

Secondly, NSFT's Board papers of 26th October 2017 indicate that of 82 service users occupying NHS acute adult inpatient beds on 31st August 2017, only six (7.3%) could be described as attributable to Delayed Transfer of Care with all six inpatients for more than 100 days, indicating a difficult and intractable situation (p. 40).

NSFT's Board papers indicate that during August 2017, NSFT had 1,021 out of trust (OOT) bed days, equivalent to a shortfall of 34 NHS beds at one hundred per cent occupancy and with inevitable failures given the nonlinearity of demand. NSFT's Board papers of 28th September 2017 indicate that in July 2017, Norfolk patients accounted for 90 per cent of NSFT's OOT placements and that Norfolk acute adult placements accounted for 80 per cent of Norfolk OOT placements.

Extrapolating these ratios to August 2017, it appears that NSFT had a shortfall of at least 25 acute adult psychiatric beds in Norfolk at one hundred per cent occupancy and with linear demand. Even if the impossible was achieved and all six DTOC were eliminated, there would still have had a shortfall of at least nineteen acute adult inpatients beds.

In the case of DCLL beds, the number of OOT placements is slightly more than the number of DTOCs. However, the complexity of care is such that these problems can be even more intractable than in adult services and given social care budget cuts and the aging population, we believe these problems will only worsen.

We believe that Norfolk is short of at least ten DCLL beds and that the practice of placing elderly patients on general acute adult psychiatric wards is completely unacceptable. This issue was also raised by CQC.

GIVEN HUGE NATIONAL DEMAND FOR PRIVATE PSYCHIATRIC BEDS, DOES RELIANCE ON PRIVATE PROVIDERS CREATE SIGNIFICANT FINANCIAL, OPERATIONAL AND QUALITY RISKS?

We raised these risks the last time we provided evidence to NHOSC.

GIVEN ITS OWN FAILURES AND MUNDESLEY HOSPITAL'S REPEATED FAILURE AND RAPID CLOSURE, CAN NSFT BE TRUSTED TO COMMISSION THIRD-PARTY PRIVATE INPATIENT SERVICES?

When we raised concerns about the quality of Mundesley Hospital and NSFT's overreliance upon it at NHSOC, our concerns were dismissed by the Chief Executive of NSFT sitting alongside one of Norfolk's mental health commissioners.

HOW WAS THE DECISION TO WITHDRAW PATIENTS FROM MUNDESLEY HOSPITAL MADE AND WHO MADE IT? WHY DOES IT APPEAR THAT THE CLOSURE DECISION WAS MADE A MONTH AFTER THE PUBLICATION OF THE CQC REPORT BUT VERY SHORTLY AFTER THE REPORT APPEARED IN THE EDP AND ON THE BBC? WOULD PATIENTS HAVE BEEN PROTECTED WITHOUT THE INTERVENTION OF THE MEDIA?

We do not believe that commissioners and NSFT would have acted until the issue received publicity.

WHY DOES NSFT CONTINUE TO INVEST IN LOSS-MAKING AND UNDER-OCCUPIED FORENSIC AND SECURE SERVICES WHILST SIMULTANEOUSLY REFUSING TO INVEST IN INPATIENT CAPACITY FOR ADULTS AND OLDER PEOPLE WHICH IS OVERCAPACITY AND WHERE PRIVATE PROVISION IS SCARE AND INCREASINGLY EXPENSIVE?

NSFT's Board papers indicate that it has trouble filling beds in loss-making secure services yet it is spending millions of pounds refurbishing them. Meanwhile, it does not have enough general adult and DCLL beds. We find this inexplicable.

WILL THE NORFOLK CCGS CONTINUE TO FUND OUT OF TRUST BED PLACEMENTS BEYOND THE END OF THIS FINANCIAL YEAR 17-18?

Our understanding is that they have not undertaken to do so.

If such an undertaking is not made, it will result in an immediate financial and operational crisis.

SHOULD ALL NHS TRUSTS IN NORFOLK ADOPT POLICIES AND CONTRACTS FOR DIRECTORS THAT MAKE AN EXPLICIT LINK BETWEEN AN INADEQUATE RATING FOR LEADERSHIP FROM THE CARE QUALITY COMMISSION AND INADEQUATE PERFORMANCE?

We understand that one of the reasons why NSFT's former directors continue to be paid is that NSFT's internal assessment of its performance was at loggerheads with that of the CQC. We do not believe that it should not be 'routine' as described by the NSFT Chief Executive, to pay executives six-figure salaries for six months after they leave their posts following an inadequate CQC report.