

PUTTING PATIENTS FIRST?

A Trade Union Staff Response to the AWP Staff Consultation Document

1. Introduction

This cross-Union and collectively authored document attempts to pull together concerns raised by front-line staff in Bristol community mental health teams (Recovery, EI and the Crisis service) in response to the new service model proposed in the recent AWP staff consultation paper *Modernising Mental Health in Bristol*. It does not aspire to provide an exhaustive collection of comments and questions, but instead presents some key criticisms which constitute a strong practical and ethical basis on which to demand the rejection or at least radical revision of this new model. In so doing it runs counter to the predictably fatalistic management position. This position suggests that the new model is a done deal and thus the only 'realistic' response is to get on board and find virtue in the necessity, 'opportunities' in the further narrowing of spaces to give and receive the decent care and serious therapeutic interventions which, in some cases, can mean the difference between life and death. By contrast, we believe that putting patients first requires urgent action to challenge the prioritisation of financial issues, as part of a growing national movement to defend NHS services and the pay and conditions of the staff who work in them.

2. Background to 'consultation'

We live in a time when just as increasing need is placing more pressure on mental health services, the resources made available to meet this growing demand are being cut back. Thus recent reports have pointed to a cut in Government spending on mental health services of 2% in real terms over the last two years. Just recently Professor Sue Bailey, outgoing president of the Royal College of Psychiatrists, described mental health services in England as a 'car crash'.

On top of an already growing crisis of resourcing and capacity (with mental health bearing a disproportionate amount of NHS cuts) the 2012 Health and Social Care Act represents the culmination of a long-running attack on the principle of the NHS as a public provider of universal healthcare, free at the point of delivery, and helps clear the path to privatisation.

This Act, which specifies a requirement for the new Clinical Commissioning Groups (CCGs) to - in most instances - put services out to competitive tendering, forms the backdrop for the current AWP staff consultation. Mental Health Bristol (AWP plus a number of Voluntary/Third Sector partners) won the 'race to the bottom', outdoing competing bids to provide community mental health services by at least in part claiming to be able to deliver the service specified by the CCG on a decreased budget. Now the AWP management need to deal with the resulting financial shortfall by clawing it back through, most notably, cuts in staff costs. This includes through intensification of work (squeezing out more for less), via re-banding and transferring more and more (complex) work downwards to cheaper staff

with less training, as well as job losses. Other economies, such as on buildings, also play their part. Whilst all this is being spun as placing service users more at the centre of care, as a liberating and 'modernising' move, we believe it in fact further undermines service user and staff health and safety, and the potential for quality care and real therapeutic outcomes.

3. Is this a real consultation?

It is important to note immediately that it is possible to question to what extent a real consultation is taking place given that its outcome appears to have been pre-empted from outset. As the AWP Staff Consultation Paper suggested,

...we would have preferred to have developed the ideas and service models presented in this paper at an earlier stage to staff. However, the nature of the procurement process, governed by rules formulated internationally, prevented this. Though we will consider carefully any points made about the service specifications or service models that have been negotiated with the CCG, our ability to make major changes in these areas is, realistically limited (p. 4).

Doubting the seriousness of the supposed consultation is further supported by the fact that staff have already been asked to start completing their individual appraisal forms prior to the end of the official consultation period. As will be seen in what follows, there remain many areas of vagueness about what is being proposed. The evidence is of a headlong rush to push the proposals for the new model through as quickly as possible, thus minimising time for constructive feedback from staff, and potentially increasing risks for service users. And certainly it seems that individual staff members' fears about their jobs and the competitive appraisal process will be used to help facilitate this process. Hence it is very important that a collective staff response is urgently and widely articulated and discussed.

4. A threat to the safety and well-being of service users and staff

The consultation paper and the series of team-by-team HR briefings have outlined a plan whereby in each of the three Recovery teams (to be renamed 'Assessment and Recovery Service') and the Early Intervention team there will be significant reductions in qualified staff. In particular a cut of around 50% in the amount of band 6 staff in each team, and some reduction in band 5 staff is proposed. There is still much vagueness here in that management are claiming that the exact details and amounts are not yet fully confirmed ('precise staffing numbers and roles are still being reviewed', p. 4), and calculations incorporating factors such as agency staff who haven't been replaced, and numbers of people on long-term sick still need careful attention.

a) Assessment and Recovery Service (A&R)

It is proposed that introducing 25 unqualified band 4 Recovery Navigators (RNs) (envisaged as eventually being employed wholly by Voluntary/Third Sector partners) into each

Assessment and Recovery team will make up for this loss. It is supposed that each RN will have caseloads of up to 30 service users (thus taking on effective care co-ordination responsibilities) made up, it is claimed, of the less complex/non-CPA service users. Each qualified staff member will have supervisory responsibilities for three Recovery Navigators in addition to their own caseload which we are told will consist of up to 18 people.

There are a number of major concerns and ambiguities about these proposals:

- It goes against professional standards of safety and duty of care to expect each qualified staff member to carry significant responsibility for the well-being and risk management of around 90 service users in addition to their own caseload.
- The time and effort alone required for this additional supervisory work, which is likely to require regular guidance and advice, will add much to already high workload pressures. Furthermore, it is being proposed that qualified staff will have to shoulder the major burden of completing risk assessments for service users under the care of RNs, including for service users whom they may lack a full picture for and thus will risk their professional registration. In any case, there are still many unanswered questions about the nature of the training to be given to the RNs.
- Currently Band 5's do not have supervisory responsibilities and thus this is a marked change of role. It is not evident that this change of role been properly evaluated. This also applies to the potential for band 5s to be given a new role to help fill gaps in the assessment teams.
- There is a strong case for not trusting the promises that caseloads for qualified staff will be limited to 18 service users. Previously promised limits have been ignored. Thus Recovery caseloads were supposed to be pegged at 25 at the last re-design in 2012, before rising to around 30+ (in addition to assessment and duty roles), and management itself has recognised that a number of band 4s have struggled following a change of their role to include managing a caseload of clients in the 20s, partly manifesting in a high turnover of staff. Yet it is band 4s who are billed as having a central role in the new model.
- With regard to the claim that RNs will have less complex/non-CPA clients, it is should be noted that already much work was supposed to have been done in the last year, 2013, involving two band 8 staff specifically employed to scrutinise team caseloads identifying less complex cases to be stepped to band(s) 5/4 or for discharge back to the care of their GP's. At the end of the process it was found that only about 10% of Recovery caseloads in Bristol were 'less complex cases'. Many of these were not appropriate for discharge and band 4 and 5 caseloads were already at full capacity. This exercise ended with caseloads for Bristol Recovery teams remaining at levels in excess of 30.
- This puts into question claims that avoiding risky clients being allocated to RNs will be a straightforward exercise. Currently in Central Recovery around 67% of caseload are considered complex enough to be requiring CPA. With reference specifically to

the EI caseload, non-CPA clients presently form only a small part of it hence begging the question of where the less complex clients will come from.

- Further cause for concern regarding capacity under the new model is the complex clients – requiring intensive multi-agency working - under Ministry of Justice sections, CTOs, Safeguarding, MARAC, Child Protection and MAPPA. Again, we are faced with the prospect of more of such clients being pushed down to band 5s and even band 4s. On top of this there will be additional clients with RNs who may still require depots from qualified staff.
- Halving the number of band 6 posts in Recovery teams to just eight staff on this grade creates a high likelihood that a number of qualified staff – especially, but not exclusively, band 5 - will lose their jobs.

In sum, these plans are unworkable and a threat to the well-being of already over-burdened staff, but most fundamentally they are extremely reckless in relation to patient safety. Furthermore, it is hard to see how the attendant workload pressures will allow the spaces required to deliver decent therapeutic interventions, or even just to properly listen to clients.

There has already in the six months leading up to the proposal of the new model a strongly expressed set of concerns amongst Recovery staff about excess workload (including significant amount of unpaid overtime) and consequent unsafe working practices. This had taken the form of three separate well attended meetings between staff and senior management, and a Collective Grievance having been recently officially submitted.

b) Early Intervention service

The CCG's publicly stated plan is for a service which 'replicates the existing high-performing early intervention in psychosis service presently provided', one which adheres to the national pattern of reducing suicide rates, improving longer term outcomes and helping reduce the number of service users having extended careers as patients within secondary services. However, even acknowledging that the proposed EI model remains especially poorly defined and fluid, there is good reason to question the viability of this planned continuation of EI given proposals which significantly undermine central EI principles of lower caseloads and structured psycho-social interventions.

- In the proposed new model there are reductions in the number of staff including medical staff, registered staff including band 7s, band 6s and band 4 staff as well as the re-banding of staff to lower grades.
- As in the recovery teams it is proposed that band 4 staff care coordinate a caseload of less complex, non-CPA service users. Currently these service users make up a small percentage of the EI caseload and band 4 staff in EI do not care-coordinate. This shift reduces the capacity of the band 4s to facilitate recovery via interventions

such as the Recovery Star, practical support, assertive engagement, active life, specialist Individual Placement and Support (IPS) model vocational support, and numerous core group activities.

- As in the Recovery teams this and the de-banding of half the band 6 staff will add increased supervisory pressures for registered staff reducing capacity to deliver core recovery focused interventions including psychosocial interventions. A reduction in the number of band 7s is a concern. The introduction of band 5s to make up numbers are a further concern given that staff at this grade have less post graduate specialist training to deliver the specialist interventions that this client group require to best aid recovery. Band 5's will also have less clinical experience at managing clients with complex needs and high levels of risk.
- It's proposed that qualified caseloads will expand up to 20 (and likely beyond given current pressures). Current EI caseloads are supposed to be capped at 15, but regularly run above 20. Serious concerns similar to those above have been expressed surrounding issues of expanding caseloads and resulting issues of patient safety and clinical responsibility.

c) Crisis Service

Whilst the staff consultation paper suggests that 'the new Crisis Service model will provide an enhanced high quality service to people contacting us in distress', there remains much confusion about what the staffing levels will be, the effect of the changes in geographical team bases, and the knock-on effects of the wider changes to the Recovery teams.

- The impact of the band 6 changes proposed for the Assessment and Recovery and Early Intervention teams is likely to increase risks and the team workload. There is concern that many complex service users, who are likely to feel the effects of these changes, will present regularly in crisis.
- There are concerns by staff about how the team '*must... (undertake) mental health emergency assessments seen within 60 minutes* (p.14). Although staff do acknowledge the importance of responding immediately to service users in distress, there are questions as to how feasible this will be due to the caseload pressures of the team and overall assessment numbers. 60 minutes is potentially setting the team up to fail and placing staff under increased pressure to deliver. This could put other service users at risk. Frontline assessors have highlighted the importance of taking time to think, talk and reflect on assessments that come in as this promotes good clinical practice.

a) Estates plans and change in team locations

- As also expressed by Recovery staff, there are strong concerns about becoming a '*highly mobile workforce*' (p.15). In regards to the estates plans, there was no consultation with staff on the decision to move to 'Community Mental Wellbeing

Centres' and whether this has been adequately thought through. Questions have been raised as to how the shifts will fit within the centres times e.g. 8-8pm and where staff will be for the additional 1 hour 45 when these centres are closed.

- In addition, there are concerns that the fragmentation of the team is likely to have a detrimental effect on staff decision making. Risk sharing and 'corridor conversations' are crucial to the work of the intensive team. To think carefully and have support from colleagues when making complex decisions regarding services users' care is paramount. Recovery staff have raised similar concerns, acknowledging the significantly reduced office space available in the new sites. There is also a general consensus that mobile working with laptops and using 'where appropriate public spaces' (p. 12) is inappropriate and has potential for issues around confidentiality. Non-cycling staff based in at least one of the proposed sites (Well Spring) will be faced with severely limited parking capacity and efforts to circumvent this problem (such as by using public transport or parking greater distances from the base) will eat further into already pressured work hours.
- Page 16 of the staff consultation document states there is 'less activity at present during weekends and public holidays' and has 'slightly reduced staffing at these times'. Staff would like to know what data was used and when this was collected in regards to this decision. A lot of time is spent on weekends identifying beds for example.

5. 'You matter we care' – or another Mid Staffordshire NHS Trust?

AWP management are very fond of selectively quoting from the so-called Francis report, published in April 2013 at the conclusion of the public enquiry into the 'excess' deaths of up to 1,200 patients at the Mid Staffordshire NHS Trust between 2005 and 2008. This report found that the attempt by directors to ram through £10 million in cuts, including the loss of at least 50 nursing jobs, to meet government criteria for becoming a Foundation Trust (and paving the way for privatisation) was a major factor in these preventable deaths. The report criticizes the Trust for prioritizing financial cuts which 'had a profound effect on the organisation's ability to deliver a safe and effective service'. It seems, then, that rather than abiding with one of the key recommendations 'to put the patient first in everything that is done', 'involving a relentless focus on the patient's interests and the obligation to keep patients safe and protected from substandard care', we have instead a desperate gamble with patient safety via the prioritisation of cost savings. And of course individual practitioners are likely to be held to account if something does go wrong, thus placing their professional registration in jeopardy. How would service users and their families and carers feel to know that the key lessons of the Stafford Hospital scandal are being disregarded and the proposed changes being spun as an increase in quality care for service users?

There is no guarantee that grudging staff acceptance of this latest new model will mean the end to further de-banding operations, work intensification and continued paring back of quality care. Evidence from elsewhere in the NHS suggests that this would be a very naïve belief, and such evidence also includes a number of precedents where NHS staff have made a stand and forced management to step back from their plans. There is an urgent need now for us collectively to draw a line in the sand and exert, in alliance with service users, our professional duty to defend a context in which humane care can flourish rather than wither. In a context of austerity, where cuts and privatisation interact and where senior NHS managers' salaries have risen by almost four times the average rate for front-line staff, why should ordinary staff and their clients be made to pay the price for an economic crisis which they had no hand in creating?

Very shortly there will be an announcement of a Bristol community staff meeting for us to decide together a suitable course of action. In the meantime please make every effort to ensure that your colleagues have an opportunity to read and discuss this document.