Norfolk and Suffolk Joint Scrutiny Committee on Radical Redesign of Mental Health Services

Date: **Monday 11 February 2013**

Time: **2.00pm**

Venue: **Edwards Room, County Hall, Norwich NR1 2DH**

Persons attending the meeting are requested to turn off mobile phones.

Members of the public or interested parties who have indicated before the meeting that they wish to speak will, at the discretion of the Chairman, be given five minutes at the microphone. Others may ask to speak and this again is at the discretion of the Chairman.

Membership –

Dr Michael Bamford	Babergh District Council
John Bracey	Broadland District Council
Peter Byatt	Waveney District Council
Michael Chenery of Horsbrugh	Norfolk County Council
Tony Goldson	Suffolk County Council
David Harrison	Norfolk County Council
Robert Kybird	Breckland District Council
Dr Nigel Legg	South Norfolk District Council
Alan Murray	Suffolk County Council
Tony Simmons	Forest Heath District Council

Named Substitutes –

Jenny Chamberlin	Norfolk County Council
Annie Claussen-Reynolds	North Norfolk District Council
Vacancy to be confirmed	Suffolk Local Authority
Vacancy to be confirmed	Suffolk Local Authority

For further details and general enquiries about this Agenda please contact the Committee Officer:
Kristen Jones on 01603 223053 or email committees@norfolk.gov.uk

A g e n d a

1. Election of Chairman

2. Election of Vice Chairman

3. To receive apologies and details of any substitute members attending

4. Members to Declare Disclosable Pecuniary Interests (DPI) and Other Interests

If you have a **Disclosable Percuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Percuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter.

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Percuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects:

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role
- that of another public body of which you are a member to a greater extent than others in your ward.

If that is the case then you must declare such an interest but can speak and vote on the matter.

5. To receive any items of business which the Chairman decides should be considered as a matter of urgency

6. <u>Terms of reference</u> **(Page 5)**

Terms of reference are presented for the joint committee's approval.

7. <u>Background information and suggested programme of work</u> **(Page 10)**

A suggested programme for the joint committee from the Scrutiny Support Manager (Health)

8. Radical redesign of mental health services in Norfolk and Suffolk

To receive the latest version of Norfolk and Suffolk NHS Foundation Trust's proposed strategy for 2012/13 to 2015/16, along with other relevant information and evidence from witnesses.

9. Future meeting date

Members are asked to bring their diaries with them to the meeting.

Chris Walton
Head of Democratic Services
County Hall, Martineau Lane, Norwich, NR1 2DH

Date Agenda Published: 1 February 2013

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NORFOLK AND SUFFOLK JOINT SCRUTINY COMMITTEE (SC) ON THE RADICAL REDESIGN OF MENTAL HEALTH SERVICES

TERMS OF REFERENCE
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1. Legislative basis

1.1. This Joint SC is set up under the Direction issued by the Secretary of State for Health on 17th July 2003: 'Directions to Local Authorities (Overview and Scrutiny Committees, Health Scrutiny Functions) Health and Social Care Act 2001'. under Statutory Instrument 2002 no. 3048.

1.2. This Direction requires that where a local NHS body consults more than one SC on a proposal it has under consideration for a substantial development of the health service or a substantial variation in the provision of such a service, the local authorities of these SCs shall appoint a joint SC for the purpose of the consultation. Only that joint SC may:

- Make comments on the proposal consulted on to the local NHS body
- Require the local NHS body to provide information about the proposal
- Require an officer of the local NHS body to attend to answer questions in relation to the proposal.

1.3. This Joint Committee has been established by the following authorities:
Norfolk and Suffolk County Councils.

1.4 The following authorities were invited to participate in the Committee but decided not to do so:
None

2. Overall Purpose

2.1. To review and scrutinise matters relating to the planning, provision and operation of mental health services in Norfolk and Suffolk, including substantial developments or variations in NHS services being consulted upon by the relevant NHS bodies, across the whole or substantial parts of the areas of Norfolk and Suffolk social services authorities, together with any relevant technical papers or proposed plan(s) for implementing the proposals being scrutinised.

3. Purpose of review

To consider Norfolk and Suffolk NHS Foundation Trust's proposals for radical redesign of mental health services as set out in its proposed Strategy 2012/13 – 2015/16 in relation to:

- The extent to which they are in the interests of the health service in Norfolk and Suffolk.

- The impact of the proposals on patient and carer experience and outcomes and on their health and well-being.
- The quality of the clinical evidence underlying the proposals
- The extent to which the proposals are financially sustainable

To make a response and recommendations to Norfolk and Suffolk NHS Foundation Trust and other appropriate agencies on the above.

To consider and comment on the extent to which patients and the public have been consulted on the proposals, and the extent to which their views have been taken into account.

The review will run from February to March 2013.

4. Membership/chairing

4.1. All health SCs consulted on the proposals and/or with an interest in the subject under scrutiny will be entitled to up to 5 representatives, and 2 substitutes. These numbers will be agreed by the individual authorities concerned and members will be nominated by them.

4.2. Members will be politically proportional to the membership of their local authority, unless both:

- that authority's Council agrees to waive the political proportionality requirement for their own members

and

- Members of all authorities represented on the joint committee agree to waive that requirement.

4.3. A local authority may if it wishes nominate fewer members than it is entitled to on to the joint SC. This will also require the consent of its full Council, with no-one dissenting, and the agreement of members of all authorities represented on the joint committee.

4.4. The joint SC members will elect a Chairman and Vice-Chairman

4.5 Each member of the joint committee will have one vote.

5. Co-option

5.1. Representatives of other organisations or groups may be co-opted on to the joint SC as non-voting members, but with all other member rights.

Any organisation with a co-opted member will be entitled to nominate a substitute member.

Representatives of authorities outside the East of England region who are significantly affected by the issues to be scrutinised may be co-opted to the joint SC

6. Supporting the Joint SC

6.1. Norfolk County Council will be the lead authority, as decided by negotiation with the participating authorities.

6.2. The lead authority will act as secretary to the joint SC. This will include:

- Appointing a lead officer to advise and liaise with the Chairman and committee members, ensure attendance of witnesses, liaise with the consulting NHS body and other agencies, and produce reports for submission to the health bodies concerned
- Providing administrative support
- Organising and minuting meetings

6.3. The lead authority's Constitution will apply in any relevant matter not covered in these terms of reference.

6.4. Where the Joint SC requires advice as to legal or financial matters, the participating authorities will agree how this advice is obtained and any significant expenditure will be apportioned between participating authorities. Such expenditure, and apportionment thereof, would be agreed between the participating authorities before it was incurred.

6.5. The lead authority will bear the costs of arranging, supporting and hosting the meetings of the joint SC. If the joint SC agrees any action which involves significant additional costs, such as obtaining expert advice or legal action, the expenditure will be apportioned between participating authorities. Such expenditure, and the apportionment thereof, would be agreed with the participating authorities before it was incurred.

6.6. Each participating authority will appoint a link officer to liaise with the lead officer and provide support to the members of the joint SC.

6.7. Meetings shall be held at venues, dates and times agreed between the participating authorities

7. Powers

7.1. In carrying out its function the joint SC may:

- Require officers of appropriate local NHS bodies to attend and answer questions
- Require appropriate local NHS bodies to provide information about the proposals
- Obtain and consider information and evidence from other sources, such as Local Involvement Networks (LINks), patient groups, members of the public, expert advisers, local authorities and other agencies. This could include inviting witnesses to attend a joint SC meeting; inviting written evidence; and delegating joint SC members to attend consultation meetings, or meet with interested parties and report back.
- Make a report and recommendations to the appropriate NHS bodies and other bodies that it determines

- Refer the proposal to the Secretary of State if it considers that:

    - The proposal would not be in the interests of the health service in the area of the authorities forming the joint SC.
    - The joint SC is not satisfied that consultation of the committee by Norfolk and Suffolk NHS Foundation Trust or other relevant NHS bodies has been adequate in relation to content, method or time allowed.

NB: New health scrutiny Regulations expected to come into force on 1 April 2013 may vest the power of referral in the County Councils, who may choose whether or not to delegate it to a health scrutiny committee.

8. Public involvement

8.1. The joint SC will meet in public, and papers will be available at least 5 working days in advance of meetings

8.2. The lead authority will arrange for papers relating to the work of the joint SC to be published on its website. Other participating local authorities may make links from their website to the joint committee papers on the lead authority's website

8.3. A press release will be circulated to local media at the start of the process

8.4. Local media will be invited to all meetings.

8.5. Patient and voluntary organisations and individuals will be positively encouraged to submit evidence and to attend

8.6 Members of the public attending meetings may be invited to speak at the discretion of the Chairman.

9. Press strategy

9.1. The lead authority will be responsible for issuing press releases on behalf of the joint SC and dealing with press enquiries

9.2. Press releases made on behalf of the joint SC will be agreed by the Chairman or Vice-Chairman of the SC

9.3. Press releases will be circulated to all link officers

These arrangements do not preclude participating local authorities from issuing individual statements to the media on the consultation provided that it is made clear that these are not made on behalf of the joint SC.

10. Report

10.1. The lead authority will prepare a draft report on the deliberations of the joint SC including comments and recommendations agreed by the joint SC. The report will include whether recommendations are based on a majority decision of the SC or are unanimous. The draft report will be submitted to the joint SC or to the representatives of participating authorities for comment.

10.2. The final version of the report will be agreed by the joint SC Chairman.

10.3. The primary objective of the joint SC is to reach consensus. If consensus cannot be achieved, minority reports may be attached as an appendix to the main report. The minority report shall be drafted by the appropriate member(s) or authority (ies) concerned.

11. Quorum for meetings

11.1 The quorum will be a minimum of 4 members, with 2 from each of the participating local authorities.

Norfolk and Suffolk Joint Scrutiny Committee on Radical Redesign of Mental Health Services
11 February 2013
Item No 7

Background information and suggested programme of work

Maureen Orr, Scrutiny Support Manager, Norfolk County Council

This report outlines the background to the establishment of the joint committee and suggests a programme for the scrutiny of Norfolk and Suffolk NHS Foundation Trust's proposed Strategy 2012/13 – 2015/16.

1. Background

1.1 Norfolk and Suffolk NHS Foundation Trust (NSFT) has presented its proposed Strategy 2012/13 – 2015/16, which involves radical redesign of mental health services, to both Norfolk Health Overview and Scrutiny Committee (22 November 2012) and Suffolk Health Scrutiny Committee (17 January 2013). The presentations took place during the Trust's formal consultation period with staff, which ended on 21 January 2013.

1.2 The two scrutiny committees agreed to establish a joint scrutiny committee on a task and finish basis to receive consultation from NSFT on its plans as they stand after the results of the staff consultation have been taken into account.

1.3 Local NHS organisations are required to consult health scrutiny committees on substantial variations or developments to services and local authorities are expected to form joint scrutiny committees to receive that consultation in a situation were a local NHS body is consulting on changes that cover the geographic area of more than one committee.[1]

1.4 Although NSFT is proposing different service delivery models for much of Norfolk and Suffolk a joint scrutiny committee was considered appropriate because the Norfolk delivery model applies to Waveney and the Suffolk delivery model may apply to Thetford. Moreover, the new access and assessment service applies across the two counties.

2. Issues highlighted by the scrutiny committees

2.1 Members of Norfolk Health Overview and Scrutiny Committee (HOSC) and Suffolk Health Scrutiny Committee (HSC) have highlighted various issues that the joint committee may wish to pursue:-

[1] Direction issued by the Secretary of State for Health in July 2003 under the Health and Social Care Act 2001.

(a) The reasons for and implications of early / immediate introduction of changes to services as part of the four year strategy.

(b) The ability of the redesigned services to meet demand **before** mental health beds are taken out of the system.

(c) The need for mental health evening / night time support for patients and health professionals, e.g. a telephone advisory service, particularly when mental health beds are taken out of the system.

(d) The feasibility of the mental health locality boundaries that do not coincide with Clinical Commissioning Group boundaries (e.g. West Norfolk).

(e) The need for more clarity around service delivery intentions in the Thetford area.

(f) Clarity on differences in service delivery intentions between each of the localities.

(g) The need for risk assessment before changes are implemented.

3. Developments since 17 January 2013

3.1 On 23 January 2013 the Norfolk Clinical Commissioning Groups (CCGs) reported to NHS Norfolk and Waveney Board that although they generally support Norfolk and Suffolk NHS Foundation Trust's approach to the proposed changes they believe that the timetable for the implementation is too ambitious. They highlighted the planned bed reductions in West Norfolk as a particular example.

They recognise NSFT's concerns about the financial implications of any delay to their plans and believe that a bid should be made to the Transformation Fund which is held, in effect, by the shadow National Commissioning Board Local Area Team, to support legitimate double running costs to ensure safe implementation of the changes.

4. The Joint Committee's programme of work

4.1 NSFT has made clear that its Strategy 2012/13 – 2015/16 includes a series of interdependent changes that will be brought into effect over the next four years. It is possible that the plans or the timetable may be modified within that period, depending on progress in the early stages. At this stage NSFT is able to consult the joint committee on its initial plans, as they stand following the staff consultation period.

4.2 The joint committee's meetings need to be held before the start of the lead in period to the County Council elections, which are on 2 May 2013. This means that meetings need to be planned within the five weeks up to 21 March 2013. A suggested programme is attached at Appendix A.

4.3 Norfolk and Suffolk County Councils may consider reconvening a joint committee after the elections if NSFT needs to consult on specific proposals for substantial changes to service as its Strategy develops. A joint committee would be necessary for any such proposals that affect services in both counties. Proposals that affect just one county could be received by the relevant scrutiny committee in Norfolk or Suffolk, as appropriate.

4.4 New health scrutiny Regulations under the Health and Social Care Act 2012 are expected to come into force on 1 April 2013. These may affect the way in which the County Councils organise their health scrutiny functions, which may consequently affect joint scrutiny arrangements. If the counties wish to reconvene a joint scrutiny committee on the radical redesign of mental health services after the elections on 2 May, it would be constituted according to the new Regulations.

5. Action

5.1 The joint committee is asked to agree or amend the programme attached at Appendix A.

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Appendix A

Norfolk and Suffolk joint scrutiny committee on radical redesign of mental health services

Programme

Date, time & venue	**Invitees**	**Programme**
Meeting 1 2.00pm Monday 11 February 2013 County Hall Norwich NR1 2DH	Norfolk & Suffolk NHS Foundation Trust (NSFT)	NSFT to present:- • the Strategy 2012/13 – 2015/16 as it stands following the staff consultation period; • a clear timeline for implementation of changes 'on the ground', including any that have already happened; • a clear timeframe for consultation with health scrutiny and with patients / public, including dates by which consultation will close and dates by which the Trust will take decisions on the proposed changes in the light of consultation results; and other information relevant to the joint committee's terms of reference Joint committee scrutiny to cover:- (a) .The reasons for and implications of early / immediate introduction of changes to services as part of the four year strategy. (b) The ability of the redesigned services to meet demand **before** mental health beds are taken out of the system. (c) The need for mental health evening / night time support for patients and health professionals, e.g. a telephone advisory service, particularly when mental health beds are taken out of the system.

		(d) The feasibility of the mental health locality boundaries that do not coincide with Clinical Commissioning Group boundaries (e.g. West Norfolk). (e) The need for more clarity around service delivery intentions in the Thetford area. (f) Clarity on differences in service delivery intentions between each of the localities (g) The need for risk assessment before changes are implemented. and any other questions raised by Members.
	Clinical Commissioning Groups – the lead mental health commissioners in Norfolk and Suffolk	To hear the commissioners' views on NSFT's proposals for change and raise any questions regarding funding, the commissioning process and the possible bid to the Transformation Fund.
	Other health professionals:- The British Medical Association The Royal College of Nursing	To hear health professionals views about the proposed changes
	Local Involvement Network	To hear views on behalf of patients
	Voluntary agencies working in mental health	To hear voluntary sector providers' views

Meeting 2 *w/c 4 Mar 2013?*	*Other witnesses?*	To hear other views
	NSFT	To answer questions, provide information and clarify issues, as necessary.
		Joint Committee to ascertain whether it has received the necessary information regarding NSFT's proposals for radical redesign of mental health services as set out in its proposed Strategy 2012/13 – 2015/16 in relation to: • The extent to which they are in the interests of the health service in Norfolk and Suffolk. • The impact of the proposals on patient and carer experience and outcomes and on their health and well-being. • The quality of the clinical evidence underlying the proposals • The extent to which the proposals are financially sustainable Chairman to sum up the joint committee's conclusions and the main points for its report to NSFT
To draft and agree a concise report to NSFT by 28 March 2013 – may be done via email.		

Norfolk and Suffolk Joint Scrutiny Committee on Radical Redesign of Mental Health Services
11 February 2013
Item no. 8

Radical redesign of mental health services in Norfolk and Suffolk

A report from Norfolk and Suffolk NHS Foundation Trust and additional information for the joint committee.

1. Report from Norfolk and Suffolk NHS Foundation Trust (NSFT)

1.1 Norfolk and Suffolk NHS Foundation Trust (NSFT)'s report, including a revised Strategy 2012/13 – 2015/16 and the summary of changes made to the strategy in response to the staff consultation feedback, is attached at Appendix A.

2. Additional information for the joint committee

2.1 The implementation timetable originally presented by NSFT to Norfolk and Suffolk health scrutiny committees is attached at Appendix B. This is included as an aide memoire for members. NSFT intends to update its implementation plan after its Board meeting on 8 February 2013.

2.2 With the permission of the Local Negotiating Committee (LNC) the British Medical Association has submitted a copy of the LNC's letter to NSFT in response to the staff consultation. The letter is attached at Appendix C.

2.3 Dr Marlies Jansen, Consultant General Adult Psychiatrist and Member of the Royal College of Psychiatrists has submitted the letter at Appendix D.

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Appendix A

Norfolk and Suffolk NHS
NHS Foundation Trust

Title of Report:	Norfolk and Suffolk NHS Foundation Trust (NSFT) Strategy 2012/13 to 2015/16
Date of report:	4th February 2013
Report for:	Report to Joint Norfolk and Suffolk Health Overview and Scrutiny Sub - committee 11th February 2013
Action sought:	Consultation process

1.0 Introduction

1. Norfolk and Suffolk NHS Foundation Trust's proposed Strategy for 2011/12 to 2015/16 has been drawn up by clinical leaders working with service users and carers and other stakeholders.

2. The Strategy aims to improve health and social care outcomes for our service users and carers and increase efficiency and value for money.

2.0 Efficiency

1. The Strategy responds to an anticipated reduction of 20% over the four years – this requirement is in line with the NHS Operating Framework for 2012/13 and 13/14.

2. The Trust will achieve the required savings by introducing new models of care, clearly defining care packages and streamlining and integrating pathways of care.

3. There will be no reduction in the number referrals and number of service users and carers receiving a service.

4. Should further funding become available, the Trust will use this increase the number of service users and carers receiving a service or make other changes to improve quality, safety and outcomes.

3.0 Engagement and consultation

1. The proposed pathways have been developed over a 2 year period with service users and carers and other stakeholders and our external engagement and the consultation process will continue over the coming months.

2. The Trust has recently completed a 90 day (22nd October to 21st January) consultation with all employees in order to ensure that everyone has the opportunity to contribute to the plans. The Trust has received over 900 responses from staff groups and individuals.

3. Following preliminary analysis of consultation responses, senior managers and clinicians have identified more than 50 changes to the plans and these will be considered by the Trust Board of Directors on 8th February 2013.

4. Following Trust Board of Directors, changes will be worked up and detailed plans, workforce structure and timing of plans, will be published.

5. Discussions with commissioners are continuing and will influence the final strategy. In particular, discussions are focusing on whether transitional funding could be made available to provide additional support for quality and safety during the change process and to support of aim to avoid redundancy and retain experienced and skilled staff throughout the change process.

4.0 Quality, safety and evidence

1. The new pathways comply with National Service Framework and National Institute for Clinical Excellence (NICE) guidance.

2. The pathways have clear quality goals aimed at ensuring that quality and outcomes are maintained, or in many cases improved. These will be measured and results published.

3. The Trust is in the process of agreeing a safety dashboard (a list of indicators designed to provide early warning of concerns re safety during the change process and within the new models.

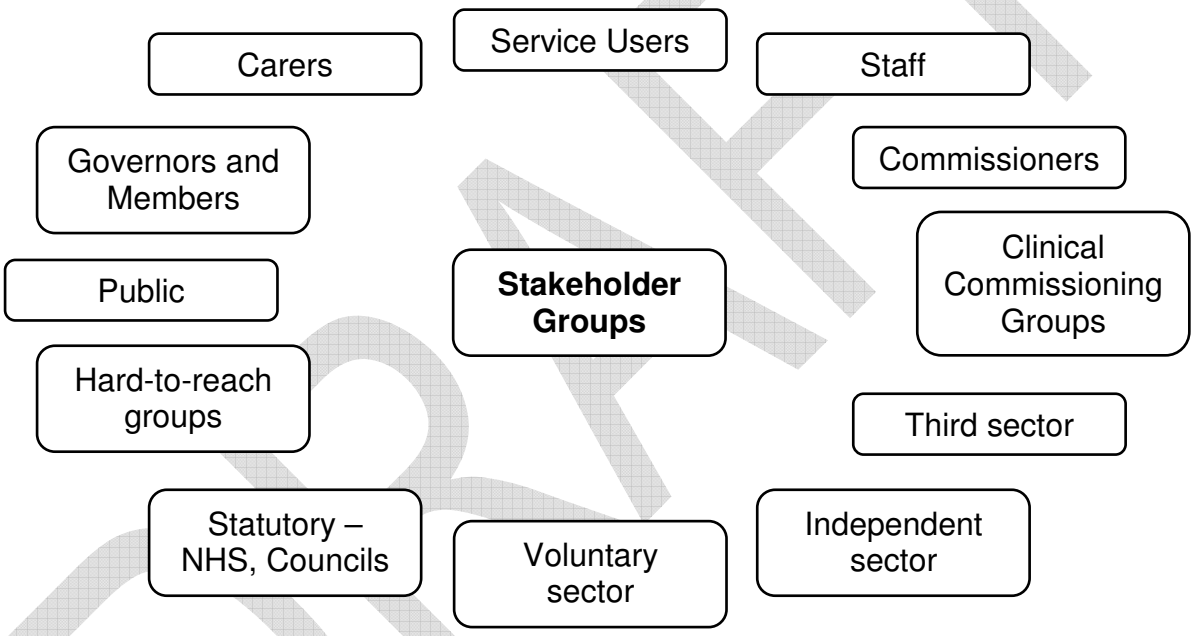
4. The Trust has compiled a detailed portfolio of evidence underpinning the new models and this has been shared with commissioners

Norfolk and Suffolk NHS
NHS Foundation Trust

Title	Trust Service Strategy Summary of Stakeholder Meetings – Norfolk and Waveney (excludes commissioner/CCG meetings)
Date	04 February 2013

1.0 Service Strategy / Radical Pathway Redesign – design meetings April 2012 and ongoing

1.1 The stakeholders involved from the start of the process and which is ongoing are given below



2.0 Engagement events

2.1 **6th October 2011: Radical Pathway Redesign Stakeholder Event**

Stakeholders:

- Age UK Norwich
- DENDRON
- Julian Suppport
- LINk
- West Norfolk and Great Yarmouth & Waveney MIND
- NHS Norfolk
- Norfolk County Council
- Norwich CCG
- NWMHP service users, carers, staff and governors
- Space East
- Stonham Housing
- The Matthew Project

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2.2 **27th October 2011: Youth Mental Health Day**

The following organisations were represented:

- City College
- Community Music East
- Mancroft Advice Project
- Matthew Project
- Momentum
- Norfolk County Council Children's Services
- NHS Great Yarmouth & Waveney
- NHS Norfolk
- Norwich MIND
- Off-Centre Counselling
- UEA
- Young Minds

2.3 **27th January 2012: Presentation of draft pathway designs**

Representation from NHS Norfolk and all 6 CCGs including mid-Norfolk

2.4 **11th May 2012: Acute Services Stakeholder Event**

The following organisations were represented:

- Barchester Healthcare
- Crossroads Care East Anglia
- Health East CIC
- Hebron Trust
- Julian Support Ltd
- LINk
- MIND – Norwich
- NHS Norfolk and Waveney
- Norfolk Coalition of Disabled People
- Norfolk County Council – social services
- Norfolk Mental Health Advocacy Service
- North Norfolk CCG
- NSFT service users, carers
- Queen Elizabeth Hospital NHS FT, King's Lynn
- Rethink
- Sign
- Stonham Housing

2.5 **17th May 2012: Radical Pathway Redesign Stakeholder Event**

The following organisations were represented:

- Age UK Norwich
- Barchester Healthcare
- Crossroads Care East Anglia
- DAAT
- Feedback
- Great Yarmouth & Waveney MIND
- HealthEast
- Julian Support Ltd
- NHS Norfolk & Waveney
- Norfolk Coalition of Disabled People
- Norfolk Community Health & Care
- Norfolk County Council
- Norfolk Mental Health Advocacy service

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- Norfolk RCC
- North Norfolk CCG
- NSFT staff, service users, governors and non/executive directors
- St Martin's Housing Trust
- Stonham
- The Matthew Project
- Voluntary Norfolk
- West Norfolk MIND

3.0 On-going engagement

3.1 Presentations have been given at the Board of Governors and Board of Directors' meetings held in public.

3.2 Since August 2011, Gary Hazelden, Partnership Manager, and the clinical leads have had regular monthly meetings with the GP leads. Presentations have also been made to the following groups:

- Age UK Norwich
- Alzheimer's Society
- Crossroads Care
- Great Yarmouth & Waveney MIND
- Julian Support Ltd
- NCC Children's Services
- Norwich MIND
- Stonham Housing
- West Norfolk MIND

3.3 There have been monthly meetings with service users since November 2011 and carers since September 2012. A particular pathway is presented and discussed at each meeting.

4.0 Future events

4.1 There have been monthly meetings with service users since November 2011 and carers since September 2012. A particular pathway is presented and discussed at each meeting. This work continues and monthly meetings and topics have been planned for 2013.

4.2 **January 2013: Implementing Recovery through Organisational Change**

This event will be opened up to the widest list of attendees, so service users, carers including at least 50% service users and carers.

4.3 **7th February 2013: Voluntary and community sector engagement event (Central Norfolk)**

Locality based events will be held sharing with the VCS the potential sub-contracting landscape and engagement workshops on how partnership working between NSFT and VCS can be improved.

4.7 **27th February 2013: Implementing Recovery through Organisational Change**

This event will be opened up to the widest list of attendees, aiming for at least 25% so service user representation, 25% carer representation, 25% NSFT staff and 25% Partners additionally 15 partner exhibitors.

4.8 **29th March 2013 – Service user strategy launch (Norfolk)**

Service user, partner, NSFT and carer engagement event to build on service user strategy and improve partnership working.

4.9 **21st March 2013 - Voluntary and community sector engagement event (East Norfolk)**

Locality based events will be held sharing with the VCS the potential sub-contracting landscape and engagement workshops on how partnership working between NSFT and VCS can be improved.

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4.10 **15th April 2013 – Service user strategy launch (Suffolk)**

Service user, partner, NSFT and carer engagement event to build on service user strategy and improve partnership working.

4.11 **29th April 2013 - Voluntary and community sector engagement event (West Norfolk)**

Locality based events will be held sharing with the VCS the potential sub-contracting landscape and engagement workshops on how partnership working between NSFT and VCS can be improved.

4.12 **May 2013 – 2 x Voluntary and community sector engagement event (East and West Suffolk)**

Locality based events will be held sharing with the VCS the potential sub-contracting landscape and engagement workshops on how partnership working between NSFT and VCS can be improved.

4.13 **20th June 2013: Have I got a bed for you?**

Sharing the learning from the Trust's innovative bed management and discharge system open to stakeholders across Norfolk and Suffolk.

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Norfolk and Suffolk NHS
NHS Foundation Trust

Title	Trust Service Strategy Summary of Stakeholder Meetings – Suffolk
Date	04 February 2013

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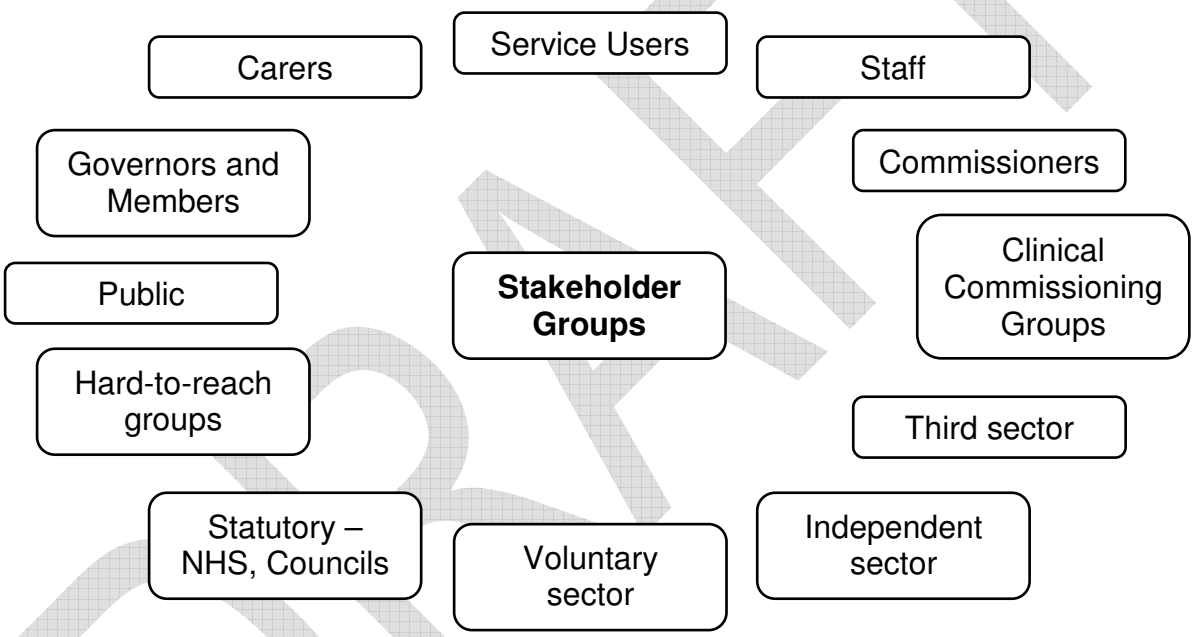
1.0 **Service Strategy / Radical Pathway Redesign – design meetings April 2012 and ongoing**

1.1 The stakeholders involved from the start of the process and which is ongoing are given below



1.2 Clinical leads & Pathway Leads consultation with groups:

- Service users and carers view represented in pathway working groups
- Survey conducted with complexity in later life service users and carers by Pathway lead
- Huntington Disease Association
- Alzheimer's Society
- Quantitative and qualitative data canvassed from all GPs in west Suffolk conducted by pathway lead for Complexity in later life
- Your Welcome initiative in CAMHs service fed into the pathway redesign for Youth service
- The Matthew Project and Catch 22 have been involved with Youth redesign via the pathway working group
- Suffolk User Forum representatives met with Clinical leads and were informed on the proposal
- PCT/CCG – ongoing discussion and information shared with the PCT and CCG leads
- Suffolk Family carers – met and informed on the proposals

2.0 Engagement events

2.1 Suffolk Radical Pathway Redesign Stakeholder Event - 8th November 12

The following organisations were represented:

East Anglian Indian Association

Ipswich & East CCG

West Suffolk CCG

West Suffolk Hospital

Ipswich Housing Action Group

Ipswich Hospital

Suffolk County Council – ACS

Workwise

Julian Support

Suffolk Libraries

Suffolk Family Carers

Stepping Stones East

BME Health Watch Group

Suffolk User Forum

Suffolk Mind

OCD Limits

20th November 2012: Personality Disorders

120 delegates attended this event.

6th December 2012 – Minding the baby , Over 180- people attended this event

2.2 On-going engagement and Presentations

NSFT Chief Executive – Aidan Thomas presented to:

9th November – Anna McCreadie (Director Adult Care Services) & Deborah Cadman (CEO) - SCC
21st November – Bob Blizzard & Dan Poulter – separate meetings
7th December – Councillor Murray of HSC

Presentation by Suffolk Staff:

The Director of Operations for Suffolk has attended the West Suffolk Users & Carers Scrutiny meetings on the 15th August and 14th November. These are regular meetings which have a Suffolk representative present

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3rd December – Presentation to Suffolk Safeguarding Board – attended by the Associate Director of Operations (Suffolk)

3rd Sector The Director of Operations for Suffolk has attended Voluntary and Statutory Partnership (VASP) meetings to provide information on the proposed Suffolk model on the 14th November and 3rd December 2012

19th December 2012- Social Care engagement Adult Services –Senior Team Meeting. Suffolk Director of Operations and NSFT/SCC Mental Health joint lead presented to this group

10th January 2013 – Social Care engagement – Childrens Services – Suffolk Director of Operations and Psychology Lead Clinician presented to Children & Young People meeting.

10th January 2013 - Suffolk BME Health Watch Group – attended and group update by Suffolk Wellbeing Manager

Presentations have been given at the Board of Governors and Board of Directors' meetings held in public.

Since August 2012, Clinical Leads and Suffolk management have had regular monthly meetings, including SLA meetings with the PCT/GP leads to inform on the model. They have also taken part in a "speed dating" event, informing GPs on the proposed model.

QUIPP forum where IHT attend.

SERCO Director of Operations attend meetings with this group and update them on proposals.

2.3 Future events

Service User & Carer Focus on TSS consultation - Partnership working with Suffolk User Forum to develop service user focus groups – event planned for 4th March 2013 and monthly thereafter in Stowmarket. Partnership working with Suffolk Family Carers to develop carer focus groups – event planned for 4th March 2013 in Stowmarket and monthly thereafter.

Implementing Recovery through Organisational Change Norfolk & Suffolk – staff & service users 27th February 2013. This event will be opened up to the widest list of attendees, so service users, carers including at least 50% service users and carers

Voluntary Sector Engagement Event - Trust wide to be held in both Suffolk Localities - Date TBC

9th May Nursing Conference Norfolk & Suffolk

Have I got a bed for you – External Partners nationwide, new clinical & ICT systems for bed management – June 2013. Sharing the learning from the Trust's innovative bed management and discharge system open to stakeholders across Norfolk and Suffolk

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Norfolk & Suffolk NHS Foundation Trust Service Strategy
Collective Consultation Feedback: Summary of Changes
4th February 2013

This document summarises significant changes and clarifications to the Service Strategy post the collective consultation, it is not a response to every comment made as these exceeded 900. The Trust will respond directly to those who commented on the proposed strategy, including external parties, by the beginning of March 2013.

The Service Strategy was widely consulted on and the significant number of comments, both internal and external to the Trust, and feedback is testament to the open way in which this was conducted. It is important to note that this was a collective consultation on the Trust's wider strategic intentions as opposed to an individual consultation on a service change that will effect a person's role.

Any changes made will be considered in the context of the agreed financial envelope for each of the service areas.

GENERAL SERVICE CHANGES

1. There were comments about both too much complexity to be able to understand the proposals and too little detail in the documentation we supplied to be able to take decisions. It is important to note that the Trust was holding a formal collective consultation on the Service Strategy (i.e. a strategic approach to service delivery). We will then hold separate shorter consultations with staff on specific service changes as they are scheduled throughout the strategy period. These individual consultations will deal with very specific changes and offer more detail on individual services and roles. This means, in effect that there will be on-going consultation with staff in relation to service change for some time. Some staff have reported that they were confused by the fact that the Trust started detailed individual consultation on the very early parts of the strategy(such as Dementia and Complexity in Later Life in Norfolk) alongside the wider consultation. This does not mean that decisions are made (as can be seen from the response to consultation), but simply that because of the proposed commencement date of the new service we are required to carry out individual consultation alongside the collective one on the strategy. The wider consultation with external stakeholders, service users etc is on-going and will continue throughout the life of the Strategy and beyond.

2. There were many understandable concerns raised about how quality and safety will be maintained during the service change and in the proposed new models themselves. The Trust has developed a "dashboard" of service safety information which it will use to formally monitor services (see Appendix 1).These will work both during change and while both old and remodelled services are running normally. The Trust will also use "soft" information such as service visits and reports from staff and managers to monitor safety alongside the dashboard. The "Dashboard" will be monitored by individual Directors, by Service Governance Committee, and by the Board. We have also suggested that commissioners use the "Dashboard" too, to

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assist in monitoring the contract. The Trust has appointed a research fellow to assist in the development and management of safety alongside the governance team. The Trust is awaiting confirmation of Transitional funding from commissioners to support the management of safety during the life of the Strategy. Where the "Dashboard" or other information reveals a problem the Trust will act to address the issues identified. Where these are of serious concern we will develop an action plan to resolve.

3. The Trust will set out further detail about its approach to reducing beds for working age adults – these have been positioned in the timetable so that a range of other developments can work to reduce the need for beds before reductions are made. These include the introduction of alternatives to admission (crisis beds, and brief admission services); the introduction of adult fostering; adoption of a Recovery culture across the Trust; the extension of Early Intervention in Psychosis principles through the under 25 service; the adoption of a Personality Disorder service model which focuses on alternatives to admission for this group, and the speeding up and simplification of discharge pathways.

4. The Trust will comply with NICE Guidance in the design and provision of proposed services.

5. The Trust agrees that parts of the Strategy staffing proposals do not clearly identify Professions Allied to Medicine. We will clearly designate these posts as appropriate in each service.

6. The Trust agrees that it should recognise wider integration with primary care and acute general hospital services. We are committed to this and it was an omission form the consultation strategy document.

7. The Trust agrees that medical staffing numbers should be reviewed taking into account the implications for research, teaching, as well as for service provision.

8. The Trust agrees that people between the ages of 25 and 35 with a first incidence of psychosis will be treated using Early Intervention principles, In Norfolk as part of the EI Service in the young people's service line, and in Suffolk as part of the Integrated Delivery Teams

9. The Trust agrees that more should be done to involve service users and carers. We have engaged service users at every stage in the development of our plans, but we can never do enough. The strategy recognises this in the investment we are making in our Implementing Recovery Programme.

10. The Trust agrees that there should be designated identified Assistant Mental Health Practitioner posts in every service.

11. The Trust agrees that nurse consultant posts will be included in the workforce where appropriate.

12. The Trust agrees that it will continue to seek new ways to generate income

13. The Trust will develop and consult on the Peer Support Worker job description

14. The Trust will develop and define alternatives to admission based on models elsewhere (including brief admission services, crisis services and fostering) with commissioners.

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15. The Trust will develop a definition of complexity in later life to assist clinical decision making.

NORFOLK AND WAVENEY SERVICE CHANGES

Access and Assessment

16. We will implement the Norfolk County Council Fair Access to Care and Support (FACS) criteria as part of the Access & Assessment Service.

17. Clinical psychology input has been included in Access and Assessment Service

Adult including Acute

18. ECT services will be included.

19. Services for homeless people will be included and clearly identified.

20. Clozapine clinic provision will be identified more clearly in the workforce model

21. Out of Hours processes will be defined to ensure that smooth hand off between crisis services and other teams

22. We will review the balance between Clinical Psychology and Psychotherapy in the workforce.

23. We will ensure managerial reporting arrangements for AMHPs are appropriate

24. The Trust will consider whether it is possible to provide more than 20 beds within Great Yarmouth & Waveney Locality within the available financial resources.

25. The Trust will identify a practice liaison worker for every GP practice in Norfolk & Waveney.

Complexity in Later Life

26. The Trust agrees it will work in an integrated way with other health and social care and third sector partners in all localities

27. The Trust agrees that changes will be made to the skill mix of the Dementia Intensive Support Team (DIST) increasing Band 7's to 2 one for GY&W and West Norfolk.

28. The Trust agrees to review the ratios of Band 6 and 5 in order to improve capacity for more complex work.

29. The Trust agrees the in-reach liaison senior nurse post working collaboratively in Acute Hospital settings will be Band 7

30. The Trust agrees that the Admiral Nurse roles will be filled by substantive (rather than fixed term) appointments, ensuring that if the pilot is discontinued the clinicians will have the opportunity to be redeployed (as with any other member of staff).
31. The Trust will ensure that the timing of the boundary change in West Norfolk Locality is managed to match capacity and demand.

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32. The Trust will introduce further non-medical prescriber roles.

33. The Trust will review psychology support to the service line

Under 25 Service

34. Management of the Norfolk Looked After and Accommodated Children (LAAC) will be within the Central Norfolk Locality.

35. The Trust will increase the medical staffing in West and Central Norfolk along with a slight increase in Yarmouth and Waveney.

SUFFOLK SERVICE CHANGES

General

36. The Trust agrees that services in Thetford should be part of the Norfolk service model and this would better fit with commissioning of both health and social care for the majority of service users and carers. The detail will need to be agreed with commissioners and other stakeholders however we will work with them to achieve this.
37. The Trust agrees it will work in an integrated way with other health and social care and third sector partners in all localities

Access & Assessment Service

38. There will be dedicated medical posts within the Access and Assessment Service

Adult

39. The Trust will clarify arrangements for the clozapine clinic.
40. The assertive outreach function will continue.

Learning Disabilities

41. The Trust agrees that community Learning Disability Services in North Suffolk (Waveney) should be managed as part of the Yarmouth and Waveney Locality.

42. The Trust agrees in-patient beds for Learning Disability services will be provided.

Children

43. The Trust agrees primary mental health workers will be retained.
44. The Trust has agreed to support and continue with the Youth Offending Service posts.

Complexity in Later Life

45. The Trust will review the medical skill mix.
46. The Trust agrees to review the ratios of band 6 and 5 in order to improve capacity for more complex work.

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WORKFORCE SERVICE CHANGES

47. The Trust will do everything possible to avoid compulsory redundancy in order to avoid losing skilled experienced staff.
48. We will explore pooling arrangements to support flexibility, maximise opportunities, while limiting disruption to the service where possible.

49. The Trust will develop transitional roles where practical and establish a flexible workforce approach to minimise redundancies, even if this means more than one role change for staff over the life of the Strategy

50. The suggestion of unpaid leave will be explored. This can only be achieved if the post does not require backfill with temporary staffing. The Trust will survey staff regards this.

51. The Trust will consider a Voluntary Early Retirement scheme.

52. The Trust will implement simple, flexible selection processes. Attendance records will be used as a selection criterion.

53. The Trust will continue to use Generic Job descriptions in order to ensure flexibility for staff and protect jobs, supported by “supplementary sheets” to identify specific duties and responsibilities.

54. The Trust has agreed there will be separate pools for Consultant Medical Staff, and SAS Doctors in both Suffolk & Norfolk & Waveney.

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Appendix 1

PROPOSED SAFETY MONITORING INDICATORS FOR TRUST SERVICE STRATEGY

1. **Service demand**. Number of referrals, number of 4 hour, 72 hour and 28 day assessments and number of service line registered cases against % expected (daily reports).
2. **Triage including risk assessment**. Time to triage new referrals (% completed in 1 working day)
3. **Waiting time for assessment**. Number of 4 hour, 72 hour and 28 day assessments completed within standard time
4. **Waiting time for treatment**. Waiting time for activation of care package following assessment (% completed within standard - KPI's to be set)
5. **Inpatient capacity**. Maximum wait (measured in minutes) for allocation of bed during a Mental Health Act Assessment
6. **Inpatient capacity**. Service users admitted to adult acute inpatient unit out of designated locality area
7. **Inpatient capacity.** Bed occupancy excluding and including leave
8. **Home treatment availability**. % admissions with access to CRHT
9. **Community safety.** % of service users followed up within 7 days following discharge
10. **Serious Incidents**. Number of SI's by Locality and Service Line (categorised – e.g. unexpected death, data breach)
11. **Complaints** by Locality and Service Line (categorised)
12. **Staffing levels** Vacancy rate, sickness absence rate, temporary staffing rate; by Locality and Service Line

NB: No one indicator on its own would suggest service failure or even a problem – indicators need to be considered together. Thresholds will be set and agreed in advance.

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Service Strategy 2012-16

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NSFT Service Strategy, 2012-2016

This document sets out Norfolk and Suffolk NHS Foundation Trust's (NSFT) Service Strategy for the next four years. The Service Strategy has been developed by clinical leaders in collaboration with service users, stakeholders, commissioners and staff and is the outcome of extensive consultation. This consultation will continue with all partners throughout the duration of the strategy, enabling it to react and adapt to the changing environment of mental healthcare.

The Service Strategy sets out how NSFT's services and support functions will operate in an environment where the key challenges are:

- the national economic situation and its impact on public finances, which will reduce NHS funding in real terms by 20% over four years
- the continual need to improve outcomes for service users and carers
- the need for NSFT to be able to respond quickly to change, in the light of the changing environment in the NHS
- the introduction of competition to mainstream healthcare, leading to tendering exercises for services that were traditionally part of NSFT's remit
- the shift of responsibility for commissioning to the new Clinical Commissioning Groups (CCGs), making GPs the customer for most of NSFT's services.

The Service Strategy includes the Access and Assessment Service for all localities as well as two proposed service models – one for the East Suffolk and West Suffolk localities, and one for the Great Yarmouth and Waveney, Central Norfolk and West Norfolk localities. The Suffolk model will involve services being delivered by Integrated Delivery Teams (IDTs) across six care pathways. The Norfolk model will involve five service lines, delivered uniformly across the three localities.

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Principles behind the Strategy

The core principles of this strategy are:

- service users, their families and carers will be directed to the most appropriate service quickly and without multiple assessments
- there will be an emphasis on prevention, early intervention, wellbeing and recovery
- NSFT will work in partnership with other providers to ensure that service users and carers receive the right service for them, even if this is not a service provided by NSFT
- the services will be affordable and efficient
- the services will deliver clear outcomes for service users and carers
- services will be delivered locally whenever possible, by appropriately trained staff

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- services will provide alternatives to hospital care and will, where appropriate, become less reliant on in-patient beds
- services will be accessible for everyone in line with NSFT's responsibilities within the Equality Act 2010.

NSFT Service Strategy aims

The following aims will apply to all localities, with specific variations in service models between localities and counties to meet local needs:

1) Core services for all ages will be provided in five localities based around King's Lynn, Norwich, Great Yarmouth and Lowestoft, Ipswich and Bury St Edmunds, reflecting arrangements for the new CCGs. This will minimise travel for service users, carers and staff. The only exceptions will be for specialist services provided to small numbers of people (e.g. inpatient children's services) or services that are commissioned to cover a wider area such (e.g. drug and alcohol services, forensic and secure services).
2) NSFT will adopt a strong cultural commitment to the recovery model in all services, and will continually invest in developing and refreshing this approach with the establishment of a Recovery College. This will be an integral part of NSFT's approach to supporting people with serious and enduring mental health problems.
3) Services will focus on wellbeing with a view to reducing mental ill health.
4) NSFT will broaden access to Wellbeing services – Improving Access to Psychological Therapies (IAPT).
5) NSFT remains committed to equality and diversity and will improve accessibility for all communities.
6) Acute inpatient services and community teams for working age adults and older people will be integrated with social care as well as with primary and secondary general health services
7) NSFT will reduce the use of inpatient beds by providing alternatives to admission and ensuring timely discharge.
8) Specialist clinical support for core services will be managed trust-wide, using both a direct delivery system and a 'hub and spoke' support model as appropriate (for example, specialist clinical support will be provided to people with Adult Attention Deficit Disorder. Learning Disability and Personality Disorder)
9) NSFT will develop strong partnerships with any partner that can complement its services or make them more efficient. This includes both direct service provision and support functions.
10) NSFT will adopt trust-wide service strategies designed to avoid admission and ensure the best possible outcomes for service users (e.g. for personality disorder and dual diagnosis).

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11) Access to services will be triaged through a single telephone number. A more in-depth assessment will then be carried out locally in a timely and clinically safe manner. Assessment will be “once only” and ensure access to all NSFT services, even in a crisis.

12) NSFT will train and develop its staff to ensure they have the skills and competencies to deliver the service strategies. This will include every effort as a responsible employer to retain valuable skills and experience among staff.

13) NSFT will establish a single electronic patient record and develop technology to support mobile and home working.

14) NSFT’s estates strategy will see services share buildings with partner agencies where possible and clinically appropriate.

15) NSFT will live within its financial means.

Focused on Quality and Safety

NSFT has developed a ‘dashboard’ of service safety information which will be used to formally monitor services in combination with information from service visits and reports from staff and managers.

This will be monitored by the NSFT Board, the Service Governance Sub-Committee (which reports to the Board) and by individual directors. Where potential problems are identified, NSFT will act to ensure patient safety remains paramount.

Every service NSFT provides will have clear, measurable quality goals that can be monitored by service users, carers and commissioners as well as staff and the Board. In particular, NSFT will:

- promote teaching and research in all services
- examine and adopt evidence-based best practice from around the country
- support and encourage incident reporting and whistleblowing
- ensure the implementation of learning from incidents and complaints
- include quality and safety monitoring in all performance monitoring of localities and services
- formally monitor safety through NSFT’s Service Governance sub-Committee and Board.

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Workforce

NSFT will continue to employ the full range of mental health and social care professionals in a range of job roles, some of which will be redesigned, while new roles will also be introduced.

NSFT is establishing professional leadership and a professional strategy for each of the professions addressing recruitment and retention and training, development and maintaining professional standards for all professions.

All of the services will include mental health practitioner posts that are crucial to the provision of high quality modern services. These posts will be filled by practitioners from a range of professional backgrounds and training, including nurses, social workers and occupational therapists. Each professionally diverse multi-disciplinary team will have access to a wide range of skills and expertise and will be managed by experienced clinical team leaders.

NSFT will continue to contribute to professional training courses and perform its role as a training provider.

All service lines will have dedicated administrative support.

Support services including HR, finance and pharmacy will be linked to every locality and service.

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Nursing

A certain proportion of the mental health practitioner posts in each service line will be reserved for qualified nurses. This will ensure an appropriate skill mix. The service strategy is compatible with NSFT's nursing strategy and that there are appropriate career development opportunities available. These opportunities will include:

- Band 7 Clinical Team Leader roles
- Non-medical prescriber roles (e.g. for diagnosis and initiation of treatment for ADHD and anti-dementia medication)
- Nurse Consultants
- Non-medical approved clinician roles
- Specialist nurse practitioner roles
- Approved Mental Health Practitioners

Social care

A certain proportion of the mental health practitioner posts in Norfolk are allocate to qualified social workers. This will ensure an appropriate skill mix for the delivery of both health and social care functions. Some of these posts will also be Approved Mental Health Professionals (AMHPs) and will spend some of their time on the AMHP rota.

Allied Health Professionals

A certain proportion of the mental health practitioner posts in each service line will be reserved for people with an allied health professional qualification. This will ensure an appropriate skill mix. Some pathways will also require specific posts, such as physiotherapists – these will be clearly identified. Allied Health Professionals will be eligible to apply for Band 7 Clinical Team Leader roles.

Assistant Practitioner roles

Assistant practitioners will be included as appropriate in all service lines. Assistant practitioners have or are working towards a foundation degree and will be supported in this. Work is on-going to define the exact role assistant practitioners will be able to perform in service lines and what responsibilities they will have.

Peer Support Workers

The role and person specification for peer support workers varies between service lines.

Peer support workers will typically be service users that have been recruited and trained to work alongside mental health practitioner roles. They bring a unique perspective which will help NSFT provide a more effective service. Peer support workers will share their experiences with service users to help them move forward.

Some service lines will have peer support workers working with service users in the community – others may involve them in the delivery of services from the new Recovery College.

A peer support worker co-ordinator role will be introduced to ensure support and development is provided in clinical and cost-efficient ways.

Psychotherapists

A wide variety of evidence-based psychotherapies will be delivered by psychotherapists from a range of different backgrounds. Some cross-team and cross-locality working is expected for rarer interventions to ensure choice and availability for service users.

All people employed as a psychotherapist will be appropriately accredited. Where it is not cost effective or practical to hire someone new to deliver a specific therapy, consideration will be given training existing staff or to spot purchasing to ensure its availability (e.g. art therapy).

Clinical psychology

Clinical Psychologists will be included in all service lines and will focus on developing staff teams through training and consultation as well as direct work with service users and carers. They will also contribute to research and service evaluation.

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Each service line will have senior clinical psychology posts. NSFT is committed to developing new ways of working to allow these posts to focus on the most complex service users, while also providing clinical leadership, high level consultation, advice and contributing to shaping service delivery plans.

Medicine

The role of the consultant medical staff will be to provide advanced professional expertise and clinical leadership, as well as professional activities such as teaching, training, research and audit and management.

The workforce has been designed to ensure that NSFT can meet the statutory responsibilities of the Mental Health Act (including Community Treatment Orders, detention under the Act and Section 117 aftercare) and the Mental Capacity Act. The medical workforce has been designed to fulfil the need for 'out of hours' cover.

All speciality doctors will achieve Approved Clinician status.

Other specialist services

Some specialist services will not be cost effective or practical for NSFT to provide (e.g. a dietician). This may be because that provision would be a duplication of expertise available elsewhere or because it will be needed only by a limited number of service users. These services will be spot purchased as appropriate.

Research

NSFT will build on its excellent track record in research and will maintain and develop its position among the top mental health trusts in the country for portfolio research. NSFT hosts the Mental Health Research Network (MHRN) Dementias and Neurodegenerative Disease Research Network (DENDRON); and the Health Innovation and Education Cluster (HIEC) Dementia Alliance.

NSFT will strengthen and develop research as a key part of the Norfolk and Suffolk node of the Anglia Academic Health Science Network linked with University of East Anglia (UEA). Research is vital to the future of mental health services, playing a key role in the development of service quality, innovation, recruitment and training.

Although NSFT's focus will be on these two strategically important areas, research will be encouraged and supported all service areas.

In light of the significant growth in morbidity across both Norfolk and Suffolk, NSFT will introduce a new research chair to focus on system and pathway development for dementia sufferers and carers. The post will link with the UEA as well as NSFT's new Dementia Academy.

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NSFT has nationally recognised academic strength in Early Intervention for Psychosis services and is extending this through the development of Youth Mental Health Services.

NSFT will develop a formal research development strategy during 2013.4

Information and Communications Technology (ICT)

The service strategy represents a significant opportunity for NSFT to rationalise and streamline the way services are provided. Underpinning this rationalisation with effective ICT solutions will be critical to its success. In particular NSFT will:

- deliver innovative systems to support the Access & Assessment service
- establish a full electronic patient record as well as internal HR, training and finance systems
- establish online information portals through which service users and stakeholders can access services and seek advice
- establish systems to help staff work more efficiently and support learning, training, systems development, business and systems analysis as well as programme and project management
- ensure its networks, computing environments and machinery are appropriate and support the delivery of these services
- deliver ICT systems, mobile phone services, and videoconferencing to enable instant communication between staff, and service users, to include voice and video instant messaging and wireless access
- deliver the Technology Innovation Model (TIM) to link NSFT's Business and Clinical systems together by presenting data in a single Central Record Service.

Estates

Effective and efficient use of all NSFT's estates will be essential in ensuring care is delivered in the most appropriate environment. In particular NSFT will:

- establish bases to enable co-location of teams, including with other public sector agencies wherever possible
- rationalise and vacate unsuitable buildings
- ensure the provision of high quality inpatient units
- evaluate all sites to establish if buildings are being used to maximum efficiency, are appropriate for health care delivery and comply with national guidance and regulations in terms of access
- rationalise and release surplus land and buildings on larger sites to ensure estates are fit for purpose while any surplus value is realised to benefit patient services

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- work with other public and third sector organisations to ensure that, where possible, the value of all publically owned buildings is shared and maximised.

By early 2013 NSFT will have a robust estates strategy outlining plans for each locality, any potential developments along with how and when it is proposed this be achieved.

Commercial development

NSFT will develop a Commercial Strategy in early 2013 to provide a more commercial, business-like approach to ensure that:

- current contracts are retained
- services are protected from potential competition
- NSFT's overall business grows appropriately.

Contractual arrangements will be robust and allocate risk and reward based on the desired outcomes. This is especially pertinent given the current economic climate.

NSFT will operate and behave in a transparent and fair manner.

NSFT will continually explore opportunities for additional income to enable investment back into frontline services.

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Access and Assessment Service for all localities

The Access and Assessment Service will make it easier for people to get the right mental health and social care service as quickly and efficiently as possible. GPs and other referrers, including those who self-refer to the Wellbeing Services (Improving Access to Psychological Therapies), will be able to call one number for access to all services and will be directed to the right team or service in a timely and clinically safe manner.

The service will work in conjunction with other provider access and referral systems in Norfolk and Suffolk. NSFT has different partners in each county so the Access and Assessment Service will reflect these local needs. In Norfolk and Waveney, this will include multi-agency systems for access for children, integrated care teams, general hospitals and Norfolk County Council (including Suffolk County Council in Waveney). In Suffolk, the service will work with the multi-agency access team which currently handles assessments for children.

Current referral methods for the forensic services and drug and alcohol services will remain in place, but with close links to the Access and Assessment Service.

The Access and Assessment Service will have a permanent team of specialist assessors from all services with enhanced assessment skills, supported by dedicated administrative staff. This will allow the clinicians to concentrate on clinical work and meet the standards set for them in terms of clinical competency, attitude, reflective skills, awareness of knowledge gaps and flexibility. The standards will be rigorous as it will be crucial that the clinical staff in the Access and Assessment service are trusted by colleagues in other services – their initial assessment will provide the basis for the care and treatment service users and carers receive.

Customer care will be the priority and GPs and other referrers will receive feedback on appointments and other follow-up information. Real-time information will be available for commissioners on the referral and assessment processes and will lead to continuous improvement.

The service will work in tandem with GP commissioner referral management systems to ensure that referrals contain the right level of information and are service appropriate. Triage and assessment protocols are being developed in collaboration with GPs.

Triage will take place within one working day and a local assessment will be booked within 4 hours (urgent), 72 hours or 28 days.

As a result of an assessment:

- the service user may be signposted to services and interventions provided by a provider other than NSFT
- the service user may be allocated NSFT's Wellbeing (Improving Access to Psychological Therapies Service)
- the service user may be allocated to the most appropriate specialist service line

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The first phase of implementation of this new service will be in place in Central and West Norfolk and from February 2013. The service will operate 24 hours a day, 365 days a year, providing a full triage and assessment service on weekdays, with extended working covering evenings, Saturday mornings. Outside of these hours, triage and 4 hour urgent assessments will be provided and all other referrals will be processed the next working day – there will be no requirement for referrers to re-refer the case. A robust technology system designed to support the service will provide real-time information on referrals and appointment slots allowing NSFT to allocate resource to meet demand and keep on top of waiting times. GPs will also be able to request assessment and advice only service.

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Service model for East Suffolk and West Suffolk localities

More than 140 clinicians have been involved in designing new services in Suffolk, which will be cost-effective and efficient, delivering safe practice and good health outcomes.

The Suffolk locality teams have engaged with service users, their families, carers and stakeholders to develop the new service model and will continue to do so during the implementation and in response to changing health needs going forward.

Integrated Delivery Teams (IDTs)

The Suffolk model is based on Integrated Delivery Teams (IDTs) providing the majority of community services for all age groups, with service users able to access the same standard and type of service irrespective of where they live in the county.

There will be five IDTs in Suffolk; two in West Suffolk and three in East Suffolk. Over time, staff in the IDTs will form and maintain strong relationships with local GPs and other health and social care partners, so that they better understand local differences as well as local opportunities and activities for service users.

Each IDT will include healthcare staff from each 'care pathway' (the journey that a service user and their family carers take through NSFT's services, including the care and treatments they receive and the staff they see).

Each team will consist of psychiatrists, psychologists, social workers, nurses, occupational therapists, support workers and other workers relevant to the pathway, based on workforce and caseload configurations. New roles will also be developed, such as assistant practitioners, non-medical prescribers, non-medical approved clinicians and responsible clinicians. This will improve the skill mix of staff and provide greater flexibility.

The interaction between staff from different service backgrounds will enable staff to have a better understanding of all service users and their service stories. This will include developing knowledge of the impact of local systems on service users, for example the impact of families on each other, on neighbourhoods and on relationships between families and other local organisations, such as education and police. Through having this local knowledge, this may help in predicting particular problems before they develop.

Each IDT will have access to expertise in the form of consultants and qualified multi-disciplinary professional staff. Flexible, responsive support staff can quickly respond by stepping up care as needed if a person's mental health is starting to deteriorate.

Service users with the least complex needs will receive wellbeing interventions or receive direct care from specialist workers. The service users with the most complex needs will be discussed frequently by a number of specialists from more than one pathway. In all cases, family carers will be involved in care planning.

For example, in a hypothetical case of a complex family that includes a child with a learning disability, a parent with a mental health problem and a teenager with an autistic spectrum disorder, each family member will have access to expertise in the same place and at the same time, with access to a responsive staff group who can step up care as required. This

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will make treatments and interventions more comprehensive and safer, while also saving time and money and improving the understanding of specialist perspectives, obligations and priorities.

This model will ensure significantly fewer moves between teams. Where people do experience a change in the team providing their care, it will have been carefully considered by staff who have a close working relationship for whom the needs of that service user are a priority.

The IDTs will also develop over time to fulfil a health improvement role, working to improve the mental health of the population.

Each of the five local integrated delivery teams in Suffolk will embrace six specialist community care pathways

Enhanced wellbeing pathway:

This is in addition to the existing Suffolk Wellbeing Service, offering a broader social inclusion approach, aiming to make links with local resources to reduce isolation and stigma. Some service users do better through long-lasting relationships and occupation, that maintain them in recovery and that provide social value. This pathway is for people with moderate depression or anxiety, people with personality disorders and people who have a psychotic illness but are stable. The workforce will include some new roles and will focus on integration with other community services to improve wellbeing.

Children and families pathway:

This pathway is primarily for children aged 13 and under, and their parents or carers. It places emphasis on the prevention of future mental health problems by addressing parenting difficulties, attachment problems, mental health problems and neuro-developmental difficulties in early childhood. There is an emphasis on looking at all factors and relationships around the child (systemic interventions) and multi-agency working. The role of the Primary Mental Health Worker is part of this pathway.

Young people pathway:

This pathway is for people aged between 14 and 24 who have or are at risk of developing mental health difficulties. NSFT will work with young people to develop services which they would feel comfortable in using. The pathway will also help young people towards healthy adult lives, focusing on developing adult life goals and reducing any adverse impact of mental health issues on these goals. There will be a focus on developmental and relationship issues and the transition from childhood to adulthood. This pathway will see people with mental health problems and mild to moderate learning disabilities and will host the eating disorder service for people of all ages as well as the current early intervention in psychosis service for under 25s.

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Adult pathway:

The adult pathway will be for people aged 25 and over whose mental health needs are more severe than can be met by the Wellbeing service. This will include adults over the age of 65 who do not have dementia or complexities associated with ageing. This pathway will see people with mental health problems and mild learning disabilities. Well-developed approaches such as assertive outreach will be incorporated into the adult pathway, and early intervention in psychosis for those adults who have a first episode aged 25 or older.

Complexity in Later Life pathway:

This pathway is for people of all ages with dementia and people with mental health problems who also have complexities associated with ageing. Emphasis will be placed on early detection and treatment of dementia, and working with other health and social care providers to provide appropriate and better integrated services. The pathway will be involved in diagnosis and pre- and post-diagnosis interventions to reduce any negative psychosocial impact of diagnosis and progression of dementia. Service users and carers are often distressed by the diagnosis and prognosis, and sometimes there are mental health and challenging behaviour issues as well as complex physical comorbidity, and polypharmacy issues. NSFT will work with the third sector to support them in their delivery of interventions that reduce distress and challenging behaviour, while providing direct clinical and consultative services to those service users and carers who need it.

Neuro-developmental pathway:

This pathway is for people aged 14 and over with mental health problems and/or challenging behaviour and severe, profound and multiple learning disabilities, autistic spectrum disorders or attention deficit hyperactivity disorder. The pathway will provide assessment, consultation and intervention and a dedicated acute inpatient unit. The management of the current north Suffolk Community Learning Disability teams (children and adults) will transfer to the Great Yarmouth and Waveney locality. Strong links will be maintained with colleagues working in the neuro-developmental pathways in the rest of Suffolk.

In Suffolk there will be four services for people likely to go into hospital or who are leaving hospital

Step-up care:

The IDTs will include a flexible service for people who may need a period of more intense care in order to reduce the likelihood of them having to go to hospital. This service will work across all six pathways. Staff who work flexible hours will be involved in proactive interventions to reduce the impact of known stressors (e.g. providing input or supporting partner organisations to provide input for a struggling carer).

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Home treatment:

This service is for people who need intensive acute support, including regular medical review, nursing and talking therapies above and beyond that available from the step-up service. This service will also be for people who are not under the care of the IDTs

Alternative to admission beds:

NSFT clinicians in Suffolk are developing effective relationships with other local healthcare providers which can offer appropriate accommodation for people who would otherwise have no alternative but to go to hospital. NSFT is pursuing a number of options such as respite care, crisis beds in the community and adult fostering, and has already identified third sector care services and carer support services to assist in developing alternatives to admission.

Acute admission:

Although there is a desire for fewer admissions, there will always be beds for service users who have a clinical need for them. Acute care models are being reviewed around the country to incorporate specialist triage and assessment wards, as they can contribute significantly to reducing the length of stay for patients (due to improved understanding and community care packages). NSFT will also review patient profiles and determine which service users benefit from acute care and which do not (e.g. people with personality disorders have complex attachment needs that are inappropriate for inpatient facilities). NSFT will work out which treatment packages work best for whom, and develop community treatments where possible as alternatives to acute care. Inpatient beds for adults and older people in both Ipswich and Bury St Edmunds will be maintained.

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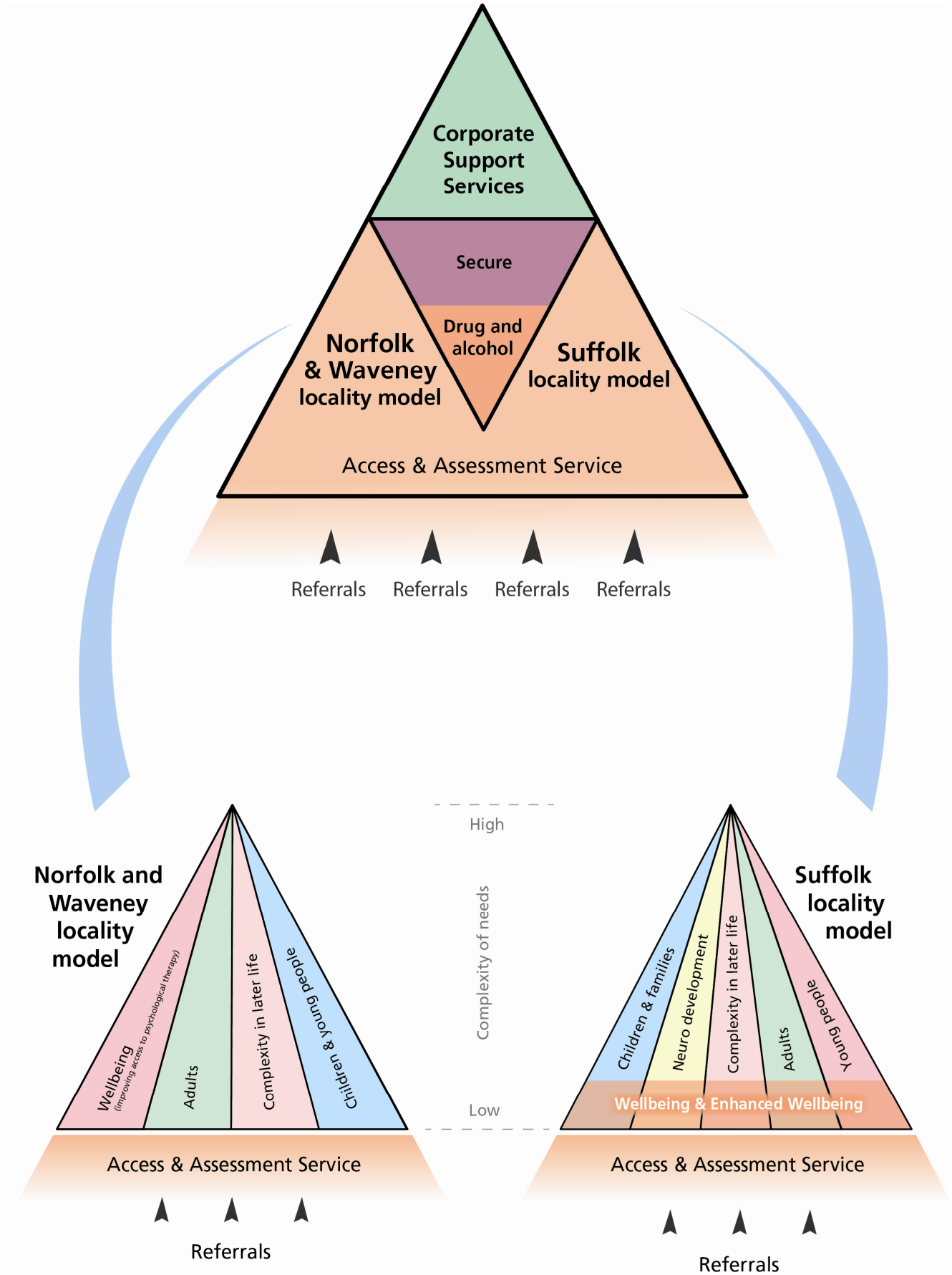

your wellbeing in mind

Norfolk and Suffolk NHS
NHS Foundation Trust

Service model for Great Yarmouth and Waveney, Central Norfolk and West Norfolk localities

A new arrangement for localities

The Norfolk and Waveney model is based on specialist service lines organised into three geographical localities. Each locality will have a complete set of service lines, ensuring that a single senior management team can oversee all care pathways within that Locality from children and young people to dementia and later life.

A care pathway is the journey that a service user and their family carers take through NSFT's services, including the care and treatments they receive and the staff they see. In the Norfolk and Waveney model the pathways and packages of care align broadly with Payment by Results (PbR) clusters or equivalent pathways and packages of care.

PbR is the new way NHS trusts have to claim funding for services they provide – in simple terms, each service user is placed in a care cluster dependent on what type of care they need; the number of service users is multiplied by the agreed level of funding for that type of care for that cluster and the commissioners are invoiced accordingly.

The three localities are:

- Great Yarmouth and Waveney (25% of the Norfolk and Waveney population)
- West Norfolk (larger than the current West Norfolk locality and covering 25% of the Norfolk and Waveney population)
- Central Norfolk (smaller than the current three central Norfolk localities and covering 50% of the Norfolk and Waveney population).

There will be five specialist service lines in each locality:

- Wellbeing (Improving Access to Psychological Therapies – IAPT)
- Child and adolescent mental health services (CAMHS)/Youth
- Adult community
- Adult acute (community and hospital care)
- Dementia and complexity in later life.

The service lines are designed to deliver entire pathways, minimising the need for service users to move from one service line to another in order to complete their care pathway.

The exception to this is when adult service users with functional mental health problems (e.g. depression in the Youth or Adult Community Service) need acute mental health care, including home treatment or hospital assessment and treatment. The fact that community and acute services are organised around a single locality will help ensure continuity between community and inpatient care.

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Service lines will deliver the same pathway and standard of care in all localities. Each service line will consist of a multidisciplinary health and social care workforce. The size of th workforce in each service line will be flexed to match the number of referrals and caseloa, as negotiated with commissioners each year.

Each of the localities in Norfolk and Waveney will have five service lines

Wellbeing (Improving Access to Psychological Therapies):

This service line remains unchanged from the current Norfolk and Great Yarmouth and Waveney Wellbeing Services, which provide talking therapies under Improving Access to Psychological Therapies (IAPT). As per the current contracts, the service will work in tandem with the Access and Assessment service, ensuring that people needing Wellbeing services are signposted appropriately.

The Wellbeing service is for people with common mental health problems - depression and anxiety. In Norfolk the service will include social care services for people aged 18 and over and their carers.

Child and Adolescent Mental Health Services (CAMHS)/Youth:

This service line is for children and young adults up to the age of 25 years with moderate and severe conditions and their families. It will include the current early intervention in psychosis service – an early detection and intervention for young people aged from 14 to 35. An intensive support team will provide care for young people in the community, avoiding hospital visits where possible. Where hospital assessment and treatment is necessary, it will be provided locally.

The service line will include an eating disorder service for children, with an inpatient element.

Social care assessments and interventions for services users aged 18 and over and their carers are included for Norfolk.

This service line will also provide specialist care for children and adults with Attention Deficit Hyperactivity Disorder (ADHD)

Community-based care will contribute to reduced admissions to hospital. Admissions that do take place will be for a shorter time than under the current system.

NSFT has developed service models with young people and will provide a service ethos that they are comfortable with.

Adult Community:

This service line is for people with mild, moderate or severe mental health conditions who are over 25.

The service will be provided by clinicians working alongside peer support workers. The service line will include the development of a Recovery College, where staff and service

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users work in partnership to train mixed groups of staff, service users and carers in a range of health and social care topics for example crisis planning, managing risk or using Individual Budgets.

Across all service lines, there will be an emphasis preventing people getting into a 'crisis' state in the community. However, if they do need to go into hospital, the Adult Community service line will take responsibility for their discharge and will put plans in place plans to prevent a further crisis.

Adult community teams will include a range of alternative to admission options - including residential care beds, bed and breakfast places, foster families and beds provided by other care partners.

Adult service lines will have increased numbers of Approved Mental Health Practitioners (AMHPs) who will play a lead role in ensuring all care plans focus on crisis planning and prevention. Peer support workers will work with service users who have a history of crisis to involve them in crisis planning.

A new personality disorder strategy and care pathway for people with personality disorders will support community teams to provide a service to this group and their carers.

Adult Acute:

The Adult Acute service line will provide crisis assessment, home treatment and inpatient assessment and intervention for people aged 18 and above. Great Yarmouth and Waveney and Central Norfolk's acute pathways are recognised nationally for their efficiency. These proven models will be implemented in West Norfolk.

All referrals will be triaged by the Access and Assessment Service, ensuring that crisis assessments are targeted at service users who are likely to require home treatment or acute admission. This will allow the Crisis Resolution and Home Treatment Service to focus on crisis response and home treatment and work in a more integrated way with inpatient services and reduce length of stay.

The Bed Management and Discharge Team will manage all adult acute beds in Norfolk and Waveney in real time to ensure resources are used appropriately and blockages causing delayed discharge are tackled swiftly.

The pathway into NSFT's Low Secure services will be made easier to access.

Dementia and Complexity in Later Life:

This service line is for people of all ages with dementia and people with mental health problems who also have complexities associated with ageing. This service line places emphasis on early detection and initiation of treatment for dementia through a shared care arrangement with GPs. Intensive support teams will provide rapid and intensive care for people with dementia or functional mental health problems (e.g. depression) to help them to stay at home for longer.

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Hospital acute assessment beds for people with dementia will be part of the service line discharge planning and alternatives to admission will always be sought to ensure that people are admitted to hospital only when necessary. Community staff will work within integrated care teams with social and community care staff.

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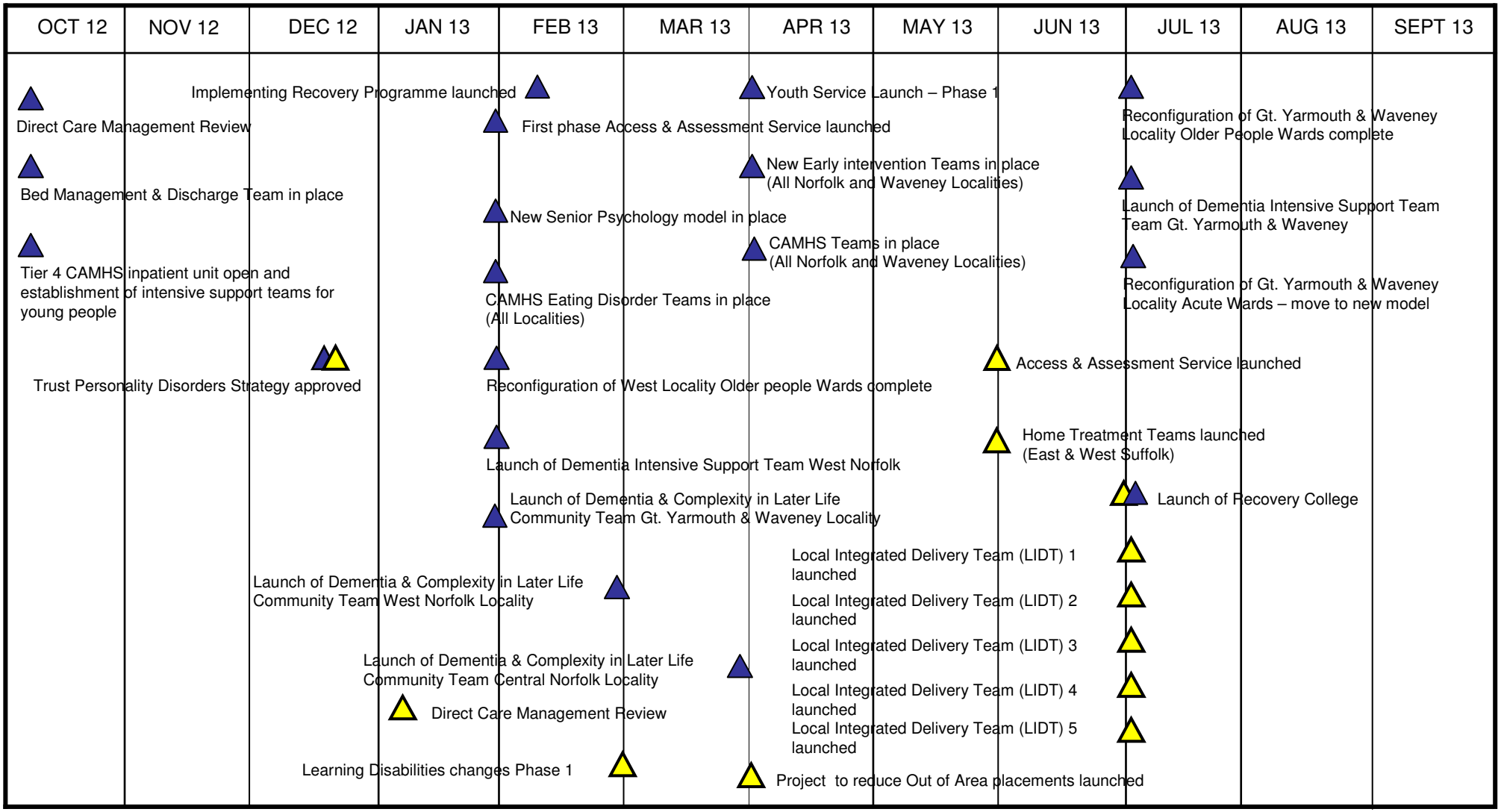
Proposed Trust Service Strategy
High Level Milestones Plan

Please note this is a work in progress plan and subject to change



Version 1.0 Release

Proposed Trust Service Strategy
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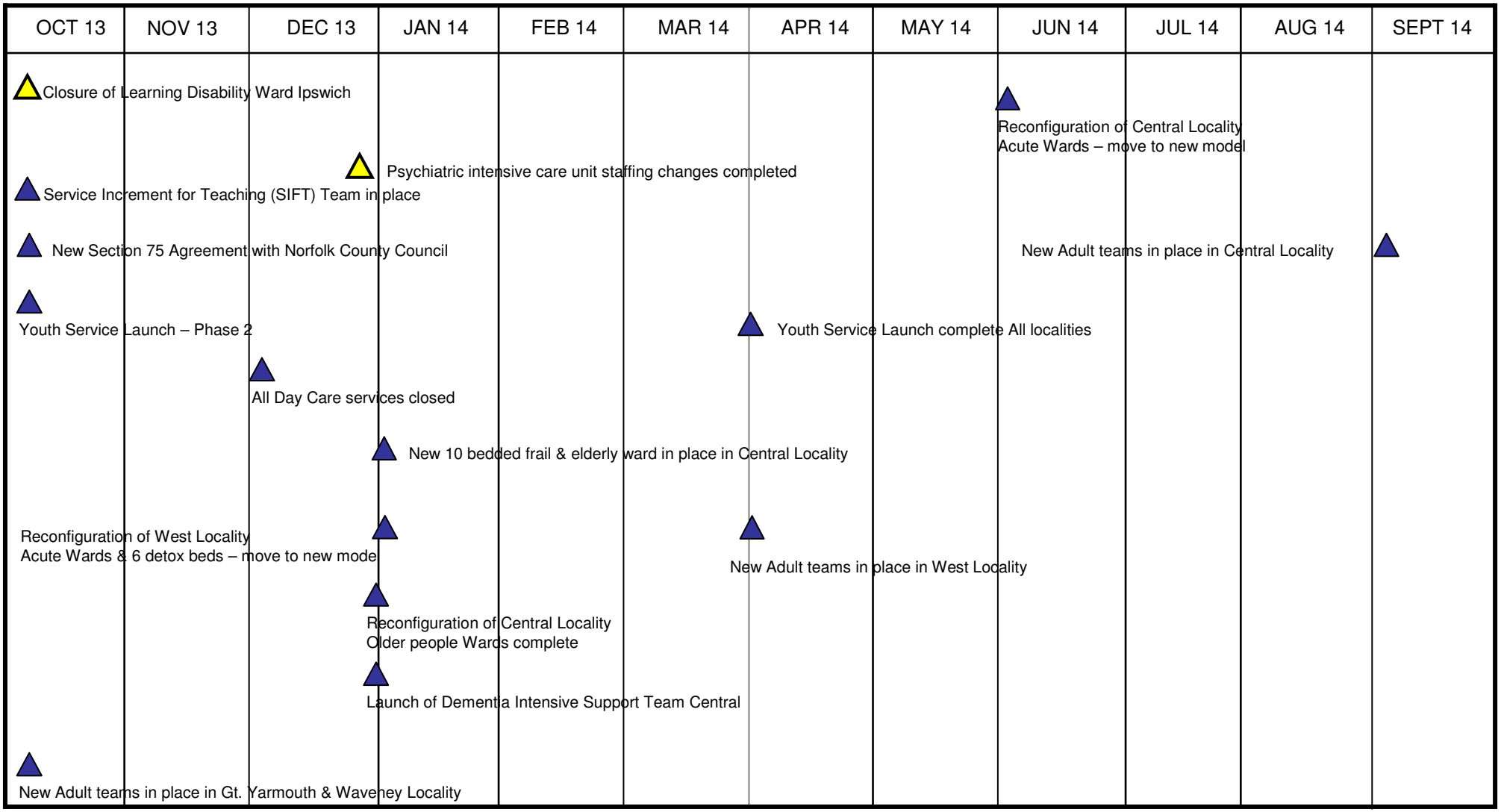

Version 1.0 Release

Proposed Trust Service Strategy
High Level Milestones Plan

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OCT 14	NOV 14	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15	JUN 15	JUL 15	AUG 15	SEPT 15
						Reconfiguration of Adult Wards complete					

 Norfolk & Waveney

 Suffolk

Version 1.0 Release

Appendix C

Copy of letter from Local Negotiating Committee (BMA) to Norfolk & Suffolk NHS FT

Ref: CJ/red

21 January 2013

Dr H Ball
Medical Director
Norfolk and Suffolk NHS Foundation Trust
St Clement's Hospital
Foxhall Road
Ipswich, IP3 8LS

Dear Hadrian

LNC RESPONSE TO 90 DAY CONSULTATION ON TRUST SERVICE STRATEGY

The Local Negotiating Committee has considered the proposed Trust Service Strategy from the perspective of medical staff.

The comments below are focused primarily on issues relating to terms and condition to service and employment rights, since this is the primary remit of the Local Negotiating Committee. However many of the same people have been involved in submitting responses individually and as part of various groups adopting a more clinically focused perspective. In addition we have contributed to the formal response from the Medical Advisory Committee, which has taken responsibility for responding in relation to Trust wide issues such as undergraduate and postgraduate training.

Summary

Responding to the proposed Trust Service Strategy has been difficult because of the lack of detail provided at this stage of the process. Many of the concerns expressed below are therefore preliminary or interim in nature, or are based on "reading between the lines" of the very general proposals that have so far been produced. Nonetheless, the following points summarise our main concerns:-

- Despite the bland assurances contained in the Trust Service Strategy documentation, we believe that the proposed reductions to medical and other clinical staff will have a major impact on the quality of clinical care provided. We believe that quality mental health care results primarily from face to face contact between patients and clinicians from all disciplines, and we do not accept that the reference to "efficiency" can in any meaningful

sense disguise the reduction in quality and quantity of care that will result from the proposals.

- We do not believe the Trust has honestly or adequately described the inevitable reduction in service quality and activity resulting from the proposed cuts. A more honest assessment of what can, and more importantly what cannot, continue to be provided within the reduced financial resources available, while potentially uncomfortable, would have produced a more meaningful consultation.

- Given that the proposals anticipate a 33% reduction in medical staffing, and a reduction in overall clinical staffing of the same order of magnitude, we believe the Trust's statements that quality and levels of service will be maintained are unsustainable.

- The consultation procedure itself has been lacking in sufficient details for meaningful dialogue, has been circumvented by the Trust's insistence on implementing some of the proposed changes even prior to the completion of the consultation, and does not, in our view, constitute adequate consultation.

- The lack of staff consultation has been mirrored by the lack of consultation by other significant stakeholders, including both service users and carers.

- We have serious concerns that highly trained and specialist medical staff will be disproportionally affected by reductions in staffing levels, because their highly specialised skills mean that redeployment opportunities will be more limited for them than for other groups within the Trust.

- Where redeployment of staff is a possibility we do not consider the Trust has taken adequate account of the need for retraining or development.

- We do not consider that the Trust has significantly acknowledged the fundamental changes to job descriptions and job plans that will be required for staff who are retained in the new structure, or whether job descriptions for medical posts within the envisaged services would comply with Royal College of Psychiatrists guidelines.

- We call on the Trust to give an understanding that all medical posts within the redesign services will comply with the guidelines recently produced by the Royal College of Psychiatrists.

- We have seen nothing in the current proposals to address concerns about maintaining levels of out of hours cover with significantly reduced numbers of medical staff at all levels of seniority, of the detriment to patient care and safety that will result from reductions, or of the impact on daytime working practices if out of hours cover is to be maintained despite an overall reduction of medical staff.

- We consider that the Trust capacity to offer training for junior psychiatrists will be drastically reduced by the proposed changes. We note that no allowances have been made for this in the new structures, and that numbers of junior posts have been transferred to the new structure, as if they will be unaffected. We believe this is completely unrealistic and unsustainable.

- We believe that the lack of medical involvement in the proposed assessment teams will have a major negative impact on the quality of assessment and treatment provided patient perception of mental health services, and also the satisfaction of referrers, particularly general practitioners.

The Nature of the Consultation Period

Before addressing individual issues we wish to express serious concern and dissatisfaction with the nature of the consultation process which has been imposed. We have broadly four areas of concern; the nature of the consultation itself, the relationship between this and detailed proposals for specific areas, the timetable for implementation, and the facilities provided for consultation.

With regard to the consultation process itself the Trust has explicitly stated its intention to consult on principles relating to the high level design of services, rather than on detailed proposals for service designs. While we understand the Trust's intention to undertake radical service redesign in response to the "Nicholson Challenge", rather than piecemeal restructuring of individual parts of the service, an inevitable consequence to this approach is that it is difficult, if not impossible, for us to provide meaningful responses to the consultation. In essence the proposals assert that the Trust can continue to provide appropriate quantity and quality of clinical services with significantly reduced staffing levels. However the information provided in terms of final staffing levels, reorganisation and redeployment, or expected workloads, is not sufficient for us to understand or comment meaningfully on how the Trust envisages such drastic changes taking effect. The nature of the consultation determined by the Trust means that it is impossible for us adequately to assess the implications of the proposed changes for the staff affected or for future patient care, and when information has been sought, either about more detailed plans for implementation, or about the assumptions in terms of population numbers and activity levels on which the Trust has relied, we have repeatedly been told that information is not yet available.

The result of this is that, while we have attempted to make a sensible response to the proposals, it is in fact impossible to know at this stage what the consequences of them will be. Related to this, our second concern is the relationship between the 90 day consultation relating to the broad brush proposals that have been made, and more detailed consultations and negotiations that will take place over the next 3 years, when individual services are refashioned in detail. We have serious concerns that once the detailed effects of specific proposals become clear the staff, and staff organisations, will be denied the opportunity to engage in meaningful consultation about the details, on the grounds, which we consider would be unjustified, that the time for consultation has passed. We feel therefore that we are in the position of being given an opportunity to comment on proposals without seeing the detail, and then risk being denied the opportunity to respond to detailed proposals when they are made. We do not consider that this is true or meaningful consultation, and we do not consider that this is allowing staff a reasonable opportunity to engage with a process which is likely to have devastating consequences, not only for patient care but also for the individual careers of members of staff.

Thirdly we have extreme concerns about the Trust's stated intention to begin implementing

changes even before the end of the 90 day consultation period, inadequate though we consider that to be. While understanding that some of these processes are being driven by financial imperatives and timetables, we do not consider that the Trust can, at one and the same time, maintain that this is a genuine consultation process, in which the Trust is willing to listen to alternative proposals and viewpoints, and also proceed with implementing the changes which have been proposed, on which consultation has not yet been completed. It is our view that the Trust's decision to proceed with implementation before the consultation period is even half over demonstrates clearly the Trust's lack of commitment to any genuine consultation with its staff. We find this not only totally unacceptable, but also an extremely worrying precedent for any future collaboration between Trust staff and Trust management.

It is clear from the Trust's stance that any consultation will only relate to the details of implementation rather than to the overall strategy which has already been determined. Yet at the same time it is that very detail which is missing from the proposals, so we can consult neither meaningfully on the strategy, which is already being implemented nor on the details, which are as yet unknown.

Finally, we would again draw your attention to the fact that, while publically stating it is committed to positive engagement with staff organisations, and while saying it wants genuine consultation on these proposals, the Trust has made absolutely no provision for medical staff to be given the time or facilitates to engage in this process. As you know this is a wider issue, and the LNC has been expressing concern for some time that the Trust does not provide any time or support for LNC members to engage in committee activities, but this is a particularly severe problem in relation to the Trust's Service Strategy because of the sheer scale of the consultation involved, the short timescale allowed, and because the Trust's refusal to provide such facilities is in direct opposition to Trust assurances that genuine consultation is desired. While the Trust has whole departments of staff dedicating weeks and months to producing thousands of pages of detailed proposals, the Trust has not provided a single member of medical staff with a single minute of time in which to respond to these proposals. Any such responses, including this one, have been produced entirely in addition to job planned duties and responsibilities, and have therefore been produced in doctors' own unpaid time. We consider that it is a disgraceful state of affairs for the Trust to abuse the goodwill and professionalism of medical staff in this way, and while we remain committed to the wellbeing of current and future patients, and are not prepared to allow these potentially highly damaging proposals to go unchallenged, the Trust's failure to support such engagement with its senior staff is reprehensible.

The overall shape of the future of Trust Services

Overall the proposed Trust Service Strategy anticipates a 33% reduction in medical staff within the Trust. The Trust has produced no evidence to suggest that there is currently spare capacity, or medical staff whose time and skills are underutilised, and although the proposals talk in general terms about reorganisation of services to work more efficiently we consider that it is totally inconceivable that the current level of service could be maintained in the face of such reductions. Although the proposals contain virtually no detail either of current levels of referrals, caseloads, or workload, or of expected changes in the future, the clear implication of much of the proposals is that current levels of quality and activity will be maintained or even increased. We consider that this is totally unsustainable, and that it is at best disingenuous

and at worst downright dishonest of the Trust to promote these proposals without clearly stating the effect that such a reduction in capacity will inevitably have on patients.

We believe that it is inevitable within these proposals that both the quantity and quality of service delivery will decline, and that this will result in significant risks to patient safety. We do not consider that these are currently quantifiable given the dearth of detailed information provided, but if the Trust genuinely believes that the quantity and quality of current services can be maintained, or even enhanced, with such reductions in staffing levels, we believe the onus must then be on those making such assertions to provide some credible evidence for them.

Effects of proposals on current staff

Much has been made by the Trust of the assertion that current levels of vacancies, combined with "natural turnover" means that the proposed reductions in staffing levels may be achievable without redundancies within existing staff. Even if that is true, and we consider that the assumptions that this calculation is based on are frankly unrealistic, this does not represent the entire picture, for several reasons.

Firstly, where currently unfilled posts are disestablished, while this may protect other staff currently in post from redundancy, the impact of failing to recruit to those posts on the workloads and job descriptions of remaining staff will be profound. Many staff within the Trust, not least medical staff, are already in the position of undertaking additional workload in order to make good the deficits arising from unfilled posts, and if that situation becomes permanent the jobs of the existing staff will also change, to their detriment.

Secondly, while vacancy and turnover figures may more or less balance job losses across the Trust as a whole, this will not be true for every individual group of staff within every individual locality. Medical staff are likely to be disproportionally disadvantaged by this, because we are only a small proportion of staff within every individual service, and therefore variations in vacancy levels are less likely to average out than would be the case for larger staff groups, and also because, as some of the most highly trained and highly specialised staff within the Trust, the opportunities for medical staff to be redeployed will be highly circumscribed. While a secretary or support worker might transfer relatively easily between, for example, Child and Adolescent Services and Old Age Psychiatry, this is much less likely to be the case for highly trained specialised clinical staff, such as senior psychiatrists, who are not fungible to the same extent.

Even where some degree of redeployment is considered feasible for medical staff there are likely to be significant issues of competence and capability, and an ensuing need for significant amounts of retraining. While it may not be necessary for an existing consultant to undergo a full 3 years of higher training in a new speciality before taking up a clinical role, the Trust would be open to considerable criticism if such staff were transferred between clinical areas without the Trust satisfying itself that all the necessary competencies were in place. In all the discussions so far of the impact of the Trust Service Strategy we have found no reference to provision for the necessary time and funding for staff retraining – something which is relevant to all staff groups not just doctors.

While it is extremely difficult to comment on the effects that the Trust Service Strategy is likely to have on individual posts, given the lack of detail so far provided, we note comments in the current proposals that there are no changes being proposed to the job descriptions of existing staff. This seems to be a completely unsustainable and incredible position for the Trust to adopt. Given the huge reductions proposed in staffing numbers, it is inconceivable that those staff remaining at the end of the process could continue working to their current job descriptions. Even if there were no proposed redesign of services this would equate to a third of the current clinical workload simply not being undertaken, but in practice the associated service redesign will inevitably mean that every single clinical job within the Trust will have to be redesigned, job descriptions rewritten, and patterns of work renegotiated. We consider it totally unrealistic to imagine that this can be done without reducing the amount of clinical activity and we have major concerns that staff will be under extreme pressure to accept increased caseloads and increased pressure of work, with the inevitable reduction in service quality and patient safety that this will entail. Although the Trust has attempted to avoid addressing this issue so far, we would foresee serious problems in obtaining approval for such job descriptions, and in negotiating valid job plans for such posts. Again, we have seen no mention in the current proposals of the likely impact that these difficulties will inevitably have on implementing the proposals.

We would like an undertaking from the Trust that all medical job descriptions will comply with Royal College guidelines in all respects, including crucially issues of caseload, catchment area, and medical and multidisciplinary support. The LNC will strongly advise all MSFT medical staff not to agree job descriptions which do not meet these minimum standards, and to seek advice from the GMC and defence organisations about the professional position of doctors on whom such arrangements might be imposed.

We also believe that it will be significantly harder to protect time for supporting clinical activities within their new jobs. As well as impairing doctors' ability to meet continuing professional development requirements (over and above any need for retraining mentioned above) and to demonstrate necessary competencies within the new appraisal and revalidation arrangements, this will also make it even harder for senior medical staff to contribute to the strategic development if the Trust and to a wide variety of management roles. We believe this will have a further serious impact on the quality of Trust services, in addition to the direct impact of reduced staffing levels. It will also seriously reduce the capacity of the Trust to engage in non-clinical activities such as research and teaching of medical students, something which may have long term effects on the Trust's ability to recruit medical staff in the future.

Impact on training capacity

Just as non training career posts will require redefining and renegotiating, this will also be true for every medical training post within the Trust. Since training approval is given for a specific post, based on a job description, weekly timetable, and identified trainer, any change to services is likely to require a wholesale re-approval of training posts. The current proposals appear to assume that the number of training posts within the Trust will remain unaffected, but we consider this is wholly unrealistic for three reasons.

Firstly the reduction in posts will mean that there are significantly fewer senior medical staff to act as trainers and supervisors. In fact the inevitable increased service pressures placed

upon the remaining consultant staff mean that the reduction in training capacity is likely to be even greater than a pro-rata reduction of 33%, but on the very best prediction it would seem inevitable that a reduction by 33% of trainers must result in a reduction of at least 33% in trainees. At the recent extraordinary MAC meeting you spoke about funding being identified for the Trust to employ additional Foundation Year trainees but gave no response when asked where the training capacity in terms of consultant trainers would come from.

Secondly, the profound changes to service delivery that are envisaged will result in radical changes to the duties and responsibilities of junior doctors. The lack of any detailed proposals for individual posts or services means that it is impossible to predict in detail how training posts will be affected, so we will restrict comments to one single example.

A central feature of the current proposals is the establishment of a "single point of referral" and streamlined assessment teams to assess new referrals into the secondary mental health services. On current proposals it appears that this is envisaged to be an almost exclusively nursing task, and that there will be little or no medical involvement with these initial assessments. This would represent a significant change to the function of junior medical staff in acute posts, and it may for example be determined that a trainee post in acute psychiatry which offers no experience in assessing referrals would not constitute adequate training experience. A fundamental change in service design such as this could therefore render services inappropriate for training junior staff, in which case this may result in approval for such a post being withdrawn, even where the capacity to service them is retained. Similar concerns are likely to emerge in respect of all training posts when services are redesigned in detail, but we do not feel able to identify specific concerns given the lack of detail provided for this consultation.

Thirdly, the reduction of training opportunities within individual jobs will be replicated across the rotation as a whole. Not only will many of the individual placements available have less experience to offer, but also some options within the rotation may be lost altogether, again it is very difficult to give specific examples of this because of the lack of detailed provision within the proposals, particularly relating to junior medical posts, which appear to have been left out of any discussion of future structures so far. However, the overall effect of this will certainly be to make the rotation less attractive to psychiatric trainees in future, and if sufficiently extensive may result in the Trust being unable to offer comprehensive training at all.

Impact on other medical roles

In addition to major concerns about the effect of these proposals on clinical care, we also believe they will have serious adverse consequences for other duties undertaken by medical staff in the Trust. In addition to the effect on postgraduate training discussed above, these duties also include undergraduate medical training, contributions to other multiprofessional training, medical involvement in service management, negotiation with commissioners, and strategic service development, medical audit and research, and contributions to outside agencies such as the Department of Health, Care Quality Commission, Mental Health Tribunal, Royal College and others. Many of these activities provide significant added value to the Trust, but they will inevitably be reduced not only by the loss of 33% of medical staff, but also by the increased pressure on remaining staff to maintain clinical services. The effect on these roles is therefore likely to be considerably greater than a pro rata 33% reduction.

The reputation and public image of the trust will inevitably be negatively affected by this reduction. In the longer term the reduced involvement of medical staff in management and planning is likely to reduce the quality and effectiveness of services in future. The reduction in medical time available will seriously reduce the Trust's ability to meet its strategic objectives, such as increasing research capacity and activity, and to meet obligations to partners and stakeholders such as the UEA Medical School and St George's University.

In addition, these changes will seriously reduce the opportunities for individual doctors to pursue career development and Continuing Professional Development, and may result in doctors in some posts being unable to comply with GMC requirements for revalidation. As well as being a disaster for the individual doctor this would have serious negative consequences for the Trust in terms of maintaining clinical services and of recruitment and retention of medical staff.

Effect on out of hours cover

Medical staff are different to most (not all) groups of staff within the Trust in that we are responsible for providing 24 hour cover for patient care. We also have a clear professional responsibility, imposed by the GMC, to ensure that adequate arrangements are made for continuity of care and seniority of cover for our patients when we are not personally available. While this is also the responsibility of the Trust, doctors perhaps uniquely have a personal duty to ensure that such arrangements are adequate.

We are aware that the Trust already experiences difficulty in maintaining adequate levels of out of hour's medical cover. Having seen the recent proposals from Suffolk attempting to reorganise cover so that two acute inpatient units are adequately staffed, we are aware of some of the difficulties achieving this. Out of hours cover is one thing that cannot be simply scaled to accommodate a reduction in medical staffing. Where 6 doctors are currently providing an out of hour's service, that rota will no longer be sustainable if the number of doctors reduces to 4. Again there seems to be no discussion in the current proposals as to the impact of reduced staffing levels on out of hours rotas, or how the Trust could possibly maintain levels of service and safety if the number of rotas is decreased, or the scope of remaining rotas is increased, in line with these proposals. These effects will be compounded because all levels of medical staff will be affected, reducing any opportunity for one rota to make good deficiencies in another.

Because of the need to maintain minimum out of hours staffing levels, and we have seen nothing to suggest that current levels are anything other than the minimum required for patient safety, any reduction in medical staff will impact disproportionally on the availability of those staff during working hours. So if, for example, total numbers are cut by 33%, but out of hours numbers are relatively protected from that reduction, then the reduction of medical staff available during normal working hours will be significantly greater than 33% if the frequency and intensity of out of hours work also increases, the impact on daytime availability will be even greater. We have already seen the effect of a similar process in the change to junior doctor availability following compliance with the European Working Time Directive, and the reduction in medical staffing proposed by these changes is considerably greater than that, and that will inevitably have a much greater effect on medical input to routine clinical care.

The changing role of the psychiatrist

Over the last decade there have already been substantial changes to the role of the psychiatrist within most mental health teams, primarily driven by "New "Ways of Working", but continuing since that was introduced. It seems inevitable that the drastic reduction in medical staffing proposed will exacerbate those changes. Again, there is little detail on which to base judgements about the future of services, but in total it seems inevitable that patients will have fewer and shorter contacts with senior medical staff, and that even greater numbers of patients in secondary mental health services will have no input from a psychiatrist at all. We consider this to be unacceptable, and completely at odds with the Trust's stated intention of maintaining and improving the quality of services. There is considerable evidence both that patients value direct contact from senior medical staff, and perceive the quality of care to be higher when this is facilitated, and also that the actual quality of assessment, treatment, and decision making is greater when these functions are undertaken by, or have the direct involvement of, consultants.

The Royal College of Psychiatrists has recently provided guidelines for appropriate workloads, catchment areas, and both clinical and non-clinical responsibilities for consultant psychiatrists in all subspecialties. The proposals make no reference to these documents, but we believe they support an evidence bases approach to providing appropriate services and ensuing patient safety. We call on the Trust to give an understanding that all medical posts within the reorganised services will comply with the Royal College recommendations.

Again, this deficiency is most apparent in the part of the service for which detailed proposals are already available; that of the "single point of contact" assessment teams. It is anticipated that these teams will have no regular medical input at all, and that initial assessment, prioritising of referrals, and signposting, will be undertaken by non-medical staff. We consider that this is both wrong in principle, and also potentially highly risky in practice for both patient care and for the Trust's reputation.

Most referrals to secondary mental health services come via general practitioners, following an assessment by a medical practitioner, who refers because there is a perceived need for specialist mental health involvement. Many reports and commentaries both formal and informal, have agreed that general practitioners want and expect an assessment and an opinion which is at least informed by the views of a senior member of medical staff, and also that they are less satisfied with a response that does not include this assessment. Although the Trust maintains that Clinical Commissioning Groups support these proposals, we note that the information provided about the Assessment Teams, while giving vague assurances about quality, does not make it clear that these will be non-medical assessments undertaken primarily by Band 5 nursing staff. We do not believe that this will adequately meet the expectations of GP commissioners.

Additionally the functioning of these teams will be central to the efficiency and quality of the Trust's services as a whole. The stated aim of these services is to reduce multiple and repeated assessments, which are perceived as being inefficient, and wasteful of resources. However, this will be achieved only if the assessments produced are of high quality. If those assessments are flawed, or even if they are in fact accurate but are perceived as having insufficient validity, there will be increasing calls for reassessments, undermining the projected efficiency savings. If the assessments are in fact inadequate then patients will be accepted into services inappropriately, both increasing workloads for the teams receiving

those patients, and also requiring additional time and resources to correct the original misallocation. If, as is equally likely, mistaken assessments lead to patients being wrongly denied services, or wrongly directed away from the services which they actually need, then the Trust is potentially open to serious criticism and liability for a failure of care. In such circumstances we believe it would be very difficult and if not impossible, for the Trust to justify having excluded the most senior and experienced clinical staff from that critical decision making process.

In any event, while accurate assessment is a vital component of service delivery, it is only the start of what for most patients is a prolonged period of treatment and support from mental health services. A more efficient assessment process will result in some savings, but the greater costs of ongoing treatment will not be reduced by this change, suggesting that the scope for savings as a percentage of overall budgets is limited.

Wider consultation issues

We have made clear already that we consider the imposed consultation to be inadequate and lacking in meaningful content. It seems clear that the Trust has already determined many of the critical features of future service design and is implementing such services, without waiting for the consultation to be completed. It is of equal concern, therefore, the Trust has made these decisions without undertaking wider consultations. Having queried the lack of any apparent input from service users and carers into this process we are informed that focus groups will be undertaken to do this, but not until after the consultation period as finished. Again it seems that key stakeholders are being denied the opportunity of meaningfully to be involved in shaping the future of mental health services in this area.

It also appears that key stakeholders in the wider NHS are yet to be consulted, and will also be put in the position of being presented with a fait accompli. In particular, as noted above, we believe that general practitioners will not be supportive of plans to deny access to frontline assessment by senior medical staff, and we strongly suspect that GP Commissioners, when presented with this plan, will have major concerns. Just as with the process of a staff consultation we believe the Trust would have been better advised to engage in consultation with these stakeholders at an earlier stage, and certainly well before service restructuring had been implemented. By undertaking consultations based on inadequate information which does not give an honest assessment of the likely impact of the proposed cuts the Trust has rendered the results of that consultation, including the claimed support from CCGs, meaningless.

Conclusions

We believe that these proposals themselves require radical redesign if they are not to have major adverse consequences for the quality of care received by our patients, and serious adverse consequences for their lives and the lives of those around them. While not underestimating the scale of changes required by the “Nicholson Challenge” we call on the Trust to reconsider the approach so far adopted, to recognise that quality services cannot be

provided without a commitment to maintaining both the quantity and quality of clinical staff, to acknowledge that reducing clinical staff to the extent proposed is non compatible with maintaining those services, and to engage meaningfully and honestly both with its staff and its wider stakeholders to agree a better way forward, rather than adopting the current approach which is consultation in name only.

Yours sincerely

Dr Chris Jones
Consultant Forensic Psychiatrist
Chair of the Local Negotiating Committee

Cc Aidan Thomas, Chief Executive
Jane Marshall-Robb, Director of Human Resources
Kate Copplestone, Head of Workforce
Peter Mitchell, BMA Regional Officer
Leela Pendle, BMA Industrial relations Officer
Lynn Wall, Staffside Officer

Appendix D

The Chairman
Norfolk and Suffolk Joint Scrutiny Committee

Regarding Radical Redesign of Mental Health Services in Norfolk and Suffolk
Date 2 February 2013

Dear Chairman,

As Consultant Psychiatrist and representative of the Royal College of Psychiatrists, I have been asked to write to you **on behalf of medical staff and non-medical colleagues to express our serious concerns about the financial cuts and radical service redesign proposals.**

The Trust's efforts to meaningfully involve clinicians in these changes are evident, but the Trust reports to be under such financial and time pressures that it is forced to push through ill-advised and insufficiently thought through cuts and reorganisations. A process that normally takes two years is attempted to be planned and enforced in a matter of months. This is causing widespread concern and opposition of clinicians. **Neither has there been sufficient time for adequate stakeholder involvement, particularly patient and carer groups.**

As the proposals currently stand, the quality and safety of the service with be seriously adversely affected. There will be great inequality in accessibility of suitable expert mental health care between different patients groups and geographical areas, with our most vulnerable patients and their carers hit the hardest.

Whereas staff fully accept the current financial restraints across public services in England, we urge the Joint Committee on behalf of our patients and clinicians:

- That the Committee satisfies itself that the Trust will *always* safeguard the quality and safety, effectiveness and efficiency of its clinical care. The Secretary of State has recently issued clear guidance for Health Trusts not to prioritise financial targets over quality and safety of clinical care, in line with one of the main recommendations to come out of the Francis Inquiry into the Mid-Staffordshire' serious failings in NHS care.

- That the Committee is satisfied that the Trust has *adequate systems in place* to monitor adverse effects of the cuts and service redesign on safety and quality of care *before* any service changes are implemented.

- That it has clarity on the actions the Trust *can and will take* should any such concerns arise. That the Trust implements the important lessons

learned from the Mid-Staffordshire inquiry regarding over-reliance on crude safety measures, such as death rates, and that it avoids undue reliance on Executive Directors rather than front-line clinical staff concerns and patient and carers' complaints.

A prerequisite for this is that the radical service redesign proposals are worked out in sufficient detail for staff to comment on them sensibly, so that clinical staff and Trust Management can make reliable predictions of the impact on the level and quality of care we will be able to provide, where and for what patient groups.

We would like the Joint Committee to consider:

- The *systematic under-funding of Mental Health Services*. The national underfunding of mental health services compared to physical health services has been highlighted as "*The most glaring case of health inequality in Britain today*" by the London School of Economics' Mental Health Policy Group in June 2012.

  Both Suffolk Clinical Commissioning Groups and the West Norfolk CCG have under-spent on mental health care compared even to the national average. This contravenes the Equality Act 2010; Care Quality Commission (CQC) requirements, Equality and Human Rights Commission (EHRC) requirements; Best Practice Guidelines for Local Government and the founding principles of the NHS and our modern society. It is indefensible and makes the planned 20% cuts unduly severe, unfair and unacceptable.

- There is an urgent need for the Trust to be given adequate time and financial resource to the plan and implement the cost improvement program (CIP) safely and minimise the adverse impact on patient care and staff by requesting the Commissioners to allocate the Trust adequate transformation funds.

- More time is also needed for meaningful patient and carer involvement in the redesign. *An audit only last month showed that patients and patient and carer' representatives where unaware of the full extent and likely impact of the cuts and redesign on service. Most were not aware at all*. The majority of our patients are very vulnerable and unable to function socially. Involving them in the redesign takes more than usual time and effort.

- We also would like to bring to the Joint Committee's attention that there seems to be considerable disparity between what the CCGs are in agreement with and what the GPs we as clinicians work with, say regarding the changes. Those GPs who are aware express their deepest

concern that mental health services as there are, particularly Child and Adolescent Services, are already inadequate.

We as clinicians believe that the Trust has not been able as yet, to meet any of the above requirements to sufficiently safeguard future mental health care services for the people of Norfolk and Suffolk in the near future and years to come.

Although the programme of cuts and redesign is planned over a 4 years period, the Joint Committee needs to be acutely aware that, as the plans stand, **community mental health services providing mental health care for the vast majority of patients in Norfolk and Suffolk are due to face the full 20% cuts and service redesign in only 4 ½ months time, even though the plans have not been worked out in any detail as to what this service should look like.** Under external time and financial pressures, the Trust is already implementing service changes in Norfolk despite the staff consultation still being in progress and no one has any idea as yet, what the services as a whole should look like.

This is unsafe and unwise. As clinicians, we strongly advice for implementation of the cuts and service redesign to be slowed down, to allow careful planning and monitoring.

To highlight *just some* of the clinical areas of concerns:

The 20% cut in funding will result in 31% cut in consultant psychiatrists posts, 50% cut in staff grade psychiatrists, 32% senior nurses (partly replaced by less experienced nurses). The suggestion is that in future, senior doctors are to provide *consulting of staff* rather than seeing patients face to face. The cuts and service redesign rely heavily on 'New Ways of Working' (less trained clinical staff taking over some of the traditional doctor roles) even though the Royal College of Psychiatrists has clearly shown the limitations of this model. Doctors are to be partly replaced by 'nurse prescribers' even though it takes years to train these nurses up and currently, Suffolk does not have any and in Norfolk there is only a very small number in pockets of the service.

In rural areas, staff are likely to be so overstretched that doing home visits will no longer be feasible. Psychiatrists will no longer have the time to travel to outlying clinics. This will seriously affect the access to care for our most isolated and vulnerable patients and result in less contact between mental health professionals and GPs. The Royal College of Psychiatrists and BMA have warned of potentially serious breaches of patient confidentiality by the proposed 'staff mobile working'. One of the current main clinical safeguards is staff team working and communications, in the new proposals much of which will be disrupted. Although the new local 'integrated' community teams each comprising of some 70 plus staff are due be up and running as per 1 July 2013, buildings to house them have not yet been identified.

The plans are for people with very significant learning disabilities, the elderly, children and adolescents and general adult psychiatry patients all to share the same community facilities. This would require an enormous investment in estates and widespread relocation of clinical areas and offices. If the experience on our inpatient wards are anything to go by, the elderly and significantly learning disabled patients are at risk from the more disturbed younger patients: these vulnerable patients are having to be placed either out of area at great financial cost with reduced access to family and friends, or nursed on a one to one basis to protect them, again, at considerable financial cost and unduly restricting their freedom.

Patients aged between 65 – 75 years and those with mild to moderate learning disabilities present clinically very differently. They have different treatment needs, communication requirements and so forth. In the redesign proposals, these vulnerable patients will loose access to specialist care and will have to compete with the current large general adult patient group for access to a diminishing and already underfunded and overstretched general adult psychiatry workforce. Taking away access to specialist care is against clinical care guidelines by the General Medical Council, NICE, and the Royal Colleges of Nursing and Psychiatrists.

NHS community mental health facilities are close to being none-existent. This is compounded by the loss in the past year or two, of third sector facilities, with organisations such as MIND withdrawing from many areas despite increasing need due to a lack of funding.

The redesign will still not address the inequality to the under 18s in Suffolk who have to be placed out of County, away from their family and friends, when requiring inpatient care. This will also be the case for learning disabled patients when the inpatient facility in Ipswich closes (Walker Close) against government targets promising equal access to locally available care.

The planned Access and Assessment Teams are another area where plans are lacking in understanding of front line working and staff expertise.

Attending the Suffolk HOSC meeting on 17 January 2013, I was struck by the number of Councillors with first hand experience of dementia in a close relative. I was encouraged by their understanding of issues around dementia care and their demands for services for this very vulnerable patient group and carer' needs.

A number of Councillors suggested that dementia is their only experience of mental health issues. I would argue though, that their experience will have given them invaluable insight into issues similarly applicable to other mental health conditions.

For example, *Dementia Praecox* is twice as prevalent as Alzheimer's Dementia. It will affect *1:100 of all young people often within less than 10 years of leaving full time education*, robbing them of their life potential and future. Unless adequately treated and supported, it is a devastating illness often described by clinicians as 'worse than cancer'. Ten percent of these young people will kill themselves shortly after diagnosis (50% of the youngsters diagnosed aged 15 will commit suicide). Because it is also known as Schizophrenia, the public does not give them the empathy they would if it was still known by its original name, showing the ongoing stigma of mental illness and resulting health inequalities.

Whereas almost all people with physical health issues are receiving some kind of treatment, only a fraction of people with mental health issues receives help, except for most (but far from all) people with a major mental illness.

Of the sixteen percent of the population suffering from anxiety and depression, only a quarter are currently receiving appropriate treatment. Amongst children aged 5-16, six percent suffer from conduct disorder/ADHD which may seriously adversely affect their future functioning unless addressed, but of whom only 28% are actually receiving any treatment. Four percent of children suffer from clinical depression and/or anxiety, of whom less than a quarter is getting any treatment. One percent of children suffer from autism, but less than half (43%) are in treatment.

Mental health issues affect as many young people (aged 15-29) as physical health issues do people aged 60 plus (source: LSE June 2012).

On behalf of all my medical and non-medical clinician colleagues, I am most grateful for your endeavours to safeguard mental health services for the people of Norfolk and Suffolk. It is essential that clinician' concerns are acted upon and that the Trust is given the time and finances to develop and monitor a *sustainable* cost improvement program, with Commissioners recognising the past shortcomings in funding of mental health services and the rising future need, particularly for dementia care.

Yours sincerely,

Dr Marlies Jansen

Consultant General Adult Psychiatrist, Member of the Royal College of Psychiatrists,