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

Date: **Tuesday 12 March 2013**

Time: **1.00pm**

Venue: **Council Chamber,**
Suffolk County Council,
Endeavour House, 8 Russell Rd, Ipswich IP1 2BX

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
Elizabeth Gibson-Harries	Mid Suffolk District Council
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. To receive apologies and details of any substitute members attending

2. Minutes **(Page 5)**

To receive the minutes of the meeting held on 11 February 2013.

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

If you have a **Disclosable Pecuniary 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 Pecuniary 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 Pecuniary 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.

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

5. Radical redesign of mental health services in Norfolk and Suffolk **(Page 21)**

To receive further information from Norfolk and Suffolk NHS Foundation Trust along with other relevant information and evidence from witnesses.

i. **Appendix C** **(To follow)**
ii. **Appendix I, Document 5: Updated table of Proposed Impact on Workforce** **(To follow)**
iii. **Appendix I, Document 10: Financial details** **(To follow)**
iv. **Appendix I, Document 11: Risk assessment** **(To follow)**

6. Conclusion of the Joint Committee **(Page 152)**

The Joint Committee, which was established on a task and finish basis to complete its work before the lead-in period to the County Council elections on 2 May 2013, will outline its potential conclusions and recommendations and discuss arrangements for production of its report.

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

Date Agenda Published: 4 March 2013

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

Minutes of the Meeting Held on Monday 11 February 2013 at 2pm at County Hall, Norwich

Members Present:

John Bracey	Broadland District Council
Peter Byatt	Waveney District Council
Michael Chenery of Horsbrugh	Norfolk County Council
Annie Claussen-Reynolds	North Norfolk District Council
Elizabeth Gibson- Harries	Mid Suffolk District Council
Robert Kybird	Breckland District Council
Dr Nigel Legg	South Norfolk District Council
Alan Murray	Suffolk County Council
Tony Simmons	Forest Heath District Council

Witnesses Present:

Norfolk and Suffolk NHS Foundation Trust (NSFT)

Dr Neil Ashford	Consultant Psychiatrist – specialist in dementia and older people's mental health
Dr Hadrian Ball	Medical Director
Heather Balleny	Consultant Clinical Psychiatrist
Dr Julian Beezhold	Consultant Psychiatrist – specialist in acute/crisis mental health services; Chair of Trust's Medical Advisory Committee (MAC)
Kathy Chapman	Director of Operations (Norfolk)
Dr Viv Peeler	Consultant Psychiatrist
Dr Laurence Potter	Consultant Psychiatrist – specialist in access and assessment and primary care mental health
Dr Siri Robling	Consultant Psychiatrist
Aidan Thomas	Chief Executive
Anna Vizor	Consultant Clinical Psychiatrist
Dr Jon Wilson	Consultant Psychiatrist – specialist in children and young people's mental health

Commissioners

Dr Penny Ayling	North Norfolk Clinical Commissioning Group (CCG)
Clive Rennie	Norfolk and Waveney Commissioning Support Unit

Clinicians

Simon Clarke	Mental Health Nurse and an RCN representative within NSFT
Dr Marlies Jansen	Consultant Psychiatrist and Member of the Royal College of Psychiatrists
Dr Chris Jones	Consultant Psychiatrist and Chair of the Local Negotiating Committee
Mike Kavanagh	RCN Officer Norfolk and Suffolk, Royal College of Nursing
Andrew Stronach	RCN Regional Communications Manager

Patient Representatives

Esther Harris	Norfolk Local Involvement Network (LINk)
Patrick Thompson	Chairman of Norfolk LINk

Voluntary Sector Representative

Amanda Hedley	Norfolk MIND organisations

1. Election of Chairman

1.1 Alan Murray was elected Chairman of the Joint Committee.

2. Chairman's Announcements

2.1 The Chairman welcomed Members, witnesses, and members of the public to the first meeting of the Joint Committee. He thanked the Members of the Joint Committee for agreeing to take part in the scrutiny and he thanked Norfolk for hosting and officers from both counties for their organisational skills and much backroom activity to prepare for this meeting.

3. Election of Vice Chairman

3.1 Michael Chenery of Horsbrugh was elected Vice Chairman of the Joint Committee.

4. Apologies and Substitutes

4.1 Apologies were received from Dr Michael Bamford (with Elizabeth Gibson-Harries substituting), Tony Goldson, and David Harrison (with Annie Claussen-Reynolds substituting).

5. Declarations of Disclosable Pecuniary Interests (DPI) and Other Interests

5.1 No interests were declared.

6. Items of Urgent Business

6.1 There were no items of urgent business.

7. Terms of reference

7.1 Members received the annexed report (6) which was a report that outlined the draft Terms of Reference for the Joint Committee. The report included information about the Joint Committee's legislative basis, its overall purpose, the purpose of the review, the Membership, Chairing, and Quorum requirements, Co-option, the arrangements to support the Joint Committee, the Joint Committee's powers, the arrangements for public involvement, the Joint Committee's press strategy, and the arrangements for writing the final report. The Joint Committee was asked to consider and approve the Terms of Reference.

7.2 The Chairman highlighted that the Joint Committee had been set up under the Health and Social Care Act 2001 and a 2003 directive from the Secretary of State which stated that a joint committee should be established when health scrutiny wished to receive consultation on substantial changes in service arrangements that affect more than one committee's geographic area.

7.3 The Chairman added that the purpose of the Joint Committee was:

- To scrutinise matters relating to the planning, provision, and operation of mental health services in Norfolk and Suffolk;
- The extent to which the proposals were in the interests of our health service;
- The impact of the proposals on the patient and carer's experience and their outcomes;
- The quality of the clinical evidence underlying the proposals;
- The extent to which the proposals were financially sustainable; and
- To make a response and recommendations to the NSFT and other involved bodies in terms of whether the proposals were in the interests of the health service in Norfolk and Suffolk and whether consultation had been adequate in relation to content, method, or time allowed.

RESOLVED

7.4 To agree the Terms of Reference as set out in the report.

8. Background information and suggested programme of work

8.1 Members received the annexed report (7) which set out the background to the establishment of the Joint Committee and suggested a programme for the scrutiny of Norfolk and Suffolk NHS Foundation Trust's proposed Strategy 2012/13 – 2015/16. The Joint Committee was asked to consider the programme of work and to agree or amend it if necessary.

8.2 The Chairman noted that following points:

- The NSFT presented its Strategy 2012-16 at the Norfolk Health Overview and Scrutiny Committee (NHOSC) on 22 November 2012 and at the Suffolk Health Scrutiny Committee (SHSC) on 17 January 2013. The formal staff consultation period was running at that time but had now finished and the NSFT had collated the responses.

- Both Norfolk's and Suffolk's Health Scrutiny Committees agreed that it was appropriate to establish this Joint Committee because NSFT's proposals covered both counties. Although different service delivery models were proposed for the two counties, the proposed Norfolk model also covered Waveney and the current arrangements in Suffolk also covered Thetford. In addition the proposed Access and Assessment Service covered both counties. Given these factors it made sense to form a joint scrutiny committee.

- He noted that there were a number of issues highlighted by the NHOSC and the SHSC and these were set out in 2.1 of the report.

- Since 17 January 2013 both Norfolk's Clinical Commissioning Groups (CCGs) and Suffolk's CCGs had reported to their Boards – NHS Norfolk and Waveney and NHS Suffolk. He noted that representatives from the Norfolk CCGs would be speaking later that afternoon.

- He said that in light of the forthcoming local County Council elections on 2 May 2013, the Joint Committee's work needed to take place within the five weeks up to 21 March 2013. It might be necessary to reconvene joint scrutiny arrangements after the elections if the NSFT needed to consult both Norfolk and Suffolk on proposals for substantial variations as the strategy develops.

RESOLVED

8.3 To receive financial figures for the plans within the agenda papers at the next meeting so that the Joint Committee could assess the financial sustainability of the proposals.

8.4 To receive further information on the timetable for the proposals and their implementation so that the Joint Committee could consider the speed of change the service faced.

8.5 To receive statistical evidence, including information about the number of patients currently using the service and the anticipated number of patients expected over future years, including a breakdown of age groups and disorders, within the agenda papers for the next meeting. These statistics and related information were needed to understand how the service planned to adapt to future demand.

8.6 To agree the programme of work as set out in the report.

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

9.1 Members received the annexed report (7) from Norfolk and Suffolk NHS Foundation Trust and the additional information for the Joint Committee. The substantive report from the NSFT formed Appendix A, which set out the revised strategy and a summary of the changes which had been made in response to the staff consultation feedback.

9.2 The Chairman highlighted additional information which was presented in the report:

- The implementation timetable was due to be revised following the NSFT Board meeting which was held on 8 February 2013. However, the original timetable was presented at Appendix B of the report.
- A letter from the British Medical Association (BMA) Local Negotiating Committee in response to the staff consultation was attached at Appendix C.
- A letter from Dr Marlies Jansen (Consultant General Adult Psychiatrist and Member of the Royal College of Psychiatrists) was attached at Appendix D. Dr Jansen was in attendance at today's meeting.

9.3 The Chairman invited the Chief Executive and the Medical Director from the NSFT and their supporting officers to join the meeting. During the discussion the Chief Executive of the NSFT made the following points:

- The Chief Executive explained that the consultation with staff ended only shortly before the agenda was despatched for this meeting. There would be significant further changes to the draft which were set out for Members at the meeting. He agreed that he would provide this updated information in time for the Joint Committee's next meeting.

- He noted that he and his team had been working closely with a range of stakeholders including CCGs in Norfolk and Suffolk, service users, and carers. They were engaging with them both in general terms on the overall strategy and around specific service changes.

- He noted that the process of the changes had taken more than a year thus far and the NSFT intended to continue to engage with stakeholders throughout the process.

- He commented on the issue raised earlier in the meeting regarding patient numbers and he noted that this data had been presented to both the NHOSC and SHSC at their previous meetings but he would be happy to provide this information again for the Joint Committee.

- He noted that the NSFT's proposed Strategy was based on 2011/12 patient numbers but that the new structure allowed services to be expanded should more funding become available. The level of funding was an issue for the commissioners.

- He noted that the clinical leads may be able to provide the age demographic information sought by the Joint Committee.

- In relation to the safety of the proposals and the pace of change, he confirmed that all of the proposals were evidence based and that a number of Trusts around the country had successfully implemented similar strategies. Regarding the NSFT's financial position he said that Monitor had given it a '3' risk rating, which was a significant level of risk.

- He pointed out that the changes should be viewed from the perspective that there were higher risks associated with the NSFT failing to implement the strategy set out. If the NSFT failed to implement these changes the Trust would find itself in serious financial difficulty. The NHS operating framework for 2013/14 included a 4% reduction in funding to providers and the Trust was considering how best to manage this reduction.

- He noted that the NSFT generally had a good track record for governance and monitoring statistics were used to respond quickly to any problems which arose.

- He stated that NSFT was in discussions with the commissioners about a potential bid for transformation funding to assist in the implementation of the strategy. He was keen to ensure the continuity of service and his team were doing everything possible to avoid compulsory redundancies.

9.4 During the discussion with the NSFT staff the following points were noted:

- The Director of Operations at the NSFT clarified that the Trust provided service all hours of every day but through different services at different times. The 24-hour Crisis Support Teams would continue to provide support out-of-hours with a team based in each locality. She noted that referrals could come in via the ambulance service, the police, social care partners, GPs, or others. The Access and Assessment Team would receive referrals and triaged the cases. If the case was deemed to be a crisis situation then it would be handled immediately by the Crisis Support Team. The Access and Assessment service would operate 24 hours a day. The full triage and assessment service would be provided on weekdays, evenings, and Saturday mornings. Outside these hours, triage and 4 hour urgent assessments would be provided and all other referrals would be processed the next working day.

- The Consultant Psychiatrist (access and assessment specialist) explained that the Access and Assessment Team was based across three areas including Suffolk, West/Central Norfolk, and Yarmouth/Waveney. He expected as time went on that this service would be an umbrella service with calls answered centrally from an 0300 number. However, the patients would continue to be seen and assessed locally. It was added that the Suffolk assessment team may be more centrally located in a town such as Stowmarket, and not necessarily in Ipswich. The Consultant Psychiatrist added that the phone calls would be received by qualified staff which included mental health nurses, social workers, and occupational health specialists. These staff would use a triage tool to determine the risk associated with the case, the time frame required for assessment, and the expertise required given the nature of the case. The Chief Executive explained that this proposed service would have two advantages: there would be a good initial assessment and by having a good assessment it took a burden off the service as a whole because fewer assessments were required. He clarified that the Trust directly employed all of the telephone operators.

- It was clarified that a private individual could call the 0300 number but they may be referred to another service if appropriate.

- Members questioned the CCG boundary issues around Thetford. The Chief Executive explained that during the GP fund-holding era, provision of mental health services in Thetford was transferred to Suffolk Mental Health Partnership. This had created significant problems because the Suffolk Trust did not have established links with Norfolk Social Services.

- It was noted that the CCGs in Norfolk and Suffolk were supportive of the transfer of Thetford to the Norfolk model but that this was not necessarily supported by all the Thetford GPs.

- The Director of Operations explained that the original intention had been to align NSFT locality boundaries with the CCG boundaries but the King's Lynn and West Norfolk CCG area only represented 13% of the mental health service user population which meant that the teams based in that locality would not be sufficiently utilised compared to other localities. It was therefore planned to organise the West Norfolk locality to cover 18% of the population so that the area was large enough to warrant the in-patient beds and a 24-hour crisis team.

- Members expressed their concern over the issue that the proposals were based on the current number of patients using the service and not on projected numbers over the next several years. It was noted that the population was set to increase 10-15% and there was an ageing population in these areas. It was noted that there were significant projections for the numbers of cases of dementia and while this was only one mental health issue it was one that would have serious implications for the Trust given the age profile of the Trust's area. The Chief Executive explained that it was not exclusively the Trust's role to examine the projected service users and this was mainly the commissioners' role.

- Members requested further information on the pressures on mental health services throughout Norfolk and Suffolk. This should include a map of hotspots which set out the type of issues in those areas, the current and projected need, and information about the age groups affected such as over 65 years and over 85 years of age. The Medical Director explained that dementia would affect 20% or more of those over 85 years of age. Members felt this figure was too low. It was noted that many people with dementia were being cared for by their families at home and the Trust were not made aware of these cases. They felt that a more holistic approach was needed to keep dementia patients in their communities and close to their families. The Chief Executive acknowledged that under-diagnosis was an issue.

- The Medical Director noted that the Trust only had a limited view from their single organisation. Members noted that the proposed Strategy 2012-2016 was solely from NSFT and commented that a joint commissioner and provider strategy for change would have provided a more strategic and system-wide approach.

- The Medical Director stated that the Trust expected there to be a certain level of funding based on historical demand and that there should be an increase in support for these age groups (over 65s and over 85s). These age groups were a strategic priority.

- The Chief Executive noted that payment by results (PbR) for mental health services, which was an element of Government's policy that was currently delayed, could help to resolve the future funding issues for mental health services.

- The Consultant Psychiatrist (dementia and older people's mental health specialist) noted the NHS Norfolk and Waveney had commissioned a report on population data, district by district, on the projection of the number of dementia cases.

- One of the Consultant Psychiatrists explained that several of the NSFT staff had visited Hull in July 2012 to see their Access and Assessment Service in operation which had been established in 2011. She explained that the service in Hull would readily translate and she was confident that the model would sit well with the services offered in Norfolk and Suffolk. The Chief Executive added that two thirds of Trusts had similar models either in planning or up and running in their areas. He did not feel that the changes being proposed were so radical for this reason.

- One of the Consultant Clinical Psychiatrists said that dementia would increase in both Norfolk and Suffolk and the Trust had been considering a more outward community focussed service which included significant support for carers. Suffolk Wellbeing Service provided services for carers who may have been referred due to depression arising from their roles.

- The Consultant Psychiatrist (dementia and older people's mental health specialist) stated that the Department of Health's publication 'Living well with dementia: A National Dementia Strategy' highlighted that early diagnosis, treatment, and care planning were very important to ensuring the best outcome for patients. It also said that the best place for those with dementia is within their own homes. Admission to a care home was both expensive and not best for the patent. He added that Norfolk and Suffolk were probably more advanced than other areas when it came to building partnerships to tackle issues. He gave the example of The Debenham Project in Suffolk, which was a unique community-led and owned project dedicated to the support of dementia carers and those with dementia they cared for.

- Members pointed out that all of the care homes in Norfolk were private homes. Therefore, they asked how the Trust planned to work in partnership with these private homes. The Chief Executive responded by saying that the Norfolk and Suffolk Dementia Alliance had already commenced training and this training would be provided in private care homes as well. The Consultant Psychiatrist (dementia and older people's mental health specialist) added that the Dementia Intensive Support teams had been going into care homes and helping them manage this condition. There was also a flexible dementia service which provided live-in care to avoid admission to hospital.

- Members asked about the timetable of the proposed changes and the changes in the numbers of bed and the numbers of staff. The Director of Operations stated that the shift in the timetable would affect both of these areas.

- Members questioned the morale of staff and said that staff with low morale were less likely to 'go the extra mile' for their employer and service users. The Chief Executive acknowledged that there was certainly a degree of anxiety however the majority of the 900 responses he had received throughout the consultation period were thoughtful and it was clear that staff took seriously the services they provided and the patients they cared for. He said that from the consultation responses he had received, staff realised that something had to be done and few responses discouraged any changes to the current system. However, there was anxiety around the speed of change, increased levels of risk, and the breaking up of teams of colleagues. He added that the level of staff morale varied between teams and localities. It was noted that he had received letters of support from staff about the changes and that there was excitement for the changes from some staff. The Medical Director agreed that wherever there was a significant reduction in the workforce there would be an impact on staff morale and alongside concerns over their ability to deliver a service there were personal concerns over job security and career development.

- Regarding the levels of anxiety and staff morale it was noted that there was a lack of understanding of the overall model. Staff had to feel they were able to engage in the discussion and it was felt that further work was required to help staff understand the changes and why they were needed.

9.5 During the discussion with the commissioners the following points were noted:

- Members queried the number of children and young people who were using the mental health service and asked whether there was any available funding from the Education budget to support these costs given that these would likely affect their education. The representative from the Norfolk and Waveney Commissioning Support Unit replied that he and his colleagues worked closely with education authorities and they did have a shared agenda but all public services were facing similar financial challenges.

- It was noted that within the Operating Framework Guidance the cost reduction and efficiency information was set out, including the 4% cost reduction.

- The commissioner from the Norfolk and Waveney Commissioning Support Unit felt that Payment by Results (PbR) was a more transparent funding system. He felt that as the population increased it was important for the service to move from a bed-based service to a modern service which enabled more patients to stay at home.

- The commissioner from the Norfolk and Waveney Commissioning Support Unit noted that the health service did negotiate annually for service funding and the highest demand areas were of West Norfolk and North Norfolk. He also noted flatlining of certain mental health conditions and that he would be attending a meeting with the Mental Health Trust the next day where discussions on the funding issues would continue.

- The commissioner from the Norfolk and Waveney Commissioning Support Unit stated that he and colleagues acknowledged that changes needed to take place and they were in favour of the proposals made by the NSFT in respect of the Access and Assessment Service. However they were less confident over the changes to the numbers of beds and required further reassurances on this issue. They supported making a bid to the Transformation Fund and wanted more evidence on the safety of the proposed changes.

- The commissioner from the North Norfolk CCG stated that she and her colleague felt that they were having sufficient engagement with clinicians and that it needed to continue.

- In response to a Member question, the commissioner from the Norfolk and Waveney Commissioning Support Unit replied that the commissioners would not complete separate risk assessments for the services but would scrutinise those prepared following the Trust's assessment.

- In response to a Member question, the Director of Operations of the NSFT responded that currently there were approximately 20 beds available in West Norfolk and this number would be reduced to 14 under the proposals. She added that the waiting list in one area could be assisted by a neighbouring area which was not working at capacity at any given time. The NSFT were currently looking at packages for a single electronic patient record system for Norfolk and Suffolk which would enable this cooperative working and ensure patient records were secure. It would also standardise patient care which should be seen as a positive step.

- In response to a question regarding training, the Consultant Psychiatrist (access and assessment specialist) explained that staff working in triage were all experienced mental health staff and had also attended two days of training by an external provider on issues such as customer care and telephone manner.

- The Consultant Psychiatrist (access and assessment specialist) stated that the proposed Access and Assessment Service would enable patients to access services closer to their place of work if that is easier for them, rather than their place of residence.

- In response to a Member question regarding point 24 of the changes listed in the report, the Director of Operations explained that the Trust would consider whether it was possible to provide more than 20 beds within Great Yarmouth and Waveney Locality within the available financial resources. There was uncertainty about the exact number as this detail was dependent on the design of the unit. It was anticipated that between 22 and 24 beds could be set out at no additional cost depending on the design.

- The Director of Operations made it clear that the new service would be implemented before any previous provision was closed. The previous provision would gradually be used less and this would allow for a gradual transfer to the new provision. If the new arrangements were not working the previous arrangements would not cease.

- The Consultant Psychiatrist (acute/crisis mental health services specialist) stated that there was clear evidence of the estimated needs of the service, including projections for acute bed need. This evidence was based on national research by Giles Glover and research carried out by the Trust in Norfolk. This research included 15,000 referrals, more than 10,000 of these being mental health referrals, and more than 5,000 of people admitted into care over an 8-year time period. He had a high level of confidence in the proposals but this depended on the whole system working together.

(The Chairman adjourned the meeting for a break. The meeting reconvened at 4:00pm.)

9.6 During the discussion with the clinicians the following points were noted:

- The Royal College of Nursing (RNC) Officer for Norfolk and Suffolk explained that services had already changed in Continuing Care Teams in Bury St Edmunds separately from the proposed Service Strategy.

- The RCN Officer for Norfolk and Suffolk said that there were concerns on the reliance on other organisations, which were also under financial pressure, and he said that staff morale could be improved.

- The RCN representative within NSFT stated that nurses had some concerns about the consultation and implementation taking place simultaneously. Some were being required to express preferences for roles within a changing landscape which raised further uncertainty. He also stated were also concerns about the mix of staff and highlighted a need for quality indicators as well as the proposed safety monitoring indicators put forward by NSFT.

- Members questioned what level of staffing would be considered safe. It was noted that national PbR work included quality indicators that NSFT could utilise.

- In relation to developing PbR it was noted that care packages were different in each county.

- The RCN Officer for Norfolk and Suffolk stated that thus far there had been no compulsory redundancies amongst clinical staff in relation to changes proposed in the draft Service Strategy. In response to a Member question about the projected figures for redundancies the RCN Officer from Norfolk and Suffolk's Royal College of Nursing replied that these numbers were not known but he anticipated approximately 300 posts would end over the next few years. He said that several hundred posts had gone through natural turnover, such as retirement or when a staff member left their role. He added that redundancy amongst clinical staff had so far only happened where staff members had felt that course of action was the best choice for them. One of the Consultant Psychiatrists noted that a small team in West Suffolk had disbanded but this was not related to the current proposals being discussed. The Chief Executive added that any compulsory redundancies as a result of the merger of Norfolk and Waveney NHS Foundation Trust and Suffolk Mental Health Partnership were not clinical staff and he confirmed that the Trust had not issued any redundancy notice as a result of the current redesign proposals. However he said that the Trust was currently consulting with some staff regarding possible redundancy.

- In summary the Chief Executive said that NSFT Board had agreed a new change management structure on 8 February 2013. He acknowledged the lessons regarding quality in the Francis report and said that the revised Service Strategy would include indicators to monitor both quality and safety during the change process. There would also be service user evaluations and carer evaluations included.

- The Chief Executive said that the Trust was listening and making necessary changes to its proposed Strategy but noted that this created additional uncertainty. He sought to reassure Members that beds would not be closed until the new proposals were up and running.

- The Consultant Psychiatrist and Member of the Royal College of Psychiatrists said there was no doubt that cutting 20% of funding would have an effect on services and this feeling was evident at a recent consultation meeting attended by the Chief Executive when more than 50 colleagues expressed their serious concerns over the changes. These staff were committed clinicians and were not simply concerned with their jobs. She said that she did not feel that the patients knew what awaited them. If the changes went through she anticipated that her own caseload would double. She said that NSFT had not made the effects of the proposed changes clear to service users.

- The Consultant Psychiatrist and Chair of the Local Negotiating Committee noted that while he agreed that the Trust wanted to genuinely consult with staff on the implementation of change it was clear that the principles of the proposed Service Strategy and the overall structure was not open to consultation. Running a consultation and implementing changes at the same time made this point obvious. He felt that the changes were about cutting costs and were not about improving the quality of mental health services and invited the Trust to have an honest discussion on this premise.

- The Consultant Psychiatrist and Member of the Royal College of Psychiatrists stated that quality in mental health services depended on face-to-face contact between clinicians and patients. As the proposals set out for a one third reduction in staff this equated to a 50% increase in workload for the remaining staff and therefore the quality of the service would reduce.

- The Consultant Psychiatrist and Chair of the Local Negotiating Committee pointed out that within the safety monitoring guidelines for the new proposals, point 9 regarding community safety related to the percentage of service users followed up within 7 days following discharge. While this sounded positive the reality of the situation was that these individuals may be followed up within 7 days but then never seen again, or they may only be seen for a few minutes, or they may be seen by an unqualified support worker. He noted that the safety monitoring guidelines did not monitor quality or outcomes.

- The Consultant Psychiatrist and Chair of the Local Negotiating Committee said he was here today to hold the Trust to account and Members should hold the Government to account for imposed these cuts. The British Medical Association had confirmed that there were no other mental health trusts in the country which were proposing this level of cuts. He asked Members to consider why there were no alternatives.

- Alluding to the Francis report, the Consultant Psychiatrist and Member of the Royal College of Psychiatrists stated that it was obvious for all to see if a patient was left in a soiled bed but mental health patients were at home and problems and risks cannot be seen or acknowledged unless there was sufficient time for clinicians to spend with patients.

- Members asked about the cuts to the clinicians and management staff. The Chief Executive confirmed that there had already been a 25% cut in corporate functions at the Trust. Hertfordshire were currently going through a similar change and they were in the third year of four of their transformation. He noted that many trusts around the country had not been as open at NSFT about their planned changes.

- The Chief Executive said that in relation to medical staffing the Trust was going to rethink senior clinical staffing levels. One of the Consultant Psychiatrists said she believed that the Trust's proposals had possibly gone too far with consultant reductions and would possibly reconsider some of the posts which had been identified to be removed.

9.7 During the discussion with the patient representative the following points were noted:

- The patient representatives acknowledged that there needed to be change due to there not being enough funding and they noted that the Trust and clinicians had been open in their discussions with the Norfolk LINk.

- The patient representatives highlighted that there needed to be further preparation of clinical pathways and that more work should be done with social care and the third sector.

- The patient representatives noted that there had not been much discussion around training and education and that staff and patients would need help to understand the changes.

- The patient representatives said that integration was very patchy and that an equitable service should be provided for everyone. One of the Consultant Psychiatrists replied that the Suffolk social care colleagues had been overwhelmingly positive about integration and had been highlighting issues they wanted management to consider such as problems with children who sexually offend. They felt it was a real opportunity to look at the bigger picture and not just those problems which met diagnostic criteria.

9.8 During the discussion with the voluntary sector representative the following points were noted:

- The representative from the Norfolk MIND organisations, who also spoke on behalf of Suffolk MIND, said that MIND had three roles which included being a critical friend, a stakeholder partner, and a co-deliverer of services. She was pleased to hear that access to services should be improved. She noted that there was great benefit in the co-delivery of services by NSFT and the voluntary sector and felt that MIND could even deliver some of the services currently delivered through the Trust which would make use of their expertise in certain areas. She also noted that there was a need for commissioners to take a stronger lead in the design of the strategy and services overall so that the part to be played by the voluntary sector could be properly considered. She acknowledged the financial pressures facing NSFT and urged the Trust not to retreat inwardly as a result. She also noted the need for transitional funding was for the whole system, not just for NSFT.

- Members questioned whether MIND was withdrawing any services. The representative from the MIND organisations stated that some of their funding had reduced and they have made changes as a result. Central Norfolk and Norwich MIND have implemented a first aid programme where people were trained and supported to form a very strong network.

- Members asked what the ratio of clinicians and non-clinicians was on the Board of Directors of the Trust. The Chief Executive stated that he, and the Finance Director were not clinicians but the Medical Director, the Nursing Director, the Operations Director (Norfolk), the Operations Director (Suffolk) all had clinical backgrounds.

RESOLVED

9.9 To receive a map of Norfolk and Suffolk which identified the mental health hotspots and the types of mental health issues in those specified areas, including current need and projected need of service users, including the over 65s and over 85s.

9.10 To invite Julian Housing to contribute to the next meeting of the Joint Committee.

9.11 To receive a list of services co-provided by MIND at the next meeting.

10. Future meeting date

RESOLVED

10.1 To hold the next meeting of the Joint Committee at 1:00pm on Tuesday 12 March 2013 at Suffolk County Council headquarters in Ipswich.

The meeting closed at 5:20pm.

IN TRAN
communication for all

If you need this document in large print, audio, Braille, alternative format or in a different language please contact Kristen Jones on 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Norfolk and Suffolk Joint Scrutiny Committee on Radical Redesign of Mental Health Services
12 March 2013
Item no 5

Radical redesign of mental health services in Norfolk and Suffolk

The Joint Committee will receive further information and evidence from witnesses and from Norfolk and Suffolk NHS Foundation Trust (NSFT).

1. Service user, carer and public views

1.1. Submissions from carers of service users are included for the Joint Committee's information at Appendix A and B.

1.2 Suffolk LINk has been invited to give views at the meeting on behalf of the public and service users.

1.3 The Joint Committee may wish to invite Norfolk and Suffolk NHS Foundation Trust (NSFT) to comment on these views.

2. Staff views

2.1 The NSFT branch of Unison has submitted the paper at Appendix C (*to follow)* giving staff views on the effects on patients of the Trust's proposed Service Strategy and a representative has been invited to present staff views at the meeting.

2.2 The Joint Committee may wish to invite NSFT to comment on these views.

3. Housing support partner's views

3.1 Julian Support Ltd provides outreach, supported housing and health and wellbeing services and works with NSFT to help service users maintain independent living or to provide other housing solutions to meet their needs in Norfolk and Suffolk. A representative of Julian Support Ltd has been invited to give views at the meeting.

4. Adult and children's social care

4.1 Norfolk adult social care and children's social care departments were invited to submit views to the Joint Committee and have provided the papers at Appendix D and E respectively.

The Joint Committee may wish to ask NSFT to address the points made in these submissions.

4.2 Representatives from Suffolk adult and children's social care have been invited to the meeting to inform the Joint Committee about their level of involvement in helping to shape NSFT's proposed Service Strategy 2012 – 2016 and their views on the proposed changes.

5. Commissioners

5.1 A representative from the Suffolk Clinical Commissioning Groups, has been invited to give the Suffolk mental health service commissioners' views.

5.2 A representative of the NHS Commissioning Board East Anglia has been invited to the meeting to answer questions about the bid for Transformation funding to support legitimate double running costs to ensure safe implementation of the proposed changes.

6. Future needs assessment data

6.1 At the last meeting the Joint Committee heard that NSFT's Service Strategy 2012 – 2016 is based on 2011-12 service user numbers but that the new structure allowed services to be expanded should commissioners decide to make available more funding. The joint committee asked to see statistical information on projected level of need for mental health services in Norfolk and Suffolk during the life of the Service Strategy.

6.2 Public Health in Norfolk is currently preparing an NHS Norfolk and Waveney Mental Health Needs Assessment 2013, which will be complete within the next few weeks. A Summary document is attached at Appendix F. Chapter 4 deals with the Projecting Adult Needs and Service Information System. The full Summary gives the Joint Committee an indication of the broad scope of information that is currently available in draft form to the Norfolk and Waveney commissioners and will shortly be finalised.

6.3 The chapter from the forthcoming NHS Norfolk and Waveney Mental Health Needs Assessment 2013 document that deals with dementia needs is included at Appendix G for the Joint Committee's information.

6.4 Public Health in Suffolk has provided the Child and Adolescent Mental Health Services (CAMHS) Needs Assessment 2013 (Appendix H). An adult mental health need assessment for Suffolk has not been completed but NHS Norfolk and Waveney public health officers have linked with NHS Suffolk colleagues and plan to work collaboratively in future across the two counties.

7. NSFT - further information

7.1 As requested at the first meeting of the Joint Committee on 11 February 2013, NSFT has provided the following information:-

Appendix I

- Updated Service Strategy 2012-16
- Details of the addition of quality indicators to the safety monitoring indicators
- Changes made as a result of the staff consultation
- Revised implementation timetable
- Updated bed impact plan
- Updated impact on wte posts by band and within services *(Changes to medical staffing numbers to follow)*
- A summary of the clinical case for change in each service, including statistical info where appropriate.
- Full details of the financial basis for and implications of the Strategy, i.e. current expenditure in services, predicted cost pressures, predicted level of income, the amounts of savings that the cost saving assumptions are expected to deliver within each service, the percentage of saving within each service *(To follow)*
- Updated service capacity plan, showing the numbers of patients / service users currently served and how the numbers are to be served within each service in the new structure (also showing the age ranges to which services are applicable under the service line headings)
- Risk assessment *(To follow)*
- Update on progress of the bid to the Transformation Fund
- A timetable for the consultations on specific service changes
- A list of the services co-delivered with Mind and other third sector providers.

Representatives of NSFT will be available to answer Members' questions.

To the Chairman

Joint Health Overview and Scrutiny Committee for Norfolk and Suffolk

Redesign of the Mental Health Service in Norfolk and Suffolk

28 February 2013

Dear Chairman,

I am a carer for a SU with an acute mental health condition who has been in the care of the NSF Trust for fifteen years. Formerly, I served on the Patient and Public Involvement Forum, and Local Involvement Network. Since its inception, I have served intermittently as Chair of the Trust's Norfolk Carers' Council. I served for three years as a governor of the NWF Trust. I consult with SUs and carers on a regular basis. I have been involved in strategic planning and on operational boards on a voluntary basis in the Trust for ten years.

My comments will presently be concerned with the second of the points HOSC is considering:

The impact of the proposals on patient and carer experience and outcomes and on their health and well-being.

I have attended all the stakeholder events involving SUs and carers, listed in the report of the NWFT: (Revised Strategy 2012/13-2015/16, and summary of changes in response to staff consultation, (2.0)).

Also, I have attended all of the Carer Focus Groups organised by the Trust, specific to different aspects of the proposed service which so far have comprised Dementia, Single Point of Access, Bed Management and Adult Community. Focus groups on Wellbeing, Early Intervention, Personality Disorder, Adult Acute, CAMS and Young people, are yet to be scheduled. With the exception of Dementia, these meetings have been poorly attended, some un-chaired and one not minuted! I have been the only carer present at all of them.

In my opinion, in Norfolk, the Trust offers SUs and carers opportunity to comment on the new design proposals for mental health services. However, few people have the time or knowledge and understanding to contribute effectively to the process of redesigning a mental health service which reflects the needs and preferences of SUs their families, carers and society in general. As yet, I have no evidence that the comments made so far by SUs and carers are effecting changes to the evolving strategy. The framework for the redesign was designed with scant input from SUs and carers, with the exception of the Dementia Pathway where carers were integral to the design from its inception. Generally, plans are presented to users for comment

after decisions have been made and implementation of aspects of the redesign have already commenced!

It is difficult for SUs and carers to comprehend both the detail, (such as is available), and the impact of how the redistribution of human and financial resources between the 22 care clusters will affect the service they receive.

Due to carer involvement, lagging behind implementation, at present my comments are limited:

Adult Community

I am concerned about the effect of reductions in staffing levels, even if this is presented as natural attrition over several years. SUs and carers depend upon and are anxious to retain and increase the level of support offered by skilled, clinically trained Outreach Teams. Research supports the view that SUs 'recover' faster after psychotic interludes living with support in the community. It takes years of sustained individual monitoring and therapeutic intervention to help the majority of SUs gain an insight into acute conditions, to find their own level of coping mechanisms and to remain independently medication compliant. Outreach teams support SUs living in the community to achieve this end and from my experience keep people out of the hospital beds that in the future will not be available. (In a recent national survey published by RETHINK, cited in the recent Commission on Schizophrenia, the staff group whose input was rated most highly by SUs with psychosis/schizophrenia was community mental health nurses.)

The Trust states it will train and develop its staff to ensure they have the skills and competencies to deliver the service strategies. Where is the funding for this coming from? How many staff members are receiving funding to extend experience and improve qualifications? Fewer higher band staff will equate to less in-service training.

Mental Health Services are no longer hospital based. The majority of the Trust's SUs, already live in the community. These people are vulnerable, living in less than salubrious homes, often frightened to go out and mix with a society that misunderstands and rejects them. Treatment for these people consists largely of medication resulting in side effects which often render the user incapable of leading satisfying, rewarding lives. The RETHINK Commission asks why the integrated therapies that work so well in early intervention are not being offered to people throughout the course of their illness.

Carers of people may have their own lives curtailed by the need to be available, at a moment's notice, during periods of crisis. Carer assessments do not generally result in significant help for carers. In the RPR Strategy document 22 October, 2012, it

states that ‘a range of carer support services...’ are available for carers from the Trust. I am not aware of what these services comprise, nor of their availability.

As a carer, I am concerned about the risks around commissioning beds from organisations that are not staffed by NHS trained mental health clinicians. I question where accountability lies between the Trust, GPs and non-NHS services. Who is accountable for the safety of the SU living in the community? How are outside agencies to be trained, assessed and monitored?

Wellbeing Service

The Trust’s strategy states that there will be an ‘emphasis on prevention, early intervention, well-being and recovery’ - which is commendable.

The Trust states it will ‘...broaden access to Wellbeing services – IAPT...’. However, to my knowledge, this service is a government initiative, aimed at treating mild depression and anxiety delivered in primary care with CBT. It is not available to SUs in the acute secondary service. Moreover, training required to offer psychological therapy for acute conditions is at a different level. This academic session, funded by the Trust, ten people are being trained at UEA to deliver CBT in the Wellbeing Service. The only nurse working in secondary care who was entered on this CBT Diploma Course had her funding withdrawn two days before commencement! Such is her commitment, she is funding herself.

From my understanding, a saving of 33 percent is to be made from the Adult Community and Adult Acute clusters. I am concerned resources saved by closing hospital beds are being disproportionately assigned to Wellbeing and Early Intervention. To my knowledge, the introduction of IAPT has not benefitted those in secondary care.

NICE guidelines

The Trust states that ‘services will be delivered in line with NICE guidelines’. NICE guidelines recommend the use of CBT in the treatment of schizophrenia. However the recent RETHINK Commission on Schizophrenia states that only 1 in 10 who would benefit from psychological therapy interventions receive them. There has never been sufficient accessibility to a range of psychological therapies available for SUs of the Trust. This deficit in the quality of the Trust’s services has been long recognised. When will a range of psychological therapies be accessible to all SUs?

Financial resources are being focussed on Early Intervention and prevention. How will the recommendation published in the Trust’s Service Governance Report (8 January, 2013’, that ‘...PBR and clustering will provide a more consistent approach

to care packages and service delivery of psychological therapies...' be implemented? How will this quality goal be achieved equitably for people with schizophrenia psychosis across the care clusters?

General comments

It was worrying to hear at the last HOSC meeting, representation from clinicians, expressing the view that '...a reduction in medical and clinical staff will diminish the quality of care.' As it stands, quality of care is already perceived by SUs and carers as lacking.

The description (3.4) page 14 of the NSFT's Radical Pathway Design Proposal, 22 October, 2012, Adult Pathway, promises, '...an ethos of empowering people to actively take steps to improve their own wellbeing...', including '...access to psychosocial, psychological and practical approaches to mental wellbeing from practical resources to help with debt, housing, employment as well as access to psychological therapies and work with community resources.' This aspect of recovery has been fugitive in the past. It is difficult to envisage a halcyon future on a radically reduced budget. The initiative of ImROC and the concept of a Recovery College will not benefit those people who find it difficult to engage. Less access to psychiatrists and other skilled, trained medical and social care specialists will increase risk of self neglect, isolation and non-compliance in taking medication.

My main concern is the apparent apathy of the general public. Despite the Trust's attempts to involve people, most members of the public, service users and carers are unaware of the redesign and the impact this will have on their lives. There is a robust Trust SU Council, but the majority of SUs living in the community are lonely, vulnerable people who find it difficult to function socially and take the initiative to assert their needs.

I am extremely concerned that the increasing numbers of SUs and carers, managing severe mental health conditions in the community, are represented by a suitably informed person on the forthcoming Healthwatch Board. From my experience, in such organisations, there is often an emphasis on the physically disabled and older people. Organisations monitoring the progress of the redesign of mental health services need to delve beneath ethos and strategy documents into the detail of the individual clusters and pathways to ensure services are upholding and delivering NHS constitutional principles.

The Trust intends to set up disparate SU and Carer groups throughout localities with the intention of feeding representative views to the Boards of Governors and Directors. Norfolk and Suffolk have different service models, and organising this model of SU/carer representation will be unnecessarily expensive and, in my opinion, and that of others, dilute SU/carer involvement. Furthermore, the few

members of the Foundation Trust and public who attend Board of Governors' and Directors' meetings will be reluctant to travel around the counties to contribute their views directly. This puts the onus on the Trust of representing SU and carer views second hand. This process is subject to interpretation and misinterpretation.

In conclusion, I have heard the lack of flesh on the bones of the redesign as it presently stands described as 'a leap of faith' and, more than once, an analogy drawn of 'a journey on the Titanic without a lifeboat'. It is to be hoped the captains on board, crew and passengers will together guide the redesign safely around all icebergs!

Sheila Preston

28 February 2013

The Chairman
Joint Norfolk and Suffolk Health Overview and Scrutiny Committee
Norfolk County Council
County Hall
Martineau Lane
Norwich
Norfolk NR1 2DH

13th February 2013

Dear Sir,
I recently attended the first meeting of the Committee, deliberating the proposed changes to Mental Health provision within Norfolk and Suffolk. As the parent of a young person who has been (wonderfully) cared for by CAMHS over the last three years, I am deeply concerned by the proposed changes, and have had several conversations with clinicians within CAMHS who are both distressed and dismayed by some of the proposed changes. I have written to Aiden Thomas about my concerns, and had the opportunity to talk to him prior to the Committee meeting.

I would like to bring my concerns to the attention of the Committee, and have therefore provided copies of my letters to Mr. Thomas. I hope that you will share them with the Committee and perhaps raise some of the issues with Mr. Thomas and his team at the next Committee meeting.

Yours sincerely,

[redacted]

Aidan Thomas, Chief Executive

Norfolk and Suffolk NHS Foundation Trust
Hellesdon Hospital
Drayton High Road,
Norwich NR6 5BE

13th February 2013

Dear Mr Thomas,

It was a pleasure to make your acquaintance at the Joint Scrutiny Committee hearing last Monday. I was gratified to hear there had been such a large response to the consultations on the proposed changes to the Mental Health Services, that my own letter had not gone unheeded, and that the Trust was responding to the consultation and making modifications to the "Radical Redesign". The hearing itself was also interesting, on many levels, both in terms of what was said and what was not aired. Of particular concern to me was the deep division evident between the management side of the Trust and the clinicians who actually deliver the services. The reforms are heavily billed as "Clinician-led", but from the evidence given at the meeting, that obviously did not include the clinicians at the sharp end of the process under review.
Having had a couple of days to consider our conversation and the proceedings of the meeting, and in the absence of any information on the modifications to the strategy, I am afraid that I remain unconvinced by the Trust's assertions that the Mental Health Services will not be damaged by the proposed changes, at least in some aspects.
In the spirit of constructive criticism, I would like to offer the following thoughts.

The discussions at the meeting emphasised the diversity of need that the Service seeks to address, from child depression through psychosis to ageing and dementia. I have approached this debate from the perspective of child mental health, but the extensive discussions around dementias made me realise how broad the scope of the service really is. This in turn has increased my anxiety about the new proposed structures. I have never yet seen a successful system that derives from a "one-size fits all" process, and the more diverse the need, the more this applies. For instance, an elderly person suffering from dementia is not much of a clinical puzzle, and a triage process such as you have outlined makes perfect sense, finding the most appropriate support, be it clinical or social. Once diagnosed there is no cure to be found and a process of management of the patients needs is all that is required (not that that is trivial, I understand). In contrast, a young person presenting with a mental health problem, be it anorexia, depression or self-harm is often a serious enigma, requiring intensive expert assessment to define the problem, let alone seek to redress it. Young people often neither understand their own needs nor have the capacity to express their issues accurately. It therefore needs early intervention at a very high level if there is to be a positive outcome. It also should be said that an inadequate intervention in the case of a child or adolescent can have repercussions for both the individual and for society over a great many years. There is therefore a very strong argument for front-loading CAMH with consultant level staff, as the cost-benefits taken over the lifetime of the patient has to favour such resourcing.

On the general principles of the triage system that you are proposing, I heard very little about the process of recruiting and training the frontline staff who will make the decisions as to the most appropriate path to direct a referral down. As I have intimated above, I think that such a system is inherently incapable of determining appropriate intervention in the case of CAMH, but even as a general principle such a system can very easily become not a facilitator but a barrier to those seeking help. As I have mentioned previously, even for well educated and

assertive parents, being faced with an inadequate and uninformative "professional" at a time when you are desperately concerned for the welfare of a child is a deeply dispiriting and depressing experience. Erecting such barriers may well have a positive impact on the overall costs of the service, and such a system can be massaged easily to produce flattering metrics, but at a huge cost to the quality of care that is available to those in need.

Finally, I would urge you to enter into more extensive and open discussions with the clinical staff who are delivering the services at present, and take on board their concerns. I know you are probably a very busy man, but in managing change in complex systems I have found it useful to shadow key people for a couple of days, to see first hand the pressures that they operate under and the stresses in the system. It might not ultimately change your mind, but would at least go some way to assuring those under threat that their concerns were being taken seriously.

I trust that you will feed this letter back into your consultation forum, as with the first. I will also send copies of both to the Chairman of the Scrutiny Committee, to make my concerns known in that forum.

Yours faithfully,

[redacted]

[redacted]

Aidan Thomas, Chief Executive
Maggie Wheeler, Chair

Norfolk and Suffolk NHS Foundation Trust
Hellesdon Hospital
Drayton High Road,
Norwich NR6 5BE

15th December 2012

Dear Mr Thomas and Ms Wheeler,

We are writing to express our concerns about proposed plans within the Norfolk and Suffolk Foundation Trust for changes to mental-health provision in Norfolk. As we understand the situation, proposals are in hand to make cutbacks in Consultant Psychiatrists and other highly qualified professionals and replace them with less qualified or inexperienced staff. To our knowledge the Norfolk and Suffolk Trust is the only Mental Health Trust in England and Wales proposing to make such cutbacks at this time. The proposal flies in the face of all current evidence as to the optimal effectiveness of frontline services. Nowhere in the N.I.C.E. guidelines does it mention increasing numbers of inexperienced staff at the expense of experienced practitioners. Indeed, the Acute Trust at NNUH is presently frontloading its experienced staff in paediatric assessment units in order to optimise the service that unit provides. Your own Strategic Plan contains the statement "We will support and enable people with mental health problems or who need to improve their wellbeing, to live a fulfilling life, and, where possible, recover" as a Key Priority. We would ask how this statement can be aligned with a proposal that will significantly erode the capabilities of an essential and genuinely valuable service. We are sure that the irony of the proposals that are under consideration are not lost on you, in light of the Strategy Document and indeed the Trust's strapline.

As the parents of a child with Asperger's Syndrome, we have first hand experience of the issues that can arise when faced with poorly trained or under-confident practitioners being placed in a position of first-line service provision. Our first contact with the Trust's mental health service involved a non-clinically trained worker who was uninformative, defensive and obviously out of her depth; the whole experience was profoundly frustrating, depressing and disheartening. It cannot be stressed too highly what a difficult, distressing and frightening experience it is for a parent to see one's child suffer from mental health issues. Faced with a purported professional who neither fully understood the clinical condition that she was faced with, or indeed the potential therapeutic regimes or services that could be offered, we as parents were left confused and disheartened that the huge problems we were facing could be dealt with or even addressed. It was only at the point that a Consultant Psychiatrist became involved in our case that we felt any degree of confidence that we were being properly listened to and that our child's condition was being credibly addressed. From that point on, the care and understanding we have received, and the service to us as parents and to our child as a patient, has been absolutely exemplary. All the clinical professionals we have dealt with have been universally superb in their knowledge, demeanour and willingness to assist. We feel that we have, in effect, been given our child back, and we are profoundly grateful. It is therefore doubly concerning for us to find out that the service that has been of such value to us is under threat. We can say with some confidence that if the unqualified professional had been our sole recourse in this situation the outcome for us could have been profoundly different.

Failure to properly address, and properly resource the treatment of children with mental health issues is an unforgivable policy. It can only store up significant further problems for

individuals later on in life, and for society, bringing a huge downstream burden to both community and acute care provision. The policy therefore represents a substantial false economy, and I hope you'll take this opportunity to think carefully about the situation and reconsider the proposed course of action. We fully appreciate the budgetary pressures being placed on the NHS across the country, and the lack of sophistication in the calculations of NHS spending mean that it is all too easy for individual bodies to make "savings" in their own budgets at the expense of increased costs to other services in the future. This is clearly such a situation, and we hope that the Trust will have the courage to make the right choice, rather than the expedient one.

Yours sincerely,

Dear Maureen

Adult Community Services response to the NSFT Trust Service Strategy for the joint Health Overview and Scrutiny Committee – March 12th 2013

Thank you for the opportunity to respond to the question raised by the joint Norfolk and Suffolk HOSC, 'whether Adult Social Care have been involved in developing the draft strategy with NSFT and any views about it that you may wish the joint committee to consider?'.

Adult Social Care and NSFT work closely together as joint providers and as joint commissioners of services and as such have a very close working relationship. During 2012/13 Norfolk and Suffolk NHS Foundation Trust have undertaken a wide range of events to discuss proposed changes to the provision and delivery of mental health services in Norfolk and Suffolk over the forthcoming years. The strategy covers the period 2012/16 with proposed changes occurring in different aspects of service over the 4 year period.

NSFT have made it clear that the strategy is to achieve a savings target over the 4 year period of 20%. This target was issued in the NHS Commissioning Board guidance 'Everyone Counts::Planning for Patients 2013/14' (December 2012) which states "The national provider efficiency requirement for 2013/14 tariff setting is 4 per cent". The indicated 5% per annum cost saving is based 4% being an underestimate of the cost savings required to ensure that all cost pressures are met.

This is a national provider cost efficiency challenge that is relevant for all NHS provider Trusts. The changes that take place as a part of this redesign and savings challenge should not see a reduction on activity and the achievement of good patients' outcomes should not be reduced.

Representatives have attended the open stakeholder events and commented at these events on views about how the strategy should be developed outlined concerns.

Written and e-mailed submissions have been forwarded to NSFT

The areas of concern that have been outlined are as follows:

- The potential of patient's pathways changing for older people with organic or functional mental health problems who require in-patient admission. This specifically relates to the proposals for East and West Norfolk and the disconnect that this will create for families and the adjustments required in the provision of adult social care for these patients
- The movement of focus on community based service provision as opposed to in-patient and the increasing pressures that may be experienced by Adult Social Care as a result of this movement
- The increased pressures that are being experienced currently on adult acute bed provision and the usage of beds out of area to meet the needs of patients. This creates disconnect for families and makes the process of repatriation to Norfolk and the arrangement of care planning for community provision much more difficult

- Increased pressures and risk on the Approved Mental Health Practitioner system because of the Adult Acute bed redesign process and the need to ensure that patient access to bed provision can take place seamlessly
- Potential increased demand and cost shift to Adult Social Care because of avoidance of admission of patients
- System concern that if difficulties with East Anglian Ambulance Trust issues of conveyance are not addressed then this creates more delay for the patient, in terms of treatment but also creates increased demand and pressure on other services
- The need for good pathways of joint working between the Access and Assessment Team/ the Emergency Duty team and the Health 111 system
- Differential age ranges for services between the two organisations
- No coterminous alignment of geographical boundaries

Overall Norfolk Adult Community Services are committed to maintaining the joint working partnership with NSFT to ensure that clients receive a fully integrated service provision

Yours sincerely

Harold Bodmer

Mental health scrutiny - joint Norfolk & Suffolk committee

Norfolk County Council (NCC) Children's Services was asked to write a short briefing for the joint committee on whether it had been involved in developing the draft strategy with NSFT and any views about it that we may wish the joint committee to consider.

This briefing focuses on the parts of NSFT's strategic documents that relate to Child and Adolescent Mental Health Services (CAMHS).

Lead commissioning responsibility for NSFT's CAMHS lies with NHS commissioning bodies. However, NCC Children's Services works closely with both the Trust and the NHS commissioning bodies, primarily under the auspices of Norfolk's CAMHS Strategic Partnership. NCC Children's Services also hosts two joint planning and commissioning posts – posts that work on behalf of the CAMHS Strategic Partnership and CAMHS Joint Commissioning Group.

To date NCC Children's Services has received helpful, but mostly high level information outlining the overall direction of travel proposed for NSFT's CAMHS provision. We await with interest the detail behind the initial high level proposals. Once that is received we would be happy to provide detailed feedback regarding the proposals and any suggested refinements that could help to enhance care pathways for children and young people.

As a member of Norfolk's CAMHS Strategic Partnership, NSFT is welcome to share any detail (including in draft form) with the two CAMHS joint planning and commissioning postholders that we host – Jonathan Stanley and Julia Haig. Jonathan and Julia would be delighted to act as critical friends to the Trust as it moves to the next level of detailed plans and proposals.

Additionally, we have identified four particular themes/questions (prompted by the early NSFT papers/strategy) that we would ask members to consider putting to colleagues from NSFT. They are as follows:

1. **LAAC (Looked After and Adopted Children) CAMHS pathways/teams** – In Norfolk there are currently 2 discreet LAAC CAMHS teams. Please can you elaborate on what the service offer will be across Norfolk for LAAC and those who work with and support them – particularly any significant changes that are proposed?

2. **Consistency of pathways across Norfolk (and Suffolk)** – There is some significant variation in terms of inclusion and exclusion criteria between the existing CAMHS teams based in Norwich, King's Lynn & Great Yarmouth, as well as between the Norfolk and Suffolk based CAMHS. Will the new proposals ensure there is equity of access for children and young people across the whole of Norfolk (and Suffolk) – in terms of the age range served and pathways available?
   If significant variation remains in place (either within Norfolk or between Norfolk and Suffolk), it could cause difficulties, confusion and frustration

for residents/patients and for referrers - who may find it hard to understand why a different service offer is available in one area compared to another.

3. **Provision for Thetford patients/residents** is currently provided by the CAMHS team based in Bury St Edmunds. That team currently works to inclusion and exclusion criteria that are different to those applied to the rest of Norfolk. Please can you explain whether/how the radical pathway re-design work will eradicate the current differences/variation in pathways offered to Norfolk (and Suffolk) patients/residents?

4. **Pathways for young adults with ADHD** - Will the re-design work eradicate the current gap in continuing treatment & care for those patients with an ADHD diagnosis who are on long-term medication? Currently, when they reach the age of 18 some of them with a continuing need for treatment (including medication) may not routinely find their way into adult mental health services and therefore may struggle to receive continuing treatment for their ADHD. Is this a scenario that will be consigned to history by the proposed new Young Adult pathways?

Mental Health Needs Assessment

2013

NHS Norfolk and Waveney, Public Health

SUMMARY

Dr Kadhim Alabady, Principal Epidemiologist

Linda Hillman, Public Health Consultant

Clive Rennie, Mental Health commissioning Lead

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Executive Summary

Mental illness affects people in all ages and stages of life, across society, impacting upon family life, friends and relationships, education, finding work, working, caring for others, leisure pursuits and retirement, as well as the impacts purely characteristic of the disorder.

The severity, duration and impact of mental illness varies hugely, and so prevalence data alone for the various disorders will not provide all of the information required to estimate medical and social care needs, or the extra considerations for education, employment, acceptance, understanding and accommodation by society plus the reasonable adjustments that are required for routine services for people who suffer with mental illness. All services need to be flexible so that they can be tailored to the circumstances of individuals.

The data and datasets set out and explored here will contribute to a wider assessment of population-based need which also requires discussion with commissioners, service providers, patients, carers and others to:

- Evaluate existing services,
- Understand capacity and pathways, in relation to evidence of best practice,
- Understand patient perspectives and
- Take account views of patients and their carers on different aspects of care and support.

Where possible we have compared local data to national or regional figures; it will also be useful to compare with situations and services and pathways in other parts of the country, to understand whether our patients and clients get care that is equitable.

Processes of needs assessments are on-going, lead by public health and the Mental Health Programme Board of NHS Norfolk and Waveney whose leadership is transferring to the Clinical Commissioning Groups, linking with the Joint Strategic Needs Assessments of Norfolk and Suffolk, From April 2013.

Aim

The aims of the mental health needs assessment are:

- To gather information to plan, negotiate and change services for the better and to improve health in other ways.
- To build a picture of current services, i.e. a baseline.
- Why might services need changing for the better?

Objectives

The objectives of the mental health needs assessment are:

Planning:
The main objective of mental health needs assessment is to help decide what services are required i.e. for how many people, the effectiveness of these services, the benefits that will be expected, and at what cost.

Intelligence:
Provide a baseline of current picture of mental health in Norfolk and Waveney which can than be used to measure the impact of interventions or service development.

Equity:
Reduce health inequalities through early identification and improving the spatial allocation of resources between and within different groups.

Efficiency:
Having assessed needs, measuring whether or not resources have been appropriately directed i.e. Do those who need a service get it? Do those who get a service need it? This is related to audit.

Involvement of stakeholders:
Conducting out the mental health needs assessment can stimulate the involvement and ownership of the various stakeholders in the process.

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- Robert Mouland, Principal Business Intelligence Analyst
- Selina Hockley, Business Intelligence Analyst
- All those in partner organisations who provided data and information for this report

Sources of Data:

- NHS Information Centre (**IC**)
  http://nww.indicators.ic.nhs.uk/webview/
- Eastern Region Public Health Observatory (**ERPHO**)
  http://www.erpho.org.uk/
- Department of Health (**DH**)
  http://www.dh.gov.uk/
- Norfolk Insight
  http://www.norfolkinsight.org.uk/
- Office for National Statistics (**ONS**)
  http://www.statistics.gov.uk/
- Quality and Outcomes Framework (**QOF**) data
  http://www.qof.ic.nhs.uk/
- Projecting Adult Needs and Service Information (**PANSI**)
  http://www.pansi.org.uk/
- Projecting Older People Population Information (**POPPI**)
  http://www.poppi.org.uk/
- Departments for Work and Pensions (**DWP**)
  http://83.244.183.180/NESS/BEN/iben.htm
- NHS Norfolk and Waveney Business Intelligence (**BI**)
  http://www.norfolk.nhs.uk/
- Open Exeter
  https://nww.openexeter.nhs.uk/nhsia/index.jsp
- Mental Health Minimum Dataset (**MHMDS**)
  http://www.mhmdsonline.ic.nhs.uk/
- North East Public Health Observatory (**NEPHO**)
  http://www.nepho.org.uk/
- Yorkshire and Humber Public Health Observatory (**YHPHO**)
  http://www.yhpho.org.uk/default.aspx?RID=49488
- Dementia Partnerships (**Dementia Prevalence Calculator**)
  http://www.dementiapartnerships.org.uk/diagnosis/dementia-prevalence-calculator/

International Classification of Diseases: classification used[1]

Disease or medical Condition	ICD 10 code
Dementia	F00-F03
Other organic, including symptomatic, mental disorders	F04-F09
Psychoactive substance abuse	F10-F19
Schizophrenia, schizotypal & delusional disorders	F20-F29
Mood disorders	F30-F39
Neurotic, stress-related & somotoform disorders	F40-F48
Behavioural syndromes	F50-F59
Disorders of adult personality & behaviour	F60-F69
Mental retardation	F70-F79
Disorders of psychological development	F80-F89
Behavioural/emotional disorders – usual child/teen onset	F90-F98
Suicide	X60-X84
Undetermined injury (included within boarder definition of suicide)	Y10-Y34 excluding Y33.9

[1] The International Classification of Diseases (ICD 10) classifies some conditions in the mental and behavioural disorders section. However, suicide and undetermined injury are found within another section dealing with external causes of deaths.

What is health needs assessment?[2]

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.

- Is a recommended public health tool to provide evidence about a population on which to plan services and address health inequalities.
- Provides an opportunity to engage with specific populations and enable them to contribute to targeted service planning and resource allocation.
- Provides an opportunity for cross - sectoral partnership working and developing creative and effective interventions.

Potential benefits subsequent to undertaking Health needs assessment are:

- Strengthened community involvement in decision making.
- Improved team and partnership working.
- Professional development of skills and experience.
- Improved communication with other agencies and the public.
- Better use of resources.

The challenges of undertaking a Health needs assessment include:

Working across professional boundaries that prevent information-sharing

- Developing a shared language between sectors.
- Obtaining commitment from 'the top'.
- Accessing relevant data.
- Accessing the target population.
- Maintaining team impetus and commitment.
- Translating findings into effective action.

It is important to acknowledge these challenges.

Approaches to Health Needs Assessment are:

- Epidemiological- which focuses on the quantitative needs of the population in line with the available evidence base;
- Comparative- which compares services available locally with those in other areas of the country;
- Corporate which is based on the views of interest groups including health organisations, health professionals, politicians, the media, users and carers;
- Participatory Appraisal which seeks to incorporate the values of the wider community in setting priorities.

This report focuses on the epidemiological approach using currently available data.

[2] National Institute for Health and Clinical Excellence 2005, Health needs assessment: A practical guide http://www.nice.org.uk/media/150/35/Health_Needs_Assessment_A_Practical_Guide.pdf

Key findings:

Chapter I (Data from General Medical Practice Quality and Outcomes Framework, plus data on incapacity benefit)

- The rate of diagnosed severe mental illness on GP QOF registers across Norfolk and Waveney is eight per thousand (0.8% of all ages), similar to the England average, but higher than for the East of England. Highest rates are recorded in Norwich, and lowest in South and West Norfolk. There are large variations between individual practices.

- The proportion of the local practice populations diagnosed with dementia is greater across Norfolk and Waveney at six per thousand, than seen either nationally or at regional level. There is variation between areas and also between practices.

- In February 2012, there were 10,595 people claiming incapacity benefit across Norfolk and Waveney due to mental illness, 44.7% of all claimants and a rate of 1.9% of working age adults. Norwich had the highest rates, followed by Great Yarmouth and North Norfolk. Data on the top ten highest and lowest wards are available.

Chapter 2 (Estimated rates of mental illness across Norfolk and Waveney by applying survey data)

Adults

The most recent population estimates of mental disorders among adults aged 16 - 74 (based on the report of the Adult Psychiatric Morbidity Survey in England, 2007) are:

In the past week

- Common mental disorders, 16.2%.
- Two or more psychotic disorders, 7.2%.
- Post traumatic stress disorder, 3%.

Over the previous year

- Suicidal thoughts, 4.3%
- Made a suicide attempt, seven per thousand.
- Personality disorder: four per thousand.
- Antisocial behavior: three per thousand.

- For any neurotic disorder, prevalence is over 13% of men and nearly 20% of women, translating to 48,300 men and nearly 70,000 women in Norfolk and Waveney, over 118,000 in all. Common mental health disorders can result in sleep problems, fatigue, irritability and worry.

- For personality disorder, we calculate that there are about 31,500 adult sufferers across Norfolk and Waveney.

- For severe mental illness, we have calculated about 3,000 people to be affected.

- For adults with autistic spectrum disorder, we have used data from our previous work in 2012[3]; assuming 1% adults aged 16 - 64 were affected, there were just over 5,000 cases in 2011, about four fifths being male.

Children

- The most recent population prevalence estimates of mental disorders in children aged 5 - 15 years were calculated from a national survey conducted in 2004. Applied to the population of NHS Norfolk and Waveney in 2010/11, about 12,000 children would have been affected with conditions ranging from anxiety and depression, conduct disorders and hyperkinetic disorder, to the less common ones including autistic spectrum disorder, tic disorders, eating disorders and mutism.

- For Attention-Deficit Hyperactivity Disorder (ADHD), prevalence in school children is 3 - 5%: 5,209 – 8,682 children in Norfolk and Waveney.

- For Autistic Spectrum disorder, there may be 1,248 children to age 19, exceeding the estimates for 'classic' autism alone, which would that between 73 and 150 children would be affected.

Eating disorders

For eating disorders, we applied prevalences estimated by the third sector organisations, MIND and BEAT, to the populations of Norfolk and Waveney.

- For anorexia nervosa, among young women aged 15 - 30, we estimated 860 sufferers, and across all sexes and ages, 108 new cases per year.

- For bulimia, we estimated 177 new cases per year.

- For an eating disorder 'not otherwise specified', a much higher proportion of people are affected, accounting for 50% of people who present for treatment, but up to 6%, 59,000 people, in our population.

[3] http://www.norfolkinsight.org.uk/Custom/Resources/FinalAutisumdocument18July2012KALHSM.pdf

Chapter 3: Findings from the Minimum mental health dataset

- In 2011/12, 23,987 people were referred to mental health services in Norfolk and Waveney, some more than once, such that there were 33,305 episodes of care, of which just over half were for females. About 40% of these patients were single.

- Almost 70% referrals come from GPs, but there is a wide range of other sources including A&E and self referral. Referrals are to a wide range of services, most commonly, the Wellbeing service, followed by adult acute services and child and adolescent mental health services.

- 2401 patients were accepted into the Care Programme Approach for treatment (for severe mental illness) in 2011/12 and 1,572 were admitted to hospital, some more than once, such that in total there were 2,110 hospital admissions, either voluntary or through being sectioned.

Chapter 4: Projecting adult needs and service information system: (PANSI)

- This national data system has been designed specifically for service planners of adult services and is also based on the Adult psychiatric morbidity survey for England, 2007 and takes account of other data and research to predict the rates and hence numbers of likely sufferers of different mental illnesses by 2030, by applying these to local population projections. The system assumes that 12.5% males and 19% females have a common mental disorder, nearly 7% men and 7.5% females have two or more psychiatric disorders and 0.6% men and 0.1% women have antisocial personality disorder. As the general population size increases, so the numbers with these and other disorders will increase. Predicted numbers, based on these assumptions, have been calculated for each CCG. Across Norfolk and Waveney by 2030, there could be 195,000 people with neurotic disorder, over 52,000 with personality disorder, 37,700 who are alcohol dependent and 35,300 dependent on illicit drugs. Over 30,000 people could have depression, 27,000, dementia, nearly 12 000, autism and about 6,500 with a psychotic disorder.

Chapter 5: Community mental health profile: Norfolk

- The North East public health observatory has compiled data at county level across a range of measures grouped into five themes: wider determinants of health, risk factors for mental illness, levels of mental health and illness, treatment and outcomes. Using this, population values for the Norfolk population can be compared with regional and England values.

- Indicators used for wider determinants were 16 to 18 year olds not in employment, education or training ('NEET's), violent crime rates, proportions of the population living in the most deprived fifth of geographical areas in England, unemployment, hospital admissions for alcohol attributable conditions and numbers of people in drug treatment. In all these, the Norfolk population overall does better than the average for England (i.e. lower rates), and is similar to or better than regional averages.

- Indicators used to assess risk for mental illness were homeless households, proportion of the population with a limiting long term illness, and both school children and adults actively participating in physical activity. Norfolk has higher rates of limiting long term illness than the England average and the regional average, but for the others, the population is close to or better than these averages.

- However, looking at the given indicators of mental health and illness, dementia rates, depression rates and learning disability register sizes held in doctors' practices, Norfolk has relatively more people diagnosed than in other parts of the country, particularly for the learning disabilities register, where the proportion of the whole population registered is significantly higher. This is in part due to recent drives to ensure that people's illnesses and disabilities are recognised and recorded.

- Treatments: here the indicators were emergency hospital admissions for mental illness in general, for unipolar depressive disorders, for Alzheimers and other related dementia and for schizophrenia and delusional disorders. These are all slightly below national averages, close to the regional averages. The average spend for mental health per head is lower than the English average, but higher than that across the region. Population rates of use of adult and elderly NHS secondary mental health services are very close to both the regional and national averages, the numbers of mental health bed days are below the national and regional average and the proportion treated using the Care Programme Approach is significantly below the national average. Contacts with community staff, and total mental health contacts are also a little below the national average, but are much lower than the England 'best'.

- In terms of outcomes, emergency bed use is a little below the national average, albeit higher than the regional one, and suicide rates are also slightly below the national average.

Chapter 6: mental health mortality

- Between 2003 and 2011, 4.3% of all deaths in Norfolk and Waveney were attributed to mental and behavioural disorders, giving an average of 408 deaths per year, not including suicides. The most common cause was dementia in older people, but in younger age groups substance misuse was the predominant cause. Data is available by CCG.

Chapter 7: inpatient admissions in Norfolk and Waveney

- Over two years April 2010 – March 2012, across Norfolk and Waveney, the most common reason for someone to be admitted was for mental and behavioural disorders due to psychoactive substance abuse, accounting for 982 people. A further 385 were admitted with neurotic, stress-related and somatoform disorders, and 355 people were admitted on account of their dementia. 142 people were admitted with 'other organic, including symptomatic, mental disorders' and 119 people were admitted with behavioural syndromes associated with physiological disturbances and physical factors. 101 people were admitted with mood disorders and 93 with schizophrenia, schizotypal and delusional disorders. Among men, admissions become more common with increasing age, rising slowly to a peak among 40 - 54 year olds. Then they drop slightly, followed by a sharp rise among men over the age of 75. The pattern for women is different, as they are more likely then men to be admitted when they are below the age of 25. However, above this age, rates remain similar across the age groups until the age of 75 + when rates also rise sharply, and to a higher level than seen in men. Post code data have shown that admissions were more common among people living in the most deprived areas, although rates across the other areas were relatively evenly spread. Detail is given by clinical commissioning group.

Chapter 8: suicide and injury undetermined

- Data from the Office of National Statistics show deaths due to suicide or injury undetermined by year. Across Norfolk and Waveney between the years 2000 and 2010, the highest number, 107, occurred in 2004 and the lowest, 61, was seen in 2007. Over the 11 year period, the highest numbers of deaths from these causes were amongst residents of Great Yarmouth and Waveney with the least in the North Norfolk CCG area, and there were nearly 900 deaths in all. The long term trend has been a reducing rate, but this may have now reached a plateau.

- Through applying geo-demographic segmentation, it can be seen that just over half of these sad deaths took place among residents of isolated communities and nearly 40% among residents of 'small and mid sized towns with strong local roots'.

- Numbers of suicides expected for the future, if trends don't change, have been predicted using data on mortality rates between 2006 and 2008. These have highest rates amongst males aged 35 - 64 followed by males aged 18 - 34, and lower rates for females aged 35 - 64, with young women aged 18 - 34 having the lowest rates of all.

Chapter 9: dementia

- A tool has been recently published to estimate true dementia prevalence, including those still undiagnosed by their GP. For Norfolk and Waveney it predicted, for 2010/11, 15,459 people with dementia of whom 4,547 would have been living in residential care, with 10,912 in the community and only 6,561 diagnosed and placed on the GP register.

  Of the 15,459 cases estimated, 8,482 (55%) would have been mild, 5,023 (32%) moderate and 1,953 (13%), severe.

Chapter 10: special population groups and mental illness

The recent government strategies, 'No Health Without Mental Health' and the Suicide Prevention Strategy, both recognise special population groups as being at higher risk of mental illness than the general population, and they set out ways to ensure equity. The key points below highlight some of these groups and the issues.

Prison populations

- There are separate needs assessments available that have been recently updated, for prison populations in Norfolk and Waveney; these can be found on 'Norfolk Insight'. Applying published prevalence estimates for mental illness in prison populations to the numbers of people in the four male prisons in the area, one would expect over 1,700 prisoners to have a personality disorder and over 800 with an antisocial personality disorder. A further 100 are predicted to have a psychotic illness and nearly 300 with major depression.

Gypsy travellers

- Research suggests that rates of anxiety and depression amongst gypsy travellers may be as much as 35%. There were 504 caravans recorded in July 2012, and if each held two adults, over 350 travellers would be suffering from these conditions. It is important that services are provided in a way that is accessible for individuals if they want to use them.

Economic migrants

- The potential has been noted here that people in these communities may be unaware of services, or how to access them even though rates of mental illness are likely to be fairly high in these groups.

Asylum seekers and refugees

- People in these communities are also acknowledged to be at a higher risk of mental illness and services should ensure they are suitable for individuals who stand to benefit from them.

Women with perinatal mental illness

- In 2011, there were 10,633 births in Norfolk and Waveney. Applying published rates of postnatal depression, it is anticipated that between 1,000 and 1,500 mothers would have been affected, underlining the need for vigilant general health services, and mental health services that are appropriate for this client group.

Homeless people

- Homelessness can be both a cause and a consequence of mental illness and services and approaches need to be tailored accordingly. Addressing homelessness as part of recovery from mental illness is a key part of current mental health strategies.

People with learning disabilities

- Applying to the local numbers of people on the GP learning disabilities registers in 2010/11, published estimates of between 25% and 40% of people aged 18+ with learning disability also having a mental illness, there were between a thousand and 1,600 people affected. Service providers require the capacity and specialist skills to deal with this need.

People with sensory impairment

- Levels of mental ill health are likely to be higher among people with sensory impairment and in order to ensure they have fair access to mental health services, diagnosis needs to be good, and reasonable adjustments made.

Lesbian, gay and bisexual populations

- Possibly less than 1% of the population of the East of England reports being lesbian, gay or bisexual, but research shows that they are at higher risk of experiencing mental health problems than society in general.

Chapter 11: Programme Budgeting and Outcomes[4]

- Expenditure per head overall on mental health disorders for 2010/2011 for NHS Norfolk was £199.06, and for NHS Great Yarmouth and Waveney, £199.81 compared to £182.11 for East of England, and £208.97 for England. Therefore, expenditure in the two PCTs was relatively less than England (NHS Norfolk ranked 82, and NHS Great Yarmouth and Waveney ranked 79th out of 152 PCTs).

- For other comparators related to mental health disorders for 2010/11, NHS Norfolk expenditure for Substance Misuse was equal to England, while it was higher for Organic Mental Disorders, Psychotic Disorders and Child and Adolescent Mental Health Disorders, and it had considerably lower expenditure than the England average for the remainder.

  For NHS Great Yarmouth and Waveney, the expenditure was considerably lower than the English average for Substance Misuse, Organic Mental Disorders, Psychotic Disorders and Other Mental Health Disorders. For Child and Adolescent Mental Health Disorders and Problems of Learning Disability, expenditure was higher compared to East of England and England averages.

Next steps

- Further analysis will be undertaken, comparing the data from the different chapters of this report, and also looking at services and pathways in counties that are achieving better outcomes in relation to their local population needs.

- This will be taken forward in the next few weeks and it is expected that this will be done in liaison with commissioners of services.

[4] Information on two mental health disorder outcomes are also available within the information produced by the Yorkshire and Humber Public Health Observatory (Y&H PHO) programme budgeting tool, http://www.yhpho.org.uk/default.aspx?RID=49488

Contact information

If there are any errors or you have suggestions for improving the document please contact

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This is a chapter from a mental health needs assessment for Norfolk and Waveney that is in preparation by Public Health. The whole document that presents key data and information in equity is expected to be completed in the next few weeks.

Linda Hillman

Kadhim Alabady

March 2013

Chapter 9: Dementia

Key points:

- Using the NHS tool that has been recently published[1] to estimate true dementia prevalence in England, including those still undiagnosed by their GP, it was estimated that in 2010/11, there were 15,459 sufferers in Norfolk and Waveney. Of these, 4,547 would have been living in residential care, and 10,912 in the community. Data from our GP registers however, document only 6,561 diagnosed cases in total.

- Of the 15,459 cases estimated, according to the tool, 8,482 (55%) would have been mild, 5,023 (32%) moderate and 1,953 (13%), severe. The summed estimates of moderate and severe cases, (6,976), is comparable to the actual numbers that were on the GP registers at the time (6,561), but there is no data to confirm the classification of these. If it is assumed that the 6,561 patients that the GPs had identified were in the moderate and severe categories only, there would remain a further 415 of people in these categories still undiagnosed. In addition, none of the remaining 8,482 who would be categorized as mild would have been on the registers either.

- Work is ongoing to improve access to healthcare for dementia sufferers at an earlier stage in the course the disease, of whom it was estimated there were 8,482 people in 2010/11 with mild disease.

The prevalence of diagnosed dementia is given in Chapter 1[2] of the needs assessment (Section 1.1.2 Dementia Prevalence -all ages) for each CCG in NHS Norfolk and Waveney from 2007/8 to 2010/11 from local GP QOF systems.

The total number of deaths from dementia for NHS Norfolk and Waveney over 9 years (2003-2011) was 3,669 (4% of all deaths), an average of 376 deaths from dementia each year (more details on dementia deaths will be given in Chapter 6). Over the two financial years 2010/11 and 2011/12, there were 355 (123 males, 223 females) admitted with dementia as the primary diagnosis, into acute hospitals. This was 15.6% of all mental and behavioral disorders admissions to acute hospitals (more details can be seen in Chapter 7).

This chapter will look at the undiagnosed cases of dementia by comparing the current GP practice QOF disease registers and the estimated numbers using most up to date version of the NHS CCG Dementia Prevalence Calculator which was released recently.

The number of patients with diagnosed dementia and the prevalence as recorded on the GP QOF disease registers is 6, 561 as illustrated in **Table 1**.

[1] http://www.dementiapartnerships.org.uk/diagnosis/dementia-prevalence-calculator/
[2] Other chapters in the needs assessment document are expected to be available within a few weeks

Table 1: The GP practice dementia registers and the estimated national estimate calculator tool – for dementia by CCG, 2010/11

					Using Adjusted NDPR & Residential care		
	Total population	% of list at 65+ years	Practice dementia register	Using NDPR	Living in the community	Living in Residential Care	Total
GY&W	230,813	22%	1,864	3,686	2,592	1,021	3,613
North	166,958	26%	1,335	3,205	2,250	1,022	3,272
Norwich	202,489	16%	1,043	2,625	1,833	643	2,476
South	217,820	21%	1,393	3,235	2,284	1,045	3,329
West	162,989	24%	926	2,771	1,953	816	2,769
NHS N&W	**981,069**	**22%**	**6,561**	**15,522**	**10,912**	**4,547**	**15,459**

This table also gives the estimated number of dementia cases for each CCG. This is calculated using the National Dementia Prevalence Rates (NDPR). The NDPR are taken from the Alzheimer's Society's report Dementia UK (2007) and are held to be the best UK rates available. It is worth noting that in reality the impact of using alternative rates is marginal at this local level.

With Dementia being predominantly an age-related disease the presence or otherwise of care homes for the elderly will have a significant impact at local level. In an attempt to identify this impact the Dementia Prevalence Calculator - model calculated the total estimated dementia cases at Strategic Health Authority (SHA) level using the NDPR. The model then calculated the estimated number of these cases that would reside in residential care using the number of care beds and occupancy levels within each SHA and the National Dementia Prevalence Rates from Dementia UK (2007) applied to the Residential Care (care homes). By subtracting the residential care cases from the total cases the model were able to calculate NDPR adjusted to include only those cases expected to be living in the community. This model therefore provides us with an estimate of dementia cases in each CCG where the patient is living at home, also shown on **Table 1**.

As mentioned above the presence of care homes often represents a concentration of dementia cases. Using home information supplied by the Care Quality Commission the model estimated the number of elderly care/nursing home residents in each CCG. The model then estimates the number of these residents that are likely to have dementia using the National Dementia Prevalence Rates. The model therefore provides an estimate of the number of persons with dementia living in residential care and this is also listed on **Table 1**.

The national estimate calculator tool has created a model which can be used to produce the estimated number of people with dementia. Projecting Adult Needs and Service Information System (PANSI), and Projecting Older People Population Information (POPPI) Systems has also produced local and national estimates and projections for people with dementia. This information is presented within **Chapter 4**.

In general when such models have been produced, the model is based on research undertaken elsewhere in the UK examining the prevalence of diagnosed disease in the community, which has then been modelled and applied to different populations such as those living in a particular CCG area. Therefore, how accurate the estimates are, depends on the quality of the initial research and the modelling itself. It is possible that the original research did not include very deprived areas, in which case it would be very difficult to generalise and apply the model to very deprived areas like Great Yarmouth, Waveney, King's Lynn, Thetford or parts of Norwich. Furthermore, there are many reasons why the prevalence could differ between medical practices. Therefore, just because

practices have a particularly low recorded prevalence or a relatively large undiagnosed prevalence, it does not necessarily mean that they are performing badly in any way relative to other general practices. Nevertheless, a comparison of the differences between the modelled prevalence and the practice list registers can act as a starting point for investigation. Practices with a low prevalence of diagnosed cases or a relatively large difference between the model and the register prevalence can be examined further and considered in relation to patient characteristics using local knowledge.

The national estimate calculator tool - model just uses estimated prevalence for men and women for different age groups (0-29, 30-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-94 and 95+ years) which are applied to estimated age-gender specific population figures for each practice to obtain an estimate of the total number of people with dementia. No adjustments were made for ethnicity, deprivation or other factors. The model was based on the Alzheimer's Society's report Dementia UK (2007).

The results of the modelling and the actual diagnosed number of patients with dementia that are given in this chapter do not necessarily represent the actual number of people who should be diagnosed with dementia for each CCG; it is only a guideline.

It can be seen that there were around 58% of people with dementia who were undiagnosed in NHS Norfolk and Waveney comparing the 2010/11 QOF GP practice registers and the national estimate calculator tool for dementia. The difference between the QOF and the NDPR is 8,961 cases, and the difference between QOF and using Adjusted NDPR for home care model is 8,898 cases (**Table 1)**.

As mentioned earlier the Adjusted NDPR for home care model provides an estimate of dementia by place of residence It can be seen that it is estimated that there would be 10,912 people living in the community, and 4,547 people living in Residential Care who were suffering from dementia if this model was completely accurate for the population of Norfolk and Waveney (see also **Table 1)**.

The national estimate calculator tool for dementia provides information of the expected number of people with dementia by severity. **Table 2** shows that the expected number of people with mild dementia is 8,482, 5,023 with moderate dementia, and 1,953 with severe dementia. It is likely that it is these moderate and severe cases that are captured on GP dementia registers, and the numbers support this, however the data collections from GPs do not include detail on the level of severity of sufferers.

Table 2: The estimated number of dementia severity by CCG using the national estimate calculator tool – for dementia, 2010/11

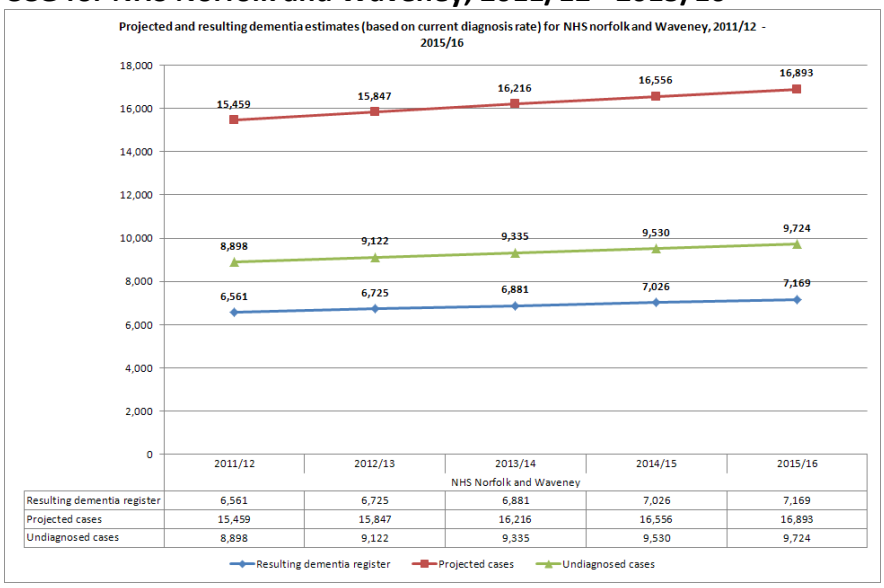
	Mild	Moderate	Severe	Total
GY&W	1,983	1,174	455	3,613
North	1,794	1,062	416	3,272
Norwich	1,356	806	314	2,476
South	1,828	1,082	419	3,329
West	1,521	899	349	2,769
NHS Norfolk and Waveney	**8,482**	**5,023**	**1,953**	**15,459**

Table 3 and Figure 1 show the projected estimated figures for dementia by CCG from 2011/12 until 2015/16 and comparing it with GP practice QOF registers applying the current rate of diagnosis for each CCG on the projected number of people registered by each CCG.

Table 3: Projected and resulting dementia estimates (based on current diagnosis rate) by CCG for NHS Norfolk and Waveney, 2011/12 - 2015/16

	2011/12	2012/13	2013/14	2014/15	2015/16	% diagnosis rate
GY&W						
Current dementia register	1,864	1,909	1,953	1,994	2,035	**51.6%**
Projected cases	3,613	3,700	3,786	3,866	3,944	
Undiagnosed cases	1,749	1,791	1,833	1,872	1,909	
North						
Current dementia register	1,335	1,370	1,402	1,431	1,461	**40.8%**
Projected cases	3,272	3,357	3,436	3,508	3,580	
Undiagnosed cases	1,937	1,987	2,034	2,077	2,119	
Norwich						
Current dementia register	1,043	1,068	1,092	1,115	1,137	**42.1%**
Projected cases	2,476	2,536	2,593	2,646	2,700	
Undiagnosed cases	1,433	1,468	1,501	1,531	1,563	
South						
Current dementia register	1,393	1,428	1,462	1,493	1,523	**41.8%**
Projected cases	3,329	3,413	3,494	3,568	3,640	
Undiagnosed cases	1,936	1,985	2,032	2,075	2,117	
West						
Current dementia register	926	950	972	993	1,013	**33.4%**
Projected cases	2,769	2,841	2,907	2,968	3,029	
Undiagnosed cases	1,843	1,891	1,935	1,975	2,016	
NHS Norfolk and Waveney						
Resulting dementia register	6,561	6,725	6,881	7,026	7,169	**42.4%**
Projected cases	15,459	15,847	16,216	16,556	16,893	
Undiagnosed cases	8,898	9,122	9,335	9,530	9,724	

Figure 1: Projected and resulting dementia estimates (based on current diagnosis rate) by CCG for NHS Norfolk and Waveney, 2011/12 - 2015/16



The national estimate calculator tool for dementia provides information of the expected number of people with dementia by age group; all figures are given in Appendix G[3] at CCG level.

Current national policy is to identify dementia at a much earlier stage than previously[4] and hence work is ongoing locally with health and social services and client groups in order to facilitate this to take place.

[3] To be available shortly
[4] The National Dementia Strategy, 2009. Department of Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058

Child and Adolescent Mental Health Services (CAMHS) Needs Assessment: February 2013

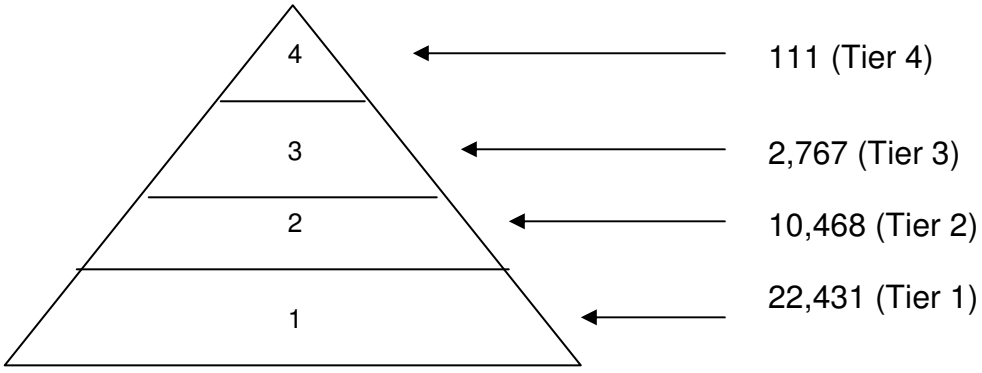
Summary

Population and prevalence

The ONS estimated that the child population (0-18) of Suffolk was 158,981 in 2010. The ONS estimates that this population will rise by around 2.6% by 2016.

The different types of CAMHS care are commonly categorised by level of need into four tiers of service. If we apply ChiMat estimates the number of children who might need to access the care provided by Tier 1 to 4 mental health services at any one point in time and this is provided below:

	Babergh	Forest Heath	Ipswich	Mid Suffolk	St Edmundsbury	Suffolk Coastal	Waveney	**Suffolk**
Tier 1: Primary of direct contact service. Professionals working in these services include, for example, social workers, general practitioners, voluntary workers, health visitors and teachers	2,679	1,830	4,419	2,994	3,435	3,687	3,387	**22,431**
Tier 2: Refers to interventions offered by individual staff of CAMHS (such as Primary Mental Health Workers)	1,250	854	2,062	1,397	1,603	1,721	1,581	**10,468**
Tier 3: Refers to interventions offered by multi-disciplinary teams of staff from CAMHS. These often centre around particularly complex needs	330	226	545	369	424	455	418	**2,776**
Tier 4: These services offer very specialised CAMH interventions and care. They include In- patient Child and Adolescent Mental Health Services	13	9	22	15	17	18	17	**111**



The CAMHS estimates suggest that level of need is higher in Ipswich and East Suffolk then West Suffolk in terms of numbers of children. Appendix A shows how the total child mental health need for Suffolk is divided by tier of need.

Risk factors for childhood mental health disorders

Nationally, the prevalence of mental ill health is significantly higher for vulnerable groups (for instance looked after children, children with learning disabilities) than for the childhood population as a whole. Factors that increase the risk of mental disorders are:

- Being male[1],
- Having special educational needs (SEN),
- Living in a one-parent household,
- Having no parent working,
- Living in a family with low income,

Additionally, prevalence is higher for children in the 11-16 age range than for younger children. There is some evidence that children of Indian ethnicity had lower prevalence of mental health disorder.

Provision

Tier 1:

These services are provided by a wide range of organisations/services who might not necessarily categorise themselves as providing a CAMHS service. Much of the work at Tier 1 level is provided by NHS GPs and health visitors, children's centres, organisations from the voluntary sector and the local authority Access Teams.

Tier 2:

As with Tier 1 services, these are provided by a variety of organisations. A large proportion of Tier 2 care is provided by Norfolk and Suffolk NHS Foundation Trust (NSFT) through the work of Primary Mental Health Workers. Additionally, services such as the Suffolk Wellbeing Service are provided through a collaboration between NSFT and numerous voluntary sector agencies and local authority services provide support through, for instance, educational psychologists.

Tier 3:

These are primarily provided by NSFT through two specialist CAMHS outpatient services (West and Ipswich and East) and specific services for particular diagnoses (e.g. eating disorders) or particular vulnerable groups (looked after children). Suffolk Community Healthcare provides Tier 3 services for ADHD and attachment disorders.

Tier 4:

These very specialist services are commissioned from out of county providers as an when required. As such, Suffolk CAMHS patients generally use inpatient services in Cambridgeshire and Essex.

Potential unmet need

The CAMHS needs assessment identified specific areas of potential unmet need. A summary of this is provided in Appendix B.

For any queries, please contact Dr Mash Maidrag
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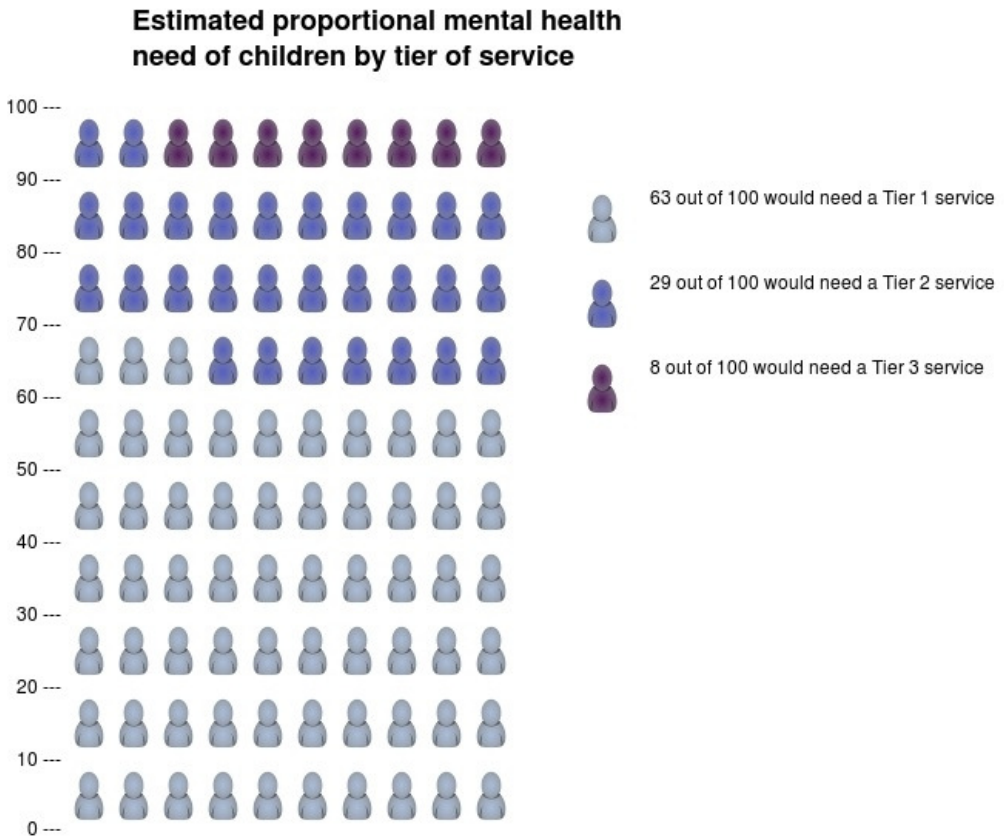
[1] For most types of mental health disorder although emotional disorders are more prevalent in girls

Appendix A



0.3 out of 100 would need a Tier 4 service

Appendix B
Potential unmet child mental health need in Suffolk

Population groups/ mental health disorders	Provision	Gaps/comments	Unmet need
Tier 1 services	Tier 1 services are mainly provided by front-line staff such as health visitors, teachers, school nurses, social workers and General Practitioners (GPs) who work directly with children and young people. These services are provided by the NHS, the private healthcare sector, local authorities and the charity/ voluntary sectors.	Tier 1-2 care, such as that provided by the Suffolk Wellbeing Service, can be delivered through a multi-agency approach with NHS and voluntary sector organisations collaborating.	It is difficult to quantify the level of met or unmet need at Tier 1 due to the complexity of collating data from the wide range of services who support children and young people and the nature of much of that support.

Population groups/ mental health disorders	Provision	Gaps/comments	Unmet need
Tier 2 services	These are primarily provided by PMHWs (ages 0-18), the Early Intervention in Psychosis service (ages 14-35) and by the Educational Psychology Service (0-19). These services are available county-wide.	The PMHW service provides the majority of Tier 2 care. The current establishment in Suffolk is 12.2 (wte). A Cambridge based research study suggested a minimum establishment of 8 PMHWs per 100,000 population but this only related to provision for psychiatric need. This would not include provision for care and support for children with primarily conduct or emotional disorders.	A primary concern of stakeholders is a perceived difficulty of accessing Tier 3 services and insufficient support at Tiers 1 and 2 for those whose referrals are rejected. The majority of stakeholder responses suggested that the work of PMHWs is of a high quality but there is a perception that the resource is not sufficient to meet demand. A key finding from stakeholder feedback suggests that CAMHS provision for conduct or emotional disorder need is insufficient and that this needs to be addressed at Tier 1 and 2. Stakeholder feedback and activity data suggests increased (or better use of) resource in these areas would bring further benefits in reducing the need for later and more intensive treatment.
Tier 3 services	These are primarily provided by NSFT through two specialist CAMHS outpatient services (West and Ipswich and East) and specific services for particular diagnoses (e.g. eating disorders) or particular vulnerable groups (looked after children). SCH provide Tier 3 services for ADHD and attachment disorders	The two Tier 3 general outpatient services (West and Ipswich and East) experience a large number/proportion of self-defined “inappropriate” referrals.	Stakeholder feedback suggests that there is frequent frustration in referrers at a perceived difficulty in access to Tier 3 services for children without a stable home/family life or for children with conduct disorders. This suggests that clear criteria for referral and care pathways are not in place. This in turn means that referrers are not always confident in knowing how to access Tier 3 specialist care.

Population groups/ mental health disorders	Provision	Gaps/comments	Unmet need
Tier 4 Services	Tier 4 services are commissioned from out of county providers. NSFT are proposing developing an inpatient site to be based in Norfolk.	There are no NSFT Tier 4 inpatient-based services in Suffolk. All Suffolk children requiring inpatient care are placed in facilities based out of county in Essex or Cambridgeshire.	Stakeholder feedback from both referrers and providers suggested that children requiring Tier 4 inpatient or residential services are often placed too far from home to maintain good familial contact. NSFT are developing a new inpatient facility in Norfolk which may reduce travel time between home and ward for some children in Suffolk should they be able to access this facility. However, Royal College of Psychiatrists standards for CAMHS note that commissioners are expected to ensure that young people are not placed out of area as a consequence of inadequate support being provided in the local community.
Autistic Spectrum Disorder / ADHD	Dedicated ASD children's service provided by Suffolk Community Healthcare. The service provides a diagnostic pathway approach up to the age of 11 and a non-diagnostic pathway approach for children of secondary education age.	A dedicated ADHD service has been provided by NSFT in Ipswich since 2008 but SCH also retain a West Suffolk caseload.	Stakeholders from both NSFT and the SCH Autism Service report difficulties in finding consensus over appropriate allocation of services for children with dual diagnosis of autism and mental health disorder. Additionally, the SCH service report increased demand on service resource for patients making the transition from primary to secondary education and is concerned over its capacity to meet this demand.

Population groups/ mental health disorders	Provision	Gaps/comments	Unmet need
Learning Disability	Services are provided for children across Suffolk up to the age of 18 with moderate, severe or profound learning disabilities.	While the service generally works within office hours, the team can work flexible hours to meet the specific needs of families.	The expected prevalence of learning disabilities for children in Suffolk is 2,600 with an estimated 1,040 of them experiencing mental health disorder requiring a Tier 1-4 service. Between April 2009 and March 2012, there were 326 referrals to the NSFT learning disability service which had a caseload of 154 as at the end of September 2012. Unfortunately, there is no data available on the number of children with learning disabilities accessing Tier 1 services for mental health reasons. Therefore, we are unable to ascertain how many children with LD are accessing non-NSFT services.
Looked After Children (LAC)	A dedicated mental health service for LAC is provided by CONNECT for both East and West Suffolk.	The service works with children with diagnosable mental illness and not with children whose primary problem is a conduct disorder. Stakeholder feedback suggests that there is a gap in provision for children with conduct or emotional disorder and this includes the LAC population.	There is robust evidence that LAC have significantly poorer mental health outcomes than the general child population. The results of a 2012 audit of the mental health of LAC in Suffolk were consistent with this. The audit suggested that between 240 and 295 LAC have a potential mental health disorder while the dedicated CAMHS team for this population (Connect) had a caseload of 117 at the end of March 2012. Again, it would be beneficial to understand how many of the LAC population received non-NSFT Tier 1 support for mental health disorder.

Population groups/ mental health disorders	Provision	Gaps/comments	Unmet need
5-9 year old children	The majority of CAMHS services are provided for children in this age range. The Leapfrog service provides care and treatment for children with attachment disorders (aged 5-7).	However, access to the Suffolk Well-being Service is not available for under 15s and access to the Early Intervention in Psychosis Service is not available for under 14s.	The number of Suffolk children in this 5 year age range is roughly equivalent to the numbers of 10-14 and 15-19 year olds. The 2012 LAC audit found potentially higher levels of mental health need for males in this age range than older boys and equivalent levels of need for young girls and older girls. However, caseload numbers for the 5-9 year age range in 2012 were markedly lower than for older children. The types of disorder found to be more prevalent in 5-9 year old boys (conduct disorder, hyperkinetic disorder) may be less likely to meet the CAMHS threshold for treatment allocation.
Older/more developmentally advanced children	CAMHS treatment across the majority of disorders is provided for children in this age range.	N/A	Stakeholder feedback suggested that some of the service-user accessed areas of clinical bases were not age appropriate in their decoration and facilities for older children. Royal College of Psychiatry CAMHS quality standard 9.1.4 notes that consideration of this factor is expected for CAMHS locations.
Out of hours services	Service users requiring emergency out of hours treatment are advised by the CAMHS website to attend A&E at Ipswich Hospital or West Suffolk Hospital. The Intensive Outreach Team provides out of hours liaison work with emergency services for children in crisis.	-	Stakeholder feedback from referrers and commissioners relating to out of hours care suggested concerns over access, highlighting a perception of an excessively high severity threshold. Few CAMHS teams offer evening or weekend services. The proposed Access and Assessment Service within the NSFT consultation will offer an out of hours crisis assessment service.

Population groups/ mental health disorders	Provision	Gaps/comments	Unmet need
BME children and adolescents	All CAMHS services record ethnicity information for service users.	There are no ethnicity specific CAMHS teams within the NSFT structure (although this has not been identified as a gap by any stakeholder responses).	The proportion of BME groups within the overall NSFT CAMHS caseload is lower than for the Suffolk population. While research evidence suggests that the prevalence of some mental disorders may be lower in specific ethnic groups, the national utilisation of services by Bangladeshi and Pakistani children is significantly below estimated prevalence and this seems to be echoed in Suffolk.
Communication	N/A	N/A	A frequent response of stakeholders concerned a perceived deficiency in communication between CAMHS services and referrers or service users and carers at key points in the care process. A lack of communication about referral decisions and at points of transfer or discharge was noted as a source of frustration. Improved clarity about referral criteria and the application of this criteria could potentially significantly alleviate this frustration.

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:	1st March 2013
Report for:	Report to sub-committee of joint Norfolk and Suffolk Health Overview and Scrutiny Committee 12th March 2013 (2nd Meeting)
Purpose:	Consultation process

Documents	
	Title and version/date
1	NSFT Draft Service Strategy 2012-16; 1st March 2013
2	Formal 90 Day Collective Consultation: Trust Response to Staff Feedback; 21st February 2013
3	Service Capacity; 1st March 2013
4	Impact on Number of Beds; 1st March 2013
5	Impact on Workforce; 1st March 2013
6	Quality and Safety Measures; 1st March 2013
7	High Level Milestones Plan Accelerated; February 2013
8	Timetable for Individual Consultations; February 2013
9	List of Services Delivered in Partnership with Third Sector Providers;1st March 2013

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. The Strategy aims to improve health and social care outcomes for our service users and carers and release savings through increased efficiency. The Strategy has been developed over an 18 month period in consultation with service users and carers and other stakeholders including staff and our external engagement and the consultation process continues.

2. The Strategy is designed to achieve savings of 5% per year (20% over the four year strategy) line with the requirements of the NHS Operating Framework 2013/14.

3. In line with national policy for mental health, our clinical leaders have developed a range of new pathways and packages of care covering mild to severe mental health problems including dementia. All pathways have measurable quality measures and outcomes, including nationally suggested quality and outcome measures.

4. In the future mental health services will be commissioned to provide a number of packages of care and services will be funded on a tariff (price per case) basis. The proposed Strategy will not result in a reduction in service capacity over the four years (the number of service users and carers receiving a service – our baseline is 2011/12 Q4). We aim to achieve the required savings by introducing new models of care, clearly defining care packages and streamlining and integrating pathways of care.

5. The planned service capacity is based on current commissioned services and activity but can be adjusted in line with future local commissioning plans.

Service reconfiguration

6. Norfolk and Suffolk mental health inpatient services are currently provided in 9 geographical locations and in order to release savings from our proposed strategy the Trust will need to review its estate. The Trust will not close or move inpatient services until community service models have been tested and following appropriate public consultation and consultation with health scrutiny. The Trust will develop plans for public consultation with CCG's, ensuring that these align with local commissioning plans.

Transitional funding

7. The Trust and Clinical Commissioning Groups in Norfolk and Suffolk have applied to the Commissioning Board for transitional funding to support the safe implementation of the Strategy. Transitional funding will allow the Trust to maintain higher staffing levels during the change to new service models and allows the Trust to make workforce change through natural turnover rather than redundancy and enabling the Trust to retain skilled, experienced clinical staff.

Post consultation changes to service and staffing models

8. Following our recent 90 day staff consultation we are making a number of changes to service models and working through the impact on staffing numbers. The medical workforce is currently subject to a detailed review.

Partnerships

9. The Trust is a provider of social care in Norfolk and the Strategy includes social care provision for people aged 18 to 64 years living in Norfolk. For people in other age groups we will continue to integrate health and social care pathways by working closely with providers of social care services.

10. The proposed Strategy builds on successful partnership models in Wellbeing and Substance Misuse services, extending this approach to developing alternatives to hospital and housing and employment support services across all pathways.

Norfolk and Suffolk NHS

NHS Foundation Trust

DRAFT

DIGNITY and RESPECT for every Individual, EFFECTIVENESS in RECOVERY and WELLBEING

Norfolk and Suffolk NHS Foundation Trust

Service Strategy 2012-16

your wellbeing in mind

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1. Service Strategy, 2012-2016 - Introduction

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.

In setting out change the Strategy aims to ultimately give stability, and certainty over the future direction and development of the service in a changing environment for staff, service users, and carers.

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.

2. 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

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.

3. Focus on Quality and Safety

The Francis report sets a responsibility on the Trust to ensure that the quality of patient Care is at the heart of decision making; that service users and carers views are listened to; and that the Trust is open about and learns from mistakes.

Service quality will generally be measured using feedback from service users and a range of indicators developed for that purpose. Our commitment to the introduction of a "Recovery" culture as part of the Strategy means that service users will play a key role in shaping and designing our services through the life of the Strategy. We also have a number of ways in which Service Users can feed back on the quality and safety of the service including surveys tailored to the needs of particular groups, active patient councils which link with the Trust at several levels, influencing the Trust services, and focus groups. The Trust is also committed to engaging with a number of independent local patient and stakeholder groups, whenever service developments or changes are considered.

The Trust has developed a set of indicators of service safety. It will use these 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 programmed and un-programmed service visits and reports from staff and managers to monitor safety alongside the dashboard. The Indicators will be monitored by individual Directors, by Service Governance Committee, and by the Board. We have also suggested that commissioners use them too, to 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.
Trust is awaiting confirmation of transitional funding from commissioners to support the management of safety during the life of the Strategy.

Where these indicators 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 them with senior clinical and managerial staff in the area concerned and then implement this. We will then ensure the implementation of that plan, We are also establishing new methods of dissemination of "lessons learned" from such events.

Alongside these new processes put in place during the Transition period the Governance team will continue to use an integrated approach to monitor safety and quality of service as business as usual, which will be reported to the Trust Board via the Service Governance Sub-Committee (SGSC). The risk management team will provide training to clinical areas on the Trust risk register which will be a live document. Training on how to use datix and a new dashboard within datix which will provide teams with the ability to monitor individual safety indicators for their areas will also be provided.

The recent publication of both the Francis report and Winterbourne View report will result in the review of Trust practice and we will ensure lessons learnt and recommendations are embedded into existing practice and process.

The Whistle-blowing line will remain as current practice so staff are able to report any concerns, the Trust's current Whistle blowing Policy is being reviewed and will take into account recommendations from the above reports. The Trust will work alongside teams to ensure safe staffing levels and skill mixes are in place to deliver a safe, high quality service, and that staff have the right training and level of skills to enable them to deliver on the new service strategy. The clinical audit schedule for 2013-14 currently completed in draft reflects the Quality and Patient Safety agenda in its selection of audit topics. To support the unannounced visits schedule the Head of Governance supported by the Modern Matrons will conduct mock CQC visits on all inpatients areas.
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 and qulaity through NSFT's Service Governance sub-Committee and Board.

4. One Strategy, Five Localities

The Service Strategy adopts a common approach across the Trust but with different models reflecting the views of clinicians and stakeholders locally and the requirements of commissioners and key partners.

The Trust will work as five Localities based around the Clinical Commissioner Group Boundaries but with a scale to enable practical management. Each locality will have a full range of community based care, together with local inpatient facilities for adults and older adults; East Suffolk and West Suffolk localities; Great Yarmouth and Waveney; Central Norfolk and West Norfolk localities.

The Trust will have a common commitment to a Recovery model of care. Wellbeing both as an approach and as a service will also be common to all Localities (although working to different contracts) reflected in its services. An Access and Assessment Service across will be common both counties (with assessments and appointments offered locally).

The Trust will provide a single model of specialist services including; Forensic Services; Learning disability services (Suffolk and Yarmouth and Waveney Localities); Substance Misuse services (as commissioned); children's inpatient services across all localities.

All Localities will also share common support functions, such as Estates; IT; H.R.; Governance; and Research functions;

All Localities will work closely with Social Services as a key partner with most teams co-located and wherever possible with a common management.

All Localities will also integrate closely with other partners including other NHS Trusts and providers linked to health such as Voluntary sector and private sector partners. How this happens will be determined in each locality working with key partners and commissioners.

Variation between localities is inevitable as each has its own commissioners, and this is a reason for adopting a locality structure.

Whilst sharing common features, there will be variation in service model between localities and between counties reflecting the views of clinicians and stakeholders and the requirements of commissioners. There are variations in provision within the Strategy between individual Localities in relation to service model and provision and most significantly between counties. The Strategy reflects this too in the different models of team structure in Norfolk and Suffolk.

5. NSFT Core Service Strategy common to all Localities

The Trust has adopted an overarching strategic approach to services in each locality, recognising that commissioning arrangements mean that specialist services such as

Substance misuse, and Neuro-Developmental (Learning Disability) Services will vary significantly between localities even in some cases within counties. The advent of more locally focussed CCGs will also mean that service models within the strategy differ between localities. We expect these differences to increase as clinicians work together with CCG clinical staff to develop more local models.

The following strategic elements will be common to all localities while beneath this will be different locally developed and evolving detailed service models:

All five localities in Norfolk and Suffolk will provide a comprehensive range of community based mental health services for children, adults of working age and adults in later life. The focus of these will be to provide effective intervention using the best evidence available to reduce reliance on inpatient services as much as possible. Local teams will include assertive outreach, early intervention and Crisis Resolution as functions although teams will be more integrated, according to the local service model adopted.

All localities will also have local inpatient mental health facilities for adults of all ages, and will share access to Psychiatric Intensive Care, Low secure, and children's inpatient services. Every locality will introduce services providing alternatives to admission, and

All localities will also adopt a progressive approach to services for young people with remodelled youth services incorporating CAMHs and Early Intervention.

There will also be a common approach to the management of Personality Disorder and other complex needs.

All localities will work closely with service users and carers to adopt a comprehensive "Recovery" model of care supported by investment from the Trust.

All localities will provide Wellbeing services, including a commitment to working with key partners to develop more accessible services and wider wellbeing.

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

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).

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.

Services will focus on wellbeing with a view to reducing mental ill health, and strengthen community wellbeing and community capital across all localities.

NSFT will broaden access to Wellbeing services – Improving Access to Psychological Therapies (IAPT).

NSFT remains committed to equality and diversity and will improve accessibility for all communities.

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

NSFT will reduce the use of inpatient beds by providing alternatives to admission, adopting policies which facilitate this and ensuring timely discharge.

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)

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.

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).

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.

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.

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

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

NSFT will live within its financial means.

a. 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 in line with commissioners targets for urgent and non-urgent assessment.

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

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 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.

b. Wellbeing Services across all Localities

Wellbeing services are a key part of the service strategy, and build on and complement mainstream mental health services, offering support to people with less serious mental health problems and also creating greater community cohesion through the provision of wider wellbeing services and strong links with key partners.

Wellbeing services were commissioned by the former PCTs against slightly different contract specifications however the Trust has adopted a similar model in Norfolk, Suffolk, and Yarmouth and Waveney, with a service which provides both IAPT (psychological therapies), and a wider wellbeing service incorporating a range of other interventions to improve wellbeing and community wellbeing.

The service model includes a wide range of third sector, and private sector organisations offering services as formal partners in each of the three contract areas.

All services will deliver at least a 50% Recovery rate for psychological therapies against standard scores.

c. Substance Misuse Services across all Localities

The Trust is commissioned to provide substance misuse services in Norfolk, via the Norfolk Recovery Partnership which is a formal partnership of several key expert agencies working closely to ensure that access and treatment programmes are accessible and effective.

The partnership model, like that in wellbeing services, provides an example of the partnership approach that the Trust will adopt with future service development

The Trust's drug and alcohol services will work contribute to the pathways for people with mental health and substance misuse problems in Norfolk and will provide alcohol services within Suffolk.

d. Forensic Services

This is commissioned regionally and provides a Medium and low secure service on a regional basis (including Norfolk and Suffolk Localities). The impact of competition and changing commissioner requirements, mean that the service will concentrate on improving value for money, with cost reductions to match the national requirements, and improvements in service quality – in particular therapeutic interventions. and social and wellbeing support will be critical to the development of the service.

6. Workforce

The Trust is committed to the development of individual staff and the engagement of its workforce in the Development of services. Detailed for the operation of services models outlined in this strategy will be matter for local decision by clinical staff and managers within localities and specialist services (such as Substance misuse and forensic services).

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, critical to the efficiency of services.

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

a. Nursing

A key 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

b. 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.

c. Social care

Some mental health practitioner posts in Norfolk are allocated 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.

d. 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.

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.

e. 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.

f. 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.

g. 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.

h. 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).

7. 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.

8. 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 working with UEA will fund a professorial role to focus on system and pathway development for dementia sufferers and carers. The post will link with NSFT's new Dementia Academy.

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 2013/14

9. 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.

10. 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
- 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.

11. Commercial development

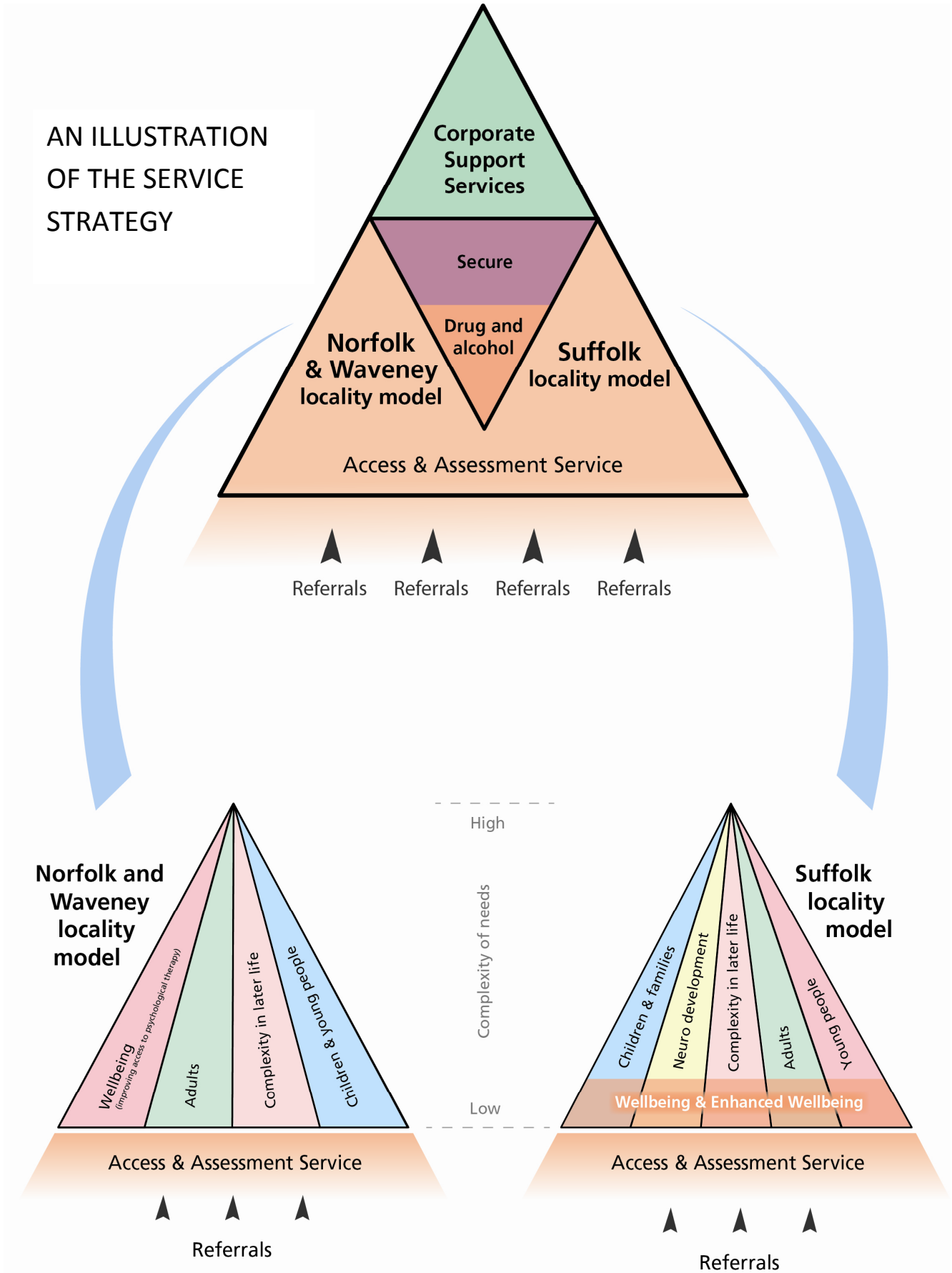
NSFT will develop a Commercial Strategy in early 2013 to provide a more commercial, business-like approach to ensure that NSFT's overall business grows appropriately.

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.

AN ILLUSTRATION OF THE SERVICE STRATEGY



your wellbeing in mind

12 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.

a. 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 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.

b. Six specialist service lines included in the Integrated Delivery Teams

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.

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.

c. 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).

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.

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

a. 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:

a. Great Yarmouth and Waveney (25% of the Norfolk and Waveney population)
b. West Norfolk (larger than the current West Norfolk locality and covering 25% of the Norfolk and Waveney population)
c. 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.

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 the workforce in each service line will be flexed to match the number of referrals and caseload, as negotiated with commissioners each year.

b. 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 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.

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.

14 Conclusion

The Service Strategy attempts to provide clarity and some certainty on the development of mental health services within the Trust over the next four years.

The document will be reviewed from time to time because the Trust intends to continue with review and consultation over the life of the Strategy.

010313

Trust Service Strategy Consultation
October 2012

Norfolk and Suffolk NHS
NHS Foundation Trust

NSFT Service Strategy

Formal 90-Day Collective Consultation

Trust Response to Staff Feedback at End Point

February 2013

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1.0 Introduction and Next Steps

This document provides a summary of the significant changes and clarifications to the service strategy agreed as a result of the feedback provided by staff over the recent 90-day collective consultation period. These changes will be taken forward in the context of the agreed financial envelope for each of the service areas.

In addition, it provides a themed overview of the many pieces of feedback which, although not resulting in a change to the service strategy, have been considered and require either an explanation, comment, or other response.

Hundreds of pieces of feedback were received from staff, outlining questions, ideas, alternatives, risks and omissions. It was heartening to see so many individuals and teams participating in the collective consultation process and thanks go out to all those who provided their expertise, experience, and perspectives. Clearly it has been a significant challenge for service strategy leaders to consider such a wealth of information, and thanks go out to them too for their open-mindedness and commitment to the process of consultation.

Now that most changes to the service strategy have been agreed by the Board and communicated to our staff side colleagues, you will see over the next few weeks opportunities to attend presentations about the amended service strategy and to engage in dialogue about what this means for the Trust. There are also some amendments to the strategy which will take a little longer to work on such as the review of senior clinical posts.

Any changes to the service strategy which impact staff members going through individual consultation will receive additional communication as part of their local consultation and one to one meeting process.

2.0 Trust Commitment to Safety and Quality Governance

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 Francis report sets a responsibility on the Trust to ensure that the quality of patient Care is at the heart of decision making; that service users and carers views are listened to; and that the Trust is open about and learns from mistakes.

At the start of planning the Strategy Clinical leads and stakeholder developed quality goals for each of our service pathways. Service quality will generally be measured using feedback from service users and a range of indicators developed for that purpose. Our commitment to the introduction of a "Recovery" culture as part of the Strategy means that service users will play a key role in shaping and designing our services through the life of the Strategy. We also have a number of ways in which Service Users can feed back on the quality and safety of the service including surveys tailored to the needs of particular groups, active patient councils which link with the Trust at several levels, influencing the Trust services, and focus groups. The Trust is also committed to engaging with a number of independent local patient and stakeholder groups, whenever service developments or changes are considered.

The Trust has developed a set of indicators of service safety in addition to our existing quality measures. It will use these 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 programmed and un-programmed service visits and reports from staff and managers to monitor safety alongside the dashboard. The Indicators will be monitored by individual Directors, by Service Governance Committee, and by the Board. We have also suggested that commissioners use them too, to 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.
Trust is awaiting confirmation of transitional funding from commissioners to support the management of safety during the life of the Strategy. Trust Directors and Mangers will also visit and work in patient services themselves.

Where these indicators 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 them with senior clinical and managerial staff in the area concerned and then implement this. We will then ensure the implementation of that plan, We are also establishing new methods of dissemination of "lessons learned" from such events.

Alongside these new processes put in place during the Transition period the Governance team will continue to use an integrated approach to monitor safety and quality of service as business as usual, which will be reported to the Trust Board via the Service Governance Sub-Committee (SGSC). The risk management team will provide training to clinical areas on the Trust risk register which will be a live document. Training on how to use datix and a new dashboard within datix which will provide teams with the ability to monitor individual safety indicators for their areas will also be provided.

The recent publication of both the The Francis report and Winterbourne View report will result in the review of Trust practice and we will ensure lessons learnt and recommendations are

embedded into existing practice and process.

The Whistle blowing line will remain as current practice so staff are able to report any concerns, the Trust's current Whistle blowing Policy is being reviewed and will take into account recommendations from the above reports. The Trust will work alongside teams to ensure safe staffing levels and skill mixes are in place to deliver a safe, high quality service, and that staff have the right training and level of skills to enable them to deliver on the new service strategy. The clinical audit schedule for 2013-14 currently completed in draft reflects the Quality and Patient Safety agenda in its selection of audit topics. To support the unannounced visits schedule the Head of Governance supported by the Modern Matrons will conduct mock CQC visits on all inpatients areas.
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:

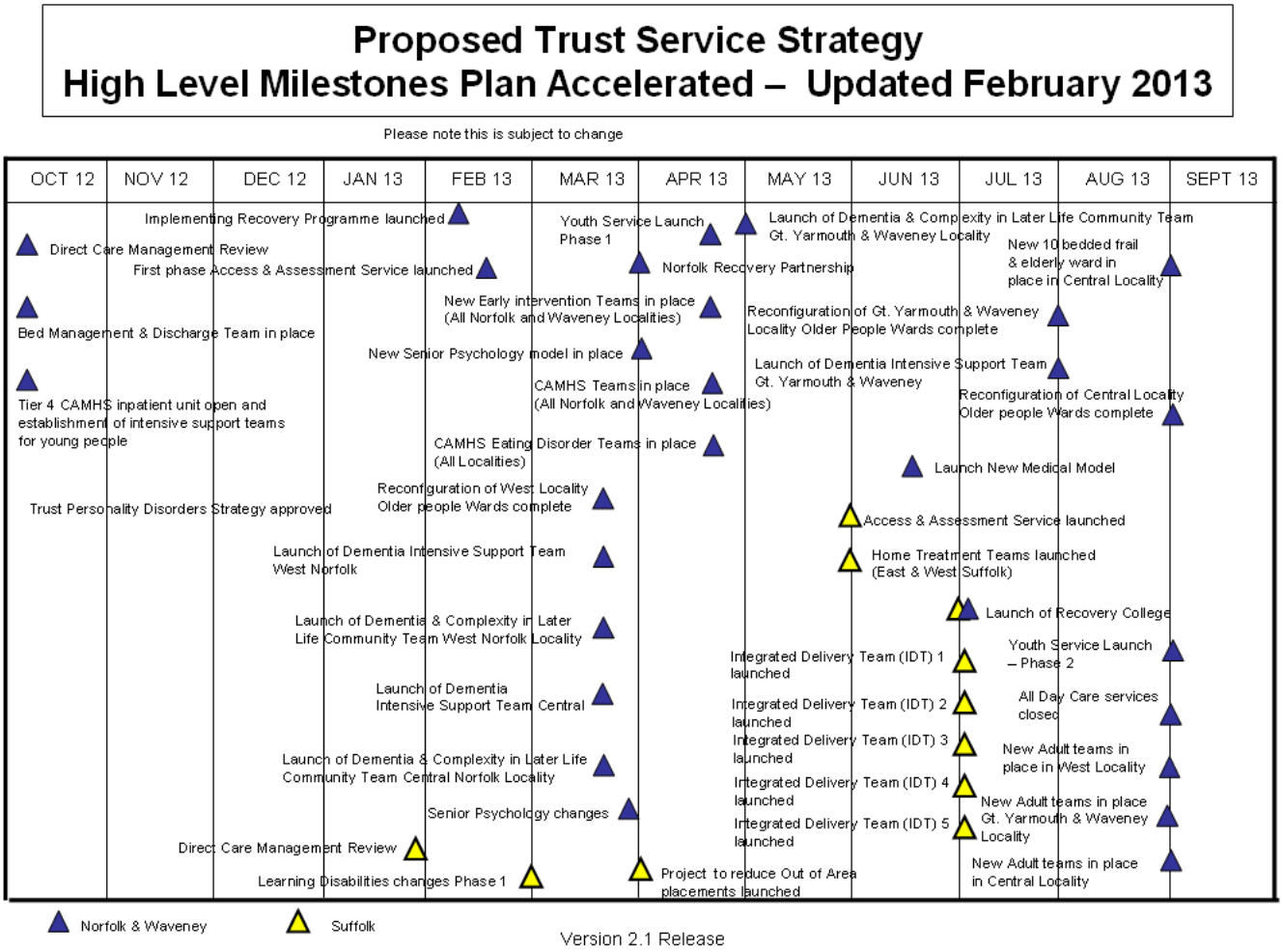
- promote teaching and research in all services
- examine and adopt evidence-based best practice from around the country
- support and encourage incident reporting and whistleblowing
- ensure the implementation of learning from incidents and complaints
- include quality and safety monitoring in all performance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

3.0 A summary of changes to the service strategy informed by staff feedback

Plans relating to any changes not already actioned will follow shortly.

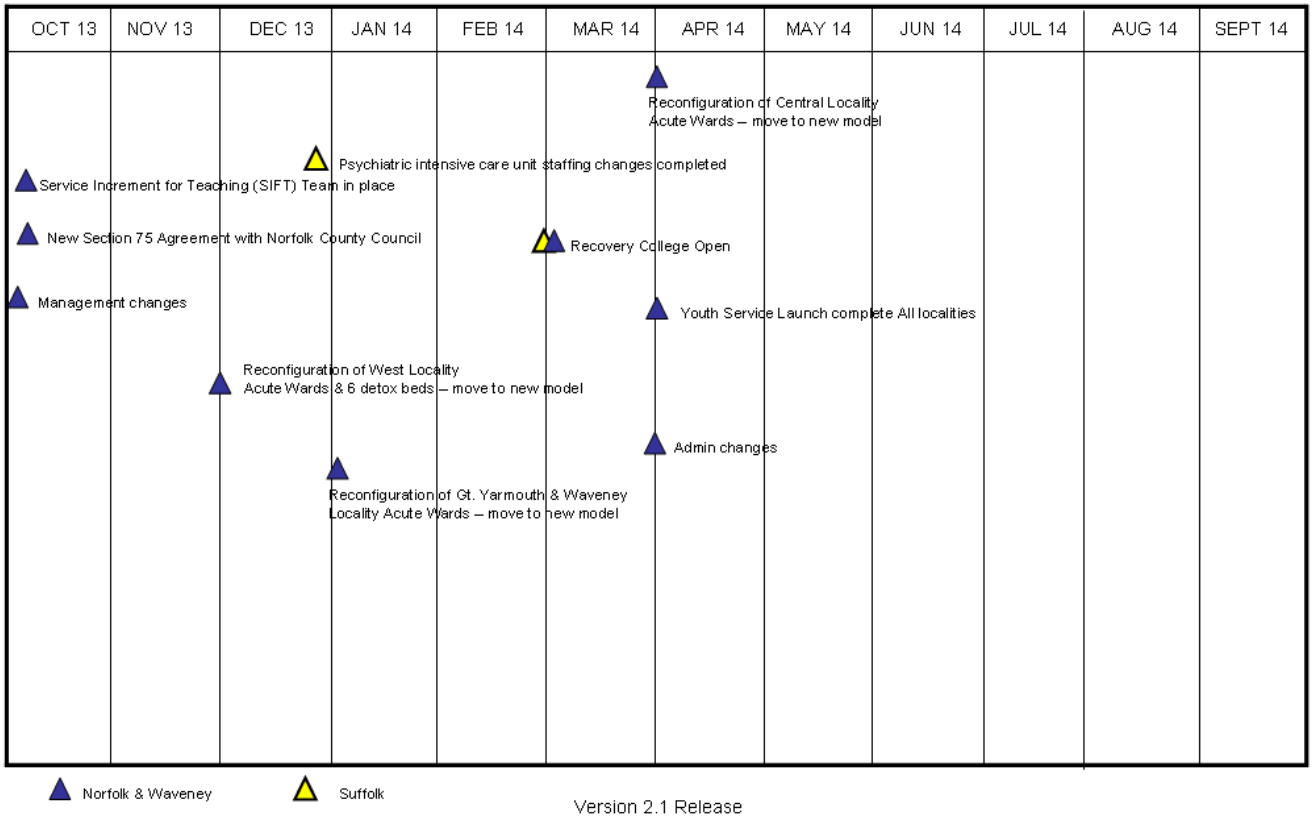
3.1 Trust-wide Changes to the Service Strategy

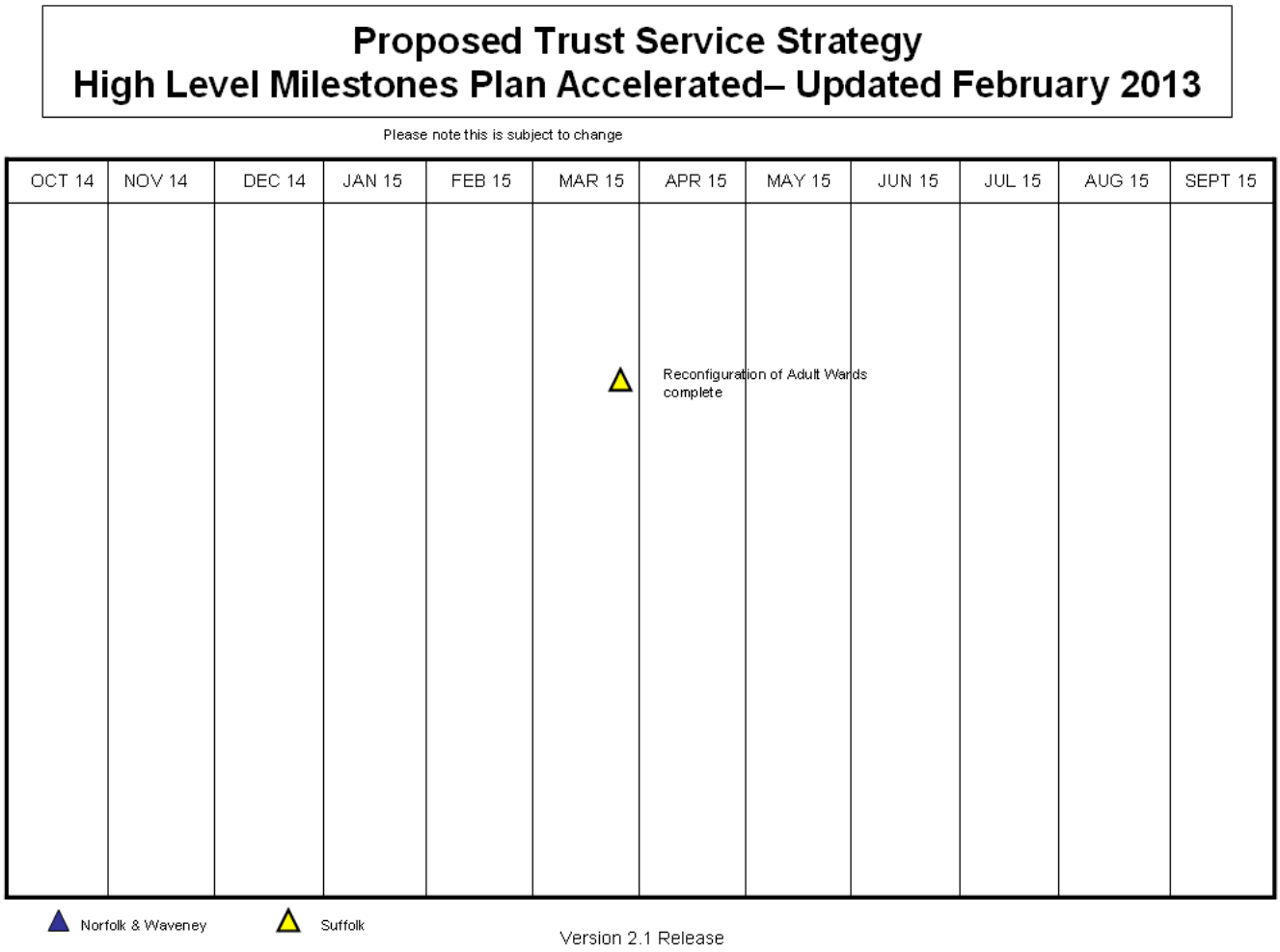
Set out below for information is the revised high level milestone plan. Alterations reflect feedback and the need to improve savings to fund increases in staffing as a response to consultation.



Proposed Trust Service Strategy
High Level Milestones Plan Accelerated– Updated February 2013

Please note this is subject to change





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 is holding a formal collective consultation on a 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 are individual consultations which 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. Some staff are 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.

2. There were many understandable concerns raised about safety risks as a result both of service change and the proposed new models themselves. We have clarified our response ion the section on service quality and safety above.

3. The Trust will comply with NICE Guidance in the design and provision of proposed services – for example Assertive Outreach will be specifically designated within Integrated Delivery Teams in Suffolk, and the adult services pathway in Norfolk.

4. Professions; The Trust agrees that parts of the Strategy staffing proposals do not clearly identify Professions Allied to Medicine – We will identify these posts and Nursing posts as appropriate in each service. The Trust is committed to employing mental health and social care professionals in a range of job roles, some of which will be redesigned and some of which may be new. All of the service lines include "mental health practitioner posts" which are key to the provision of high quality modern services. It is intended that these posts will be filled by practitioners from a range of professional backgrounds and training, including nurses, social workers and occupational therapists. It is integral to the redesigned service that each team has access to the range of skills and expertise that is available in a professionally diverse team. All of the service lines have medical posts and senior clinical psychology posts and the Trust is committed to New Ways of Working to allow these professionals to focus on the most complex service-users, providing clinical leadership and high level consultation and advice. The teams within the service-lines will be managed by clinical team leaders, these posts are open to people from a variety of professional backgrounds. The Trust is reviewing the medical input into each service. In addition to mental health practitioners the workforce plans for all service lines include clinical psychologists, psychological therapists, assistant practitioners and support workers. The individual service lines will each have other specialist posts as appropriate, for example physiotherapists in DCLL and family therapists in CAMHS. All the service lines will continue to require services such as administration support, pharmacy and inpatient/acute services.

5. The Trust agrees that it should recognise wider integration with primary care services and with acute general hospital services. It is very committed to this and this was an omission from the document

6. The Trust agrees that Medical staffing numbers should be reviewed taking into account the implications for teaching, and SIFT, as well as service provision. In particular the Trust will consider increasing proposed establishment in Access and Assessment, Adult Services (N+W), Dementia and Complexity in later life in Norfolk and Suffolk, and Central Norfolk under 25s services.

7. The Trust agrees that the Early Intervention service as part of the Under 25s service in both counties will continue to cover under 35s in line with the evidence base

8. The Trust agrees that more should be done to involve service users. 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 Recovery.

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

10. The Trust agrees that nurse consultant posts will be identified where required

11. The Trust agrees that it will seek new ways to generate income (It should be noted however that no suggestion in the consultation feedback, on initial assessment, appears viable as a significant income generator)

12. The Trust will clarify the Peer Support Worker role.

13. The Trust will clarify the alternatives to admission based on models elsewhere (including brief admission services, crisis services and fostering) with commissioners.
14. The Trust will take forward the work on Vision, Values and Behaviours to enable it to agree and roll out a staff charter which will support the implementation of the Trust Service Strategy.

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

3.2 Norfolk & Waveney – Changes to the Service Strategy

Pace and depth of Change

The Trust continues to press for transitional support to ease the pressure to change and for increased funding from commissioners.

In response to concerns about the pace of change and safety and quality during transition the Trust has made a number of changes to the implementation plan and workforce for Norfolk and Waveney. The workforce will increase by approximately 40 posts in 2013/14 to support the transition to new service models. For example, the Bed Management Team and the Access and Assessment Team now represent additional posts (as opposed to a reorganisation of existing teams). The higher staffing levels will support safe service change and allow us to evaluate the effectiveness of the new models before making permanent changes to services. The implementation plan has been changed to allow an additional year to achieve the changes to adult acute beds in Yarmouth and Waveney Locality. The number of medical posts will increase, for example by taking into account funding that the Trust receives for medical training.

Access and Assessment

1. We will negotiate with Norfolk County Council over Social Care assessments for service users of all ages as part of the S75 agreement

2. Additional psychology resource to be considered and agreed

Adult

3. ECT services will be included in the Central Acute Service Line.

4. Homeless services will be included and clearly identified. This will not affect implementation but they will be clearly identified

5. Clozapine clinic provision will be described more clearly in the staffing details.

6. Out of Hours resource will be clarified.

7. Psychology in the service line and the balance of workforce will need to change i.e. we have more psychotherapists than psychologists

8. We will resolve the structure so that the AMHP post does not report to a Band 6

9. The Trust will consider whether limited bed increases could be made to individual wards in Great Yarmouth

10. We will be reviewing all job descriptions, including those for Assistant Practitioners, to ensure that the roles are clearly defined

11. We agree that senior social care practitioners /leads are needed to ensure that social care functions are delivered effectively and efficiently. We are currently looking at the workforce plans and job descriptions to ensure this role is embedded within the strategy.

Complexity in Later Life

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

13. The Trust agrees to changes will be made to the skill mix of the DIST team increasing band 7's to 2 one for East and West

14. The Trust agrees to increase the number of band 6's and reduce the number of band 5's in order to improve capacity for more complex work

15. The Trust agrees the in reach Liaison nurse working collaboratively in the N&N and JPH Acute hospital settings will be a band 7 to reflect complexity.

16. Admiral Nurse roles are now being rolled out as a pilot in West Norfolk, clarity will be provided that the roles will be substantive and if the pilot discontinued the roles would convert to band 6 practitioners.

17. The Trust will ensure that the timing of the boundary change in West Norfolk Locality is managed to avoid services being swamped.

18. The Trust will consider further non-medical prescriber band 7 roles

19. The Trust will consider psychology support to the pathway with a view to increase it

20. The Trust has reviewed the pooling arrangements for DCLL and can confirm that there will now be two main pools as follows;

Future teams; West Community, South Central Community, North Central Community, West DIST, Central DIST – will be open for application to all current staff employed in the West Norfolk community team, Central Norfolk community teams (North, South and City), PCDPS in West and Central, Tennyson and Chase ward (including housekeepers), Allied health professionals in Central and West Norfolk, IST teams in Central and West Norfolk and Central DIST.

Please note that the Trust has agreed that staff currently employed in Central DIST will not be slotted-in to the posts in Central DIST and these pools will be opened up to other staff to apply for, as above.

Under 25 Service

21. Management of the LAAC team confirmed to sit with Central locality.
22. An overall increase in medical staffing in community teams for Central, West and Gt Yarmouth.
23. Early intervention in psychosis teams in Norfolk continue to offer a service from 14-35 years
24. The skill mix in the West will be adjusted to ensure key roles such as the ASD clinical nurse specialist post is retained and this supports the plans to improve the neuro-developmental pathway for children and young people.

3.3 Suffolk – Changes to the Service Strategy

1. Thetford: The Trust agrees that services in Thetford should be part of the Norfolk service model and this would better fit with social care for the majority of patients. We recognise this needs to be agreed with commissioners and other stakeholders however, and will work with them to achieve this.

Adult

2. The Trust will clarify the arrangements for the chlozapine clinic which is funded

Learning Disabilities

3. The Trust agrees that community Learning Disability Services in Yarmouth and Waveney should be managed as part of the Yarmouth and Waveney Locality

4. Inpatient beds for Learning Disability services will be reduced and a date for change agreed

Children

5. The Trust agrees Primary Mental Health workers will be retained

Complexity in Later Life

6. The Trust will review the skill mix to strengthen it

3.4 Change Management – Changes to the Service Strategy

1. The Trust will do everything possible to avoid redundancy – especially compulsory redundancy, and avoid losing skilled experienced staff. We will therefore review pooling arrangements to support flexibility maximise opportunities, while at the same time limiting disruption to the service where possible.

2. The Trust will where possible develop transitional roles and establish a flexible workforce to minimise redundancies, even though this may mean more than one role change for staff over the life of the Strategy

3. The suggestion of unpaid leave, will be followed up. This can only work if it is not backfilled with temporary staffing. The Trust will survey staff re this.

4. The suggestion of Voluntary early retirement (retirement in the interest of the service will be followed up to reduce redundancies.

5. The Trust will wherever possible avoid interviews for selection and simplify selection

processes. “Slotting in” will be adopted whenever possible. As suggested attendance record will be used as a selection criteria (with exception for serious ill health). Assessment centres identifying relevant skills will be used wherever possible and appropriate.

6. A number of concerns were expressed about particular job descriptions. Generic Job descriptions will continue in order to ensure flexibility for staff and protect jobs but the “supplementary sheet” to identify specific roles and responsibilities will be clarified.

8. The Trust has agreed there will be one Trust pool for Consultant Medical Staff, and SAS Doctors

9. For Norfolk and Waveney there will be one Trust pool for Bands 8d and 8c Psychology staff. Band 8 a and 8b psychologists will remain in individual service lines

4.0 Staff Feedback – Trust-wide – Themes & Response

This section focuses on the staff feedback received that did not result in a change to the service strategy. The main themes of feedback are outlined and any responses, commentary or explanation is set out.

Generic

Main themes in feedback received which have not resulted in service strategy change

a) There were concerns expressed at the speed of the introduction of the service changes and their impact on safety.

b) There were concerns expressed about having two models of care within the strategy.

c) Concerns about bed reductions;

d) Concerns that the Trust should use demographic need rather than referrals as a basis for service provision;

e) Concerns expressed about enhanced wellbeing and there being no evidence that people with milder mental health problems go on to develop more serious conditions.

f) Concerns expressed about sufficient key leadership roles

g) Concerns about access to a dietician

h) There were a wide variety of views received in relation to the pooling of clinical psychologists.

i) How will the service function with so many fewer senior clinical staff.

j) What is being done to ensure adequate administrative support.

Response / Explanation / Comment

a. The Trust has made some changes in Norfolk and Waveney which will assist in addressing this. We continue to press commissioners in both counties for funding to enable. Overall the Trust timetable is designed to try and ensure that we can implement the programme safely and we are investing in programme management to deliver this too. We are also putting in place monitoring arrangements which will assist (see section on safety and quality) We do accept that there are risks around the time-tabling, and have asked the CCGs for transitional funding through the life of the programme to enable the Trust to ease any timing problems. At the time of writing the discussions were still underway.

b. The models reflect the differences between commissioners and service history in Norfolk and Suffolk. For example reducing “hand – offs” between teams has been a priority Suffolk clinicians and commissioners. There are increasing differences between the services provided between CCGs in Norfolk and Waveney in any case, and these differences will inevitably increase as CCGs start to function. The Trust will not therefore have a

completely homogenous strategy.

c. The Trust wants to clarify its approach to bed reductions 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 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. In older peoples services there are other developments such as increased dementia intensive support which will be in place to create reduced bed usage before beds are closed. The Trust will monitor services with key stakeholders to ensure that closure is possible before decisions are taken

d. The Trust cannot provide for growth – we are funded for our current levels of service. Growth is a matter for commissioners to address. The service strategy has been designed to enable services to be extended easily as growth in referrals occur, and the introduction of Payment by Results should support this expansion.

e. The Trust agrees that there is no evidence however it is not trying to prevent people developing more serious conditions through enhanced wellbeing it is primarily dealing with an existing caseload of more serious cases which fall between wellbeing and the crisis services, and at the same time address wider wellbeing issues. This will free up the crisis services by reducing referrals from wellbeing.

f. Although there has been a reduction in the number of Clinical Team Leader posts we are developing other band 7 roles which will be able to support the CTLs in terms of leadership around social care, practice development and supporting the implementation of peer support workers. We anticipate that these roles will have a positive impact on the CTL role. Our review of other key senior clinical roles such as medical staff will also increase clinical leadership arrangements.

g. Individuals will be supported to access dietary advice and knowledge within their communities. This is consistent with the social recovery model. Where highly specialist input is needed from dieticians we need to examine how this will be commissioned and accessed.

h. No consensus emerged in the responses received. After review it has been decided that the senior psychologists will have a separate process and 8a and 8b posts will be pooled within service lines.

i. All of the service lines have medical posts and senior clinical psychology posts the number of these is under review as described elsewhere, and the Trust is committed to New Ways of Working to allow these professionals to focus on the most complex service-users, providing clinical leadership and high level consultation and advice. The teams within the service-lines will be managed by clinical team leaders, these posts are open to people from a variety of professional backgrounds.

j. In addition to Nursing staff, the workforce plans for all service lines include clinical psychologists, psychological therapists, assistant practitioners and support workers. The individual service lines will each have other specialist posts as appropriate, for example physiotherapists in DCLL and family therapists in CAMHS.

k. All the service lines will continue to include administration support. We will monitor administration capacity closely in order to ensure that capacity is sufficient to avoid diverting clinical time.

Access and Assessment

Main themes in feedback received which have not resulted in service strategy change

a Why shut down a very good service in Yarmouth and Waveney
b Access and assessment detracts from the skills of local clinical staff.

Response / Explanation / Comment

a Yarmouth and Waveney was established as a pilot – The Trust needs to run the service across all Localities and cannot afford to run five separate services, nor does it have the skills to do so safely. The concentration of triage resource will ensure that safety of triage in the wellbeing service is improved, and the Trust will use the evaluation and learning from the Yarmouth and Waveney pilot to help with implementation of the Trust wide service.
B Evidence from elsewhere (e.g. Hull and Herts.)shows that the introduction of this service will reduce the number of assessments patients experience and reduce "hand offs" between teams, and at the same time improve access for Service Users, GPs and carers. It will also improve the quality of referral and remove the high level of inappropriate referral pressure on CRHTs.

Adult

Adult pathway trust wide

a. Concerns expressed about capacity to engage in recovery orientated work under the proposed service strategy:
The service strategy includes the adoption and support of IMROC across the whole organisation. This focus of this work is on how the organisation can support the implementation of recovery approaches, working in partnership with service users and carers. This project is looking at how we can do things differently rather than doing the same but with less resources.

Dementia and Complexity in Later Life

Main themes in feedback received which have not resulted in service strategy change

a. Cognitive stimulation therapy should predominantly be delivered by NSFT staff directly and we will not be meeting one of our Quality Goals if we do not do so
b. Memory assessment proposal is not workable requires a degree of efficiency which cannot be achieved by Band 6s –skilled medical assessments are more efficient
c. The model proposed for memory assessments within CMHTs will not be achievable, memory assessments are more involved and time consuming that recognised in the model.
d. The ability and skills within DIST raised as a concern to manage patients with functional (CLL) needs as well as Dementia

e. The new service models are untested including acute bed reductions, alternatives to admission, closure of day care services (which will exacerbate this) and having adult services accept referrals currently cared for in Older Peoples Services
f. Triage, assessment and diagnosis should be within AAT with complex cases coming to secondary care as there is a reduction in the number of practitioners within DCLL

Response / Explanation / Comment

a. The scale and the potential for an increased demand for CST means that our current model for CST would not be equitable or deliverable. NSFT will work with partners to develop a more distributed model of CST delivery in order to manage current and future demand. To enable us to do this we will discuss with the dementia Academy ways which will enable NSFT to train a wide range of partners and organisations to deliver CST
b. The proposal for DCLL includes increasing both skills and operational efficiency (through identifying within CMHTs Band 6 to focus upon memory assessments) and enhanced training for band 6s in assessment currently being developed by the UEA Psychiatrists will remain key to the successful implementation of the proposal through ongoing supervision and training of non-medical assessors, and delivering face to face assessment of the most complex cases.
c. As above in the response to b. As a result of introducing dedicated memory assessment assessors, as has shown to work in parts of most localities, efficiency increases. It is a well established principle that the more often a clinician undertakes a particular procedure, the better and quicker they get at doing it.
d. With DIST staff no longer being `slot ins` there is the potential to introduce staff through selection have the skills required. It is likely if DIST did not see CLL patients DCLL clinicians would express concerns about them being cared for in Adult Services. DIST has continuously evolved to meet changing requirements of NSFT in the most flexible way possible
e. DIST has been used very successfully in reduction of bed usage in Norfolk. Alternatives to admission will still be considered as the intention is to offer clinicians choices regarding care in an acute phase including beds. Other options will be explored including hosted families and closer working with Social Services. The current day services have costs and a service model which will be difficult to sustain. In addition DCLL service users should be enabled to make choices such as personal budgets that give them the same choices and opportunities in their communities as are younger people who are receiving services based upon Recovery principles. This principle applies with older people being cared for in services which were traditionally adult ones but now can have access to their the skills of staff in those teams.
f. Assessments will occur within the DCLL service line. Having a structured standardised approach to memory assessments will enable teams to manage high volumes of referrals and maintain statutory functions. By retaining the assessments in the pathway the potential for misdiagnosis and repeat assessments in secondary care will be reduced.

Under 25s

Main themes in feedback received which have not resulted in service strategy change

Concern that there is no evidence to support the introduction of a Youth service

Response / Explanation / Comment

There is substantial evidence for this including published research and the evidence of working services like that in Birmingham.

Change Management

The Trust has received a number of pieces of feedback during collective consultation relating to the HR and Change Management Process. All feedback received has been considered and responses provided below where appropriate. A number of the queries raised have been translated into Frequently Asked Questions (FAQs) and added to the Intranet for staff to access.

In addition to the responses below, feedback relating to Job Descriptions is currently being considered separately by the Job Evaluation Working Party, changes from which will be published on the Intranet. Much of the feedback was received at the consultation mid-point and has already been actioned.

1. CHANGE MANAGEMENT, REDEPLOYMENT AND REDUNDANCY POLICY

Identifying impacted staff and Ring-fenced Pools
Feedback has been received from staff that impacted staff and 'ring-fenced pools' in Norfolk and Waveney should be re-defined by speciality rather than geographical location. The Trust has revised its approach, and although this has not been applied in its entity; for a number of milestones; additional areas have been combined, examples being;

- Medical Workforce across Norfolk and Waveney
- All and Under 25's service changes combined
- D&CLL in West and Central combined

By combining these individual milestones, the Trust envisages that based on flexibility; there will be greater opportunities for staff redeployment and minimising compulsory redundancy.

2. SELECTION

Consideration of formal sanctions during selection
Throughout the collective consultation period, a significant amount of feedback has been received relating to the proposed selection methods used as part of the change management and redeployment process.

High level proposals made available to staff included details on a range of selection methods, including the use of live formal warnings in respect of disciplinaries, performance management and attendance. The use of 'live' warnings is something widely used in private sector organisations and feedback from staff has been largely in support of their use. The use of such sanctions will be applied consistently across the various programmes of change.

Following a feedback event on 28th January 2013, a further staff questionnaire has been added to the intranet, seeking further views on the use of 'live' attendance, disciplinary and performance

management warnings when scoring during selection. Please take some time to consider the questionnaire online, the outcomes from which will help inform our final proposals.

Fit for purpose selection process
Staff have voiced their concerns about avoiding a bureaucratic and time consuming process for selection. Please be assured that bespoke selection plans for each milestone of change have and will continue to be designed to ensure that they are fit for purpose, taking into account for roles, skills and workforce changes in each area. Subject to individual consultation the Trust will be implementing the use of 'slot-ins' wherever appropriate. Because of this expect to see selection plans for each change which are slightly different for this reason. For each individual programme of change staff will have an opportunity to provide feedback on the proposed selection methods impacting them.

Some staff have commented that we should avoid a lengthy selection process and instead 'reallocate' posts to staff based on appraisal and performance management data. The Trust is committed to ensuring that all selection methods used are robust, fair and consistent; the current records used across Norfolk and Suffolk are in the process of being merged, and in their current state would not provide a 'level playing field' for assessment in these circumstances.

Timing
The proposed timetable for the different milestones to be implemented was shared as part of the consultation pack provided to all employees in October and any changes to the timetable are being communicated as and when these are confirmed. Feedback has been received that staff may have limited opportunities depending on the timing of their particular change. There are, of course, different options for implementing change from a staged approach, as is happening with the Norfolk model or a 'big bang' approach as is happening with the Suffolk model and these different options have varying advantages and disadvantages including the availability of jobs at different stages in the process if implemented incrementally. Concerns regarding the availability of posts for employees affected by the changes scheduled later on in the programme are, of course, understood. We will continue to do our best to safeguard job opportunities through continued robust vacancy management, informed by our workforce planning, so as to support the redeployment of employees wherever possible and to thereby minimise potential redundancies.

Cost of recruitment
Utilising internal venues and designing selection programs, including assessment centres internally means that the Trust is able to minimise associated costs.

3. OTHER MONEY SAVING INITIATIVES

A number of other money saving suggestions have been received from staff including the use of unpaid leave and a voluntary pay cut as a means to minimising compulsory redundancy. Further questions seeking staff views have also be included in the online questionnaire running to the 22nd February 2013.

4. STAFF SUPPORT

The Trust acknowledges and appreciates that the program of changes associated with implementing the Trust Service Strategy is causing considerable anxiety for staff. Feedback has been received during the collective consultation period that the timing with Christmas has been insensitive and necessary. The Trust is under considerable pressure to meet its new cost improvement programs targets and ensure that staff consultation is timely and meaningful. There are a number of measures in place to support staff at this time, including;

- Management supervision
- Occupational health
- Regular Communication updates and FAQs to ensure that staff are well informed
- One to One meetings during individual consultation
- Outplacement support to those staff on notice of redundancy

No specific suggestions have been received in what can be provided in addition to the above, but if staff consider they need additional support them should discuss this with their relevant line manager immediately.

5.0 Staff Feedback – Norfolk & Waveney – Themes & Response

Access and Assessment

Main themes in feedback received which have not resulted in service strategy change

a. Lack of medical involvement in the Access and Assessment Team (AAT).
b. AAT has limited access to specialist assessment.
c. Great Yarmouth and Waveney referral systems are established and working well.
d. Access to services should be managed locally, not centrally.
e. Having a separate assessment service will deskill staff.

Response / Explanation / Comment

a. There will be full time consultant psychiatrist cover to answer GP queries, oversee the triage of referrals, and support the team with assessment, formulation and management. It should be noted that this will be considered in the review of medical posts. This will be considered at as part of the medical review mentioned elsewhere.
b. Specific patient groups are recognised as requiring specialist assessment and treatment. Where these are identified at triage they will be referred on for their initial face to face assessment with the most appropriate person in the appropriate service. Continuing work both before and after the AAT launches will further improve the identification of such individuals.
c. It is recognised that there is much work going on in the trust that is working well, and GY&W have recently introduced further changes to their triage process. The effect of these changes has been reviewed and data will be compared to the work done by the Central and West AAT. Good practice from all parts of the trust will be adopted but it is expected that a single consistent triage process will be used in all localities.
d. Central triage confers a number of advantages:
    a. Natural variation in referral rates can be managed more effectively with a larger pool of staff.
    b. It is easier to have professional representation from across professional backgrounds (nursing, social work, occupational therapy) in a larger team.
    c. Staff will be drawn from all localities to share knowledge of local services.
    d. Face to face assessments will continue to take place local to the patient.
    e. A single system looking at all referrals will better allow the Trust and Commissioners to plan services and allocate resources.
e. Assessment does not stop after the first face to face contact – it is a continuing part of all clinical contact. Staff may also choose to move between assessment and treatment services, bringing existing skills into the team and developing additional

skills.

Adult

Main themes in feedback received which have not resulted in service strategy change

a. Concerns at proposed timing of schedule of closure of inpatient beds
b. Concern that Age integrated service will lose specialist frail elderly skills and knowledge
c. reasoning for team sizes within Localities
d. Concern at skill mix and reduction in specific staffing groups
e. 'Out of hours' arrangements?
f. The loss of a primary care service
g. Concern expressed about opportunities for nursing staff
h. Concerns about older people with non dementia mental health problems being seen within the adult service line
i. Access to specialist psychotherapy

Response / Explanation / Comment

a. The Trust is clear that any reduction in beds must be preceded by a period of time where it can be evidenced that these beds are not regularly in use. Therefore any reduction is dependant on the success of the new models of care proposed under RPR- not as a driver to create the changes. These include current measures already implemented to reduce bed pressures such as the BDMFT and future measures such as closer working with housing partners and authorities, reduction in LSU waiting times for both assessment and acceptance and extended community team hours. Currently each locality is developing plans for Alternative to Admission strategies, again designed to support the reduction in bed use by placing service users in the most appropriate placement for their needs at that time. Service Users with serious acute illnesses requiring treatment should be treated within an acute service pathway by people who specialise in acute illness. Part of the competency of the team to do this is to able to manage the increased physical health and social needs associated with this patient group. There is overwhelming evidence across different medical specialities that outcomes are better in specialist units.

b. Within the acute services there will be a ward which is specifically designed and staffed to meet the needs of people with high physical dependency. This area will ensure that staff are specifically trained to meet the needs of this group of service users and their families. Regular planned rotation of staff within the acute services will also be implemented to up skill the whole workforce, ensuring that the relevant skills and knowledge are there to support service users who's needs may not require the specialist unit, but have age related needs as part of their overall care needs.

c. Team sizes within localities. Under the new RPR model team sizes are fully linked to population and CCG funding models. Under the block contract resource was available to be configured by the Trust across all of its operational areas under the direction of the Trust. Direct funding by CCG's means that each area will now receive a proportional budget, based on population serviced by this CCG. If this was not to happen then one CCG could end up subsidising another's

patient group which would not be acceptable to them. Therefore areas with the smallest population areas will by necessity see a matched resource, which in some instances may be a reduction from current funding.

d. Skill mix and reduction in staffing groups. There have by necessity been some changes to skill mix for some groups of staff. This may relate to either: 1) The changes to funding by direct commissioning from the CCG areas. In some of the smaller localities this has reduced funding and therefore establishments have had to be considered against this reduced available budget, or 2) new establishments have been developed to meet the need of the future service and at times vary significantly from the 'as is model'. New service models have been designed to provide the best available skill mix within the new budgetary resource. sure that resource is not duplicated unnecessarily where possible to maximise effectiveness. It is important however to recognise within a reduced budget that cuts will at times be an unavoidable necessity as is re-skill mixing to maximise where possible the service and volume of services available for our service users.

e. Minimum staffing levels 'out of hours'. All of the new models meet the minimum staffing levels required out of hours. However for acute a specific outcome which positively supports this issue is the plans to extend hours of the community teams and the access and assessment teams. This will mean there is a supplementary resource available to support acute staff and their service users out of traditional hours, allowing for increased diversion of service users before they require acute services, providing a positive outcome for services users and families- and reducing pressure on acute out of hours teams to act as 'catch all' services in the absence of other resource.

f. PbR leads are working together with managers and CTLs to look at how we merge what was primary mental health care into the service lines. The intention is to retain the best practice from the old model. Although the initial assessment element of the work of what was primary care is now provided within the Access and Assessment Service the other functions will remain. A wellbeing focus remains crucial for service-users in the adult pathway, whatever their level of need. There is no intention for all service-users in the adult service-line to be care-coordinated, or visited at home. The plan for the adult service-line includes Practice Liaison roles to maintain good links with GP surgeries and a brief intervention arm. We need to continue to provide services as close to peoples local areas as possible. The adult service line will now be providing services for people from clusters 3-17.

g. A certain % of band 5 and band 6 posts are designated for people with a nursing qualification. There are also opportunities for more specialist roles via CTL roles, AMHPs and ongoing work around the potential for other specialist nursing posts.

h. We acknowledge that older people need to be seen within a service that best meets their needs. The boundary between the Complexity in Later Life service line and the Adult service line will need to be flexible. Some older people will have complexities associated with ageing and some will find that their needs are best met within the adult service line. At present we have estimated where this line may fall in terms of numbers but are aware that we may not get this right straight away. The numbers of older people being seen within each of these

service lines will be monitored and resources reallocated accordingly if we find that we need to make changes.

i. There are specified psychotherapy posts within the adult service line. The expectation is that these will be filled by psychotherapists practicing a variety of evidence based approaches in order to provide choice to service users and be able to match type of therapy to the individual. There will also be support for psychotherapists to extend the range of approaches they are able to use. We are also investigating options for purchasing more specialised therapy that we do not provide within the trust on a sessional basis.

Dementia and Complexity in Later Life

Main themes in feedback received which have not resulted in service strategy change

a. Continuing care staff should have been within this phase of DCLL Service Strategy Implementation
b. Managing increasing volumes of referrals will make us less cost effective with fewer staff expected to manage increasing referrals particularly in Dementia
c. Feedback has been received regarding the proposed selection methods for the DCLL service line and a suggestion that line manager opinion and appraisal records should be utilised.
d. Day Hospital staff should be able to apply for posts within the community structures
e. Physiotherapy should feature in DISTs as a specific role
f. Discharge coordinator. Queries have been raised regarding whether this should be a post or rather a function of the DIST team

Response / Explanation / Comment

a. Continuing care will not be brought into this phase of DCLL implementation. But it seems fair and equitable that when acute wards at Carlton Court and the Julian Hospital are in scope for DCLL implementation Continuing Care is added in both hospitals. No bed reductions are currently planned for CC
b. As we approach the introduction of Payment by Results for Mental Health, increased activity/volume of work will form the basis of aligning resources to demand through discussions with our commissioners.
c. For DCLL selection fair but robust processes are needed which will provide all staff with an opportunity to be within the new teams
d. Currently project plans are in development for the service changes in Day services. This is a complex process which will need some stability in the staff group. This year there will be opportunities at Carlton Court and the Julian Hospital for staff to apply for posts in the next phases of implementation
e. Predominantly Physiotherapy is a ward based service but DIST will be able to access physio for specific sessional support including falls prevention
f. This continues to be a post within the DIST Teams in Central as there is evidence that this is a valuable role in preventing admissions and reducing lenths of stay in hospital. In other localities that have reductions in bed numbers it will be integrated as a function.

Under 25s

Main themes in feedback received which have not resulted in service strategy change

a Increase in number of staff.
b Role of Psychologists and review of job descriptions.
c Full integration of LAAC into under 25s service.
d Increase age range for Psychosis to 45 years
e Lack of substance in the consultation regarding what types of patients will be seen by each part of the under 25 service.
f Inaccuracy of baseline data

Response / Explanation / Comment

a. Some increase has taken place but not to the extent requested or recommended by documents such as Council Report dated November 2012 from the Royal College of Psychiatrists. The reason for the limited increase is as a result of the financial constraints. There is an acknowledgement that it could lead to a diminished ability to safely manage the most complicated patients as a result of excessive reduction in medical staff and it is very likely to significantly compromise the ability of senior staff to fulfil their duties as clinical leaders over and above their clinical work. The plans as they stand could seriously compromise training capacity for Central Norfolk. This is based upon the significant discrepancy between what is recommended in Council Report 174: Safe patients and high-quality services: a guide to job descriptions and job plans for consultant psychiatrists (November 2012).
b. Job descriptions have not changed because within the job plan Psychologists will continue to provide supervision and consultation to other staff.
c. For the time being it will continue as a separate team as a result of the current commissioning arrangements and as per discussions in the steering group.
d. We have increased the age range for EI to 35 years, but not 45 because all patients presenting will be receiving a cluster 10 first episode psychosis care package delivered by the appropriate team.
e. The under 25 service has developed and continues to be in line with national developments for Payment by results and associated care packages. We envisage that the service will continue to develop depending on feedback and local need.
f. We used the best data we had at our disposal at the time.

Wellbeing

Main themes in feedback received which have not resulted in service strategy change

a. Linkworkers are to be withdrawn from GP practices.
b. Who will be carrying out the work currently done by the Wellbeing Service?

Response / Explanation / Comment

a. The use of Linkworkers has been variable across different GP practices. As well as easy access to advice through the AAT, Liaison Workers will be allocated to groups of GP practices to maintain links and provide information to GPs.
b. At present, Wellbeing provides three broad functions. In the new strategy these will be carried out as follows:
    1. Psychological therapy for mild to moderate mental health problems will continue to be provided by the IAPT service, much as before
    2. Triage of referrals into the Trust and assessment of many of these referrals will be provided by the AAT
    3. Treatment of moderate mental illness outside the scope of IAPT will be

	carried out within the other service lines, with resource transferred accordingly. This is the patient group previously treated by the Primary care/Linkworker service.
Alternatives / Generic **Main themes in feedback received which have not resulted in service strategy change** **Generic** **a**. Concerns around workload: To deliver the service without placing excessive demands on the workforce we will have to develop radically different ways of working. These include changing the way in which CPA is delivered to a less bureaucratic system to one of a collaborative process with service-users and carers with less onerous paperwork, changes to the Section 75 agreement to reduce the time taken to set up and review social care services, much greater use of personal budgets to provide packages of care and new initiatives such as the IMROC programme. The latter includes the development of peer support workers and recovery colleges. The Trust will establish a review of bureaucracy at an early stage in the programme.	

6.0 Staff Feedback – Suffolk – Themes & Response

6.1 Access and Assessment

Main themes in feedback

a) Loss of assessment skills throughout pathways.
b) Insufficient admin line management (1x Band 4 for 11 admin staff).
c) Concern that minimal psychological input into Access and Assessment service will result in a lack of formulation-driven interventions.
d) What is the definition of 'out of hours' and who will be responsible for urgent assessments in that time?
e) How will service users be assessed for therapy?

Response/Explanation/Comment

a) As has always been the case in mental healthcare, clinicians will undertake on-going assessments for all service users. The Access and Assessment service will ensure that service users are appropriately assessed at point of entry and are directed to the correct service, but will not replace clinicians' further involvement. Movement between pathways (and therefore into and out of the Access and Assessment service) is also common, so it is not anticipated that there will be a reduction in assessment skills in the pathways.
b) The Trust agrees that this is a pressure and should be reconsidered; however the final configuration of bandings will need to fall within the cost envelope.
c) Formulation work done by psychologists will initially sit within the Integrated Delivery Teams to ensure proper integration and a seamless experience for the service user. The Access and Assessment service will provide a thorough diagnostic formulation that will help inform this. However, the suggestion that increased clinical psychologist input should be part of the Access and Assessment service will be considered as a possible development as part of the post-service launch review.
d) Core hours are 8am-8pm Monday to Friday, excluding bank holidays. Out of hours functions will be delivered by the Urgent Assessment arm of the Access and Assessment team, which will operate 24 hours a day, seven days a week.
e) Service users will receive an initial assessment for clustering and pathway allocation, including an initial formulation and care plan. They will then be sent to the appropriate Integrated Delivery Team, which will determine whether to provide therapy and will assess further if required to determine ability to engage and other relevant factors.

6.2 Adult

Main themes in feedback

a) Maintaining safety with this level of cuts.
b) Justification for reducing the number of therapists in both Primary Care and Adult by 50%.
c) Wouldn't it make more sense to roll the changes out over a number of years, with planned savings of 4-5% each year, rather than all at once?
d) Concerns around evidence of prevention-focused models (moving funding from the most unwell to the least unwell) being effective.
e) Difficulty of assessing consultation without more detail regarding caseload sizes.

Response/Explanation/Comment

a) The Trust accepts that it will be a challenge to make services as safe as possible with fewer staff, but there is no alternative. The cuts are required in order for the organisation to survive. Measures will be put in place to monitor services as they change, while the skill mix will be reviewed on an on-going basis. Governance monitoring will be robust to ensure

patient safety – this process will be led by Dr Hadrian Ball and Roz Brooks.

b) In Suffolk, psychologists and psychological therapists will work together in the Integrated Delivery Teams. We anticipate an overall increase in psychological working, but hope that psychologists and therapists will support other workers to become more psychological. In practice psychologists and psychological therapists will oversee psychological work as well as undertaking it directly when needed, but the Trust welcomes views on how to distribute them within the Integrated Delivery Teams.
c) This was considered, but changing services one by one runs the risk of leaving individual services behind, both in terms of service model and staffing. The proposed model ensures that services are integrated and reduces the likelihood of staff moving repeatedly between different parts of the Trust. The current block on vacancies at the Trust means that some areas are already beginning to struggle, even without further cuts. An overall redesign was therefore considered necessary.
d) The focus of the model is on prevention and wellbeing, which should reduce referrals to secondary care. It is not expected that this will happen immediately, but over a period of time. Clustering and other information will be used to inform the proposed model.
e) Work is currently being undertaken to develop a better prediction of caseload size. As described above (**section 3.1**), shorter service-specific consultations will be held at a later date.

6.3 Complexity In Later Life

Main themes in feedback

a) Changing demographics in Suffolk, with more people presenting with dementia and more instances of complex dementia.
b) Reductions in medical staff and expertise.
c) Concerns regarding the proposed skill mix.
d) Consistency of interventions for people with dementia.

Response/Explanation/Comment

a) These concerns are acknowledged, but as this is an issue around the growth in need for a service, it will have to be negotiated with commissioners. The service model is being designed to be flexible enough to cope with on-going increases in demand. The Trust is in negotiation with PCT/CCGs regarding the needs of complex dementia patients.
b) Further consideration will be given to the involvement of medical staff in the Complexity in Later Life pathway, which will include seeking the advice of relevant clinical staff. However, it is important to note that memory services around the country use a range of different models, not all of which are medically-led. The current proposals include two nurse prescribers in each Integrated Delivery Team.
c) Changes to the skill mix are possible (for example it is acknowledged that there is a lack of an 8a Psychologist for inpatient areas in the proposed structure) and should be suggested as part of the service-specific working group. These concerns should be raised directly with leads for this, Ben Underwood and Rob Butler.
d) Interventions for people with dementia will be reviewed across the pathways. The proposed model is an attempt to integrate and share skills across a locality and reduce the silo working that has previously dominated mental healthcare.

6.4 Children and Families

Main themes in feedback

a) Concerns regarding access points and waiting areas for children's services.
b) Certain job roles and teams disappearing.
c) Inwards-focused consultation.

d) Flexibility of services with regards to transition age.

Response/Explanation/Comment

a) The Trust agrees that children and families should not have to use the same access points and waiting areas as adult service users. These plans are under review, with the aim being to have separate entrances, waiting areas and consulting rooms.
b) The proposals do not describe the workforce in detail – for example a number of roles have been given generic job titles such as 'clinical worker'. A range of band 6 and 7 workers will deliver services to children and families in ways that reduce and prevent difficulty and allow for early intervention. Clinicians working within the pathways will be integrally involved in defining each of these posts. Posts that have their own funding stream (e.g. Primary Mental Health workers) will remain unaffected.
   The current teams will effectively be incorporated into the Integrated Delivery Teams, so a specific team no longer being mentioned does not mean that this service is being removed.
c) The need for consultation and engagement with external stakeholders is acknowledged. The Trust has engaged with partner agencies and will continue with this while looking to expand it.
d) The Trust acknowledges that the Service Strategy does not make clear how flexible pathways are in relation to age or any other factor. Clarification will be sought during the next phase of the consultations in collaboration with the pathways.

6.5 Young People

Main themes in feedback

a) Concerns re the location of beds for young people and compliance with Article 8 of the Human Rights Act (the right to family life).
b) Lack of mechanism for the involvement of children and young people service users to be involved in the service strategy development process.
c) Concern that skills related to CAMHS and Eating Disorders will be lost as a result of specialist skilled staff being dispersed across Delivery Teams

Response/Explanation/Comment

a) Specialist beds will be provided and the best solution for how to provide them across Suffolk to give appropriate access is being sought. Alternatives to acute care will also be pursued, which may be more appropriate for some service users' needs.
b) Service user participation will be at the heart of the development of the Young People pathway. This will start with their involvement in the youth service conference planned for early April.
c) The Trust will consider how best to protect specialist skills within the integrated delivery teams. We are considering enabling specialists within teams to meet and liaise closely with this in other teams and ensuring a skill mix and supervision is retained across teams, while delivery is within them.

6.6 Neuro Development

Main themes in feedback

a) Concerns regarding the removal of inpatient beds for Learning Disability services.
b) Specific services disappearing and demand for other services increasing.
c) Possible inequity of service in different areas due to unequal population (and associated unequal staffing in Integrated Delivery Teams).
d) Concerns that historical knowledge of patients will be lost when senior staff move teams.

e) Necessity to involve pathways other than Neuro Development in Learning Disability cases.

Response/Explanation/Comment

a) This has been reviewed – the Trust acknowledges that there is a need for some inpatient beds for Learning Disability services, however this is likely to be fewer than there are currently (see **section 3.3**).
b) The Trust will continue to provide all services for which we are commissioned or have a statutory responsibility to deliver. These services will be covered in the pathway-specific service specifications. As demand changes, conversations will be on-going with commissioners to ensure that funding is appropriate. Access criteria for services will be as agreed with commissioners in the service delivery contract.
c) For practical reasons, the modelling has assumed equal populations across all teams. It is acknowledged that this is not the case and there is detailed work on-going to identify and accurately balance the demographics and needs. The number of staff in each pathway will subsequently be adapted to reflect this. This is a particular concern for more specialised professions – currently plans involve specialised practitioners being hosted by one Integrated Delivery Team and delivering services to others (rather than having multiple bases).
d) Information relating to individual service users should be recorded on the appropriate system. Part of the aim of the Integrated Delivery Teams is to eliminate the storing of information in knowledge silos – once integrated, staff will have extensive opportunities to share information regarding service users and best practice.
e) The model allows for specialist input to be provided in each of the proposed Integrated Delivery Teams. Individuals with Learning Disabilities will be able to access all the pathways, with the most complex cases receiving input from the Neuro Development pathway. The integrated model is predicated on the concept of all components of the pathways working together.

6.7 Alternative Suggestions

Main themes in feedback

a) Concerns that local services will be abandoned for county-wide ones.
b) Job insecurity.
c) Line management issues when teams are combined.
d) Alternative proposals for the structure of pathways, services and Integrated Delivery Teams.

Response/Explanation/Comment

a) Local assessment and delivery of service will be maintained. Integrated Delivery Teams will increase the prevalence of local delivery, not reduce it.
b) The Trust acknowledges that job uncertainty is unsettling and causes a concern for all staff, not just those whose jobs are potentially threatened. We are trying to minimise stress for all staff by moving the Service Strategy forward as fast as possible and appropriate.
c) There may be difficulties in taking on and managing a different structure. All managers will be provided with training to support the cultural change, through an external provider. An appropriate support structure will be put in place for all managers.
d) A number of proposals have been received for detailing alternatives to the proposed pathways. Each of them have been passed to the relevant group working on the pathway and will be considered as appropriate. In some cases the alternative proposals have gone in to more detail than the Service Strategy, so will help inform the discussion for the relevant pathways. In other cases not enough detail was provided – this will be requested through the individual responses to the consultation feedback.

6.8 Generic

Main themes in feedback

a) Concerns regarding the removal of the Assertive Outreach team
b) Will the Early Intervention approach be lost?
c) Concerns around whether the new roles that have been discussed will be introduced.
d) Lack of clarity around the Integrated Delivery model, including its location.
e) Concerns around sickness – in terms of decreasing numbers of staff and greater expectations
f) Too large reductions in numbers of medical staff.
g) Importance of appropriate IT solution for Integrated Delivery Teams.

Response/Explanation/Comment

a) The Trust acknowledges the benefits of the Assertive Outreach approach and function. This will be maintained in all of the pathways – resulting in an overall increase of its availability and ensuring that service users that need the Assertive Outreach approach will still receive it. However a separate team will not be considered.
b) This is similar to the Assertive Outreach issue. The Trust acknowledges how beneficial the Early Intervention approach is and confirms that this approach will be enhanced throughout the pathways, which will all have a significant focus on intervening as early as possible.
c) The following roles will be introduced as planned: Assistant Practitioner, Non-Medical Prescriber, Non-Medical Approved Clinician and Responsible Clinician. They will be included as appropriate in each pathway.
d) Much of the detail for the Integrated Delivery model is being worked on, with the process including workstreams from each pathway. The first Integrated Delivery team workshop was held at the start of January – each pathway worked through scenarios for how it would function in practice.
   It is expected there will be five Integrated Delivery teams. One will be at Mariner House in Ipswich; one will cover the coastal area (venue TBC); one will be in mid-Suffolk (venue TBC, likely to be Stowmarket); and the last two will be in Bury St Edmunds. In addition to this, local consulting rooms will be maintained around the county (e.g. in Sudbury, Newmarket, Haverhill). An options appraisal is currently underway and more detailed information will be available soon.
e) The Trust has a new Sickness Policy in place which is designed to enable managers to work with staff to actively reduce absence. This will be implemented by all managers.
f) The Trust recognises that the reduction in numbers of both consultant psychologists and SAS doctors has been too great. Medical numbers are currently being revised, taking into account the need to provide sufficient educational and clinical supervision. The skill mix and numbers of all professional groups are subject to change as part of the on-going response to consultation feedback.
g) The Trust's ICT department is currently working with the pathways to achieve a unified system.

Norfolk and Suffolk NHS
NHS Foundation Trust

Title of Report:	Norfolk and Suffolk NHS Foundation Trust (NSFT) Strategy 2012/13 to 2015/16 **Planned Service Capacity for 2012-2016**
Version:	V. 13; March 2013

* Totals rounded to 100

SUFFOLK			**Localities**	
Service Line	**Sub-Service line detail**	**Suffolk Total**	**West (2 Integrated Teams)**	**East (3 Integrated Teams)**
Enhanced Wellbeing (excludes IAPT)	Community	1944	810	1134
Children and Young People	Community	1666	650	1016
Adult	Community	1420	570	850
Dementia and Complexity in Later Life	Community	995	300	695
	Inpatients (dementia acute assessment)	38		
Acute	Community (home treatment)	To be determined		
	Inpatients	62		
	Inpatients (psychiatric intensive care)	10		
Neurodevelopmental (includes Learning Disability)	Community	1258	430	828
	Inpatients (learning disability)	13		
Not currently clustered*	Community	1190	495	695
TOTAL* (excludes IAPT)	**All services users**	**8,500**	**3,300**	**5,200**

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NORFOLK AND WAVENEY			Localities		
Service Line	**Sub-Service line detail**	**NW Total**	**West**	**Central**	**Great Yarmouth & Waveney**
IAPT	Community	**6217**	1541	3248	1428
Children and Young People	Community	**3338**	452	1685	1201
	Inpatients (children)	8 (1+3+4)			
	Inpatients (highly specialist out of area)	2			
Adult	Community	**3497**	553	1838	1106
	Alternative to Admission	**30**	6	15	9
	Inpatients (high specialist out of area)	8 (2+4+2)			
Dementia and Complexity in Later Life	Community	**2586**	554	1319	713
	Inpatients (dementia acute assessment)	15 (3+8+4)			
	Alternatives to Admission	**13**	2	7	4
	Inpatients (dementia continuing care)	**60**	Not commissioned from NSFT	24	36
Acute	Community (home treatment)	**60**	11	31	18
	Inpatients	**84**	23	45	16
	Inpatients (psychiatric intensive care)	10 (2+5+3)			
TOTAL (includes IAPT)	**All services users**	**15,900**	**3,200**	**8,200**	**4,500**
TOTAL (excluding IAPT)	**All services users**	**9,800**	**1,700**	**5,000**	**3,100**

Proposed Bed Impact
Norfolk & Waveney CCG areas (excluding dementia)

Norfolk and Suffolk NHS
NHS Foundation Trust

'As Is' Beds- April 2012

Location	Type	Number	Total
Gt. Yarmouth & Waveney	Adult acute	28	
	Older people's acute	12	
	Alternative to admission	6	
	Substance misuse	2	48
Central Norfolk	Older people's acute	22	
	Adult acute	38	
	Psychiatric intensive care	8	
	Alternatives to admission	13	
	Substance misuse	2	83
West	Adult Acute	22	
	Substance misuse	2	
	Older people's acute	18	42
NW	Children	0	0
TOTAL			**173**

Sections noted in italics are already or could be in the future hosted in one location in order to concentrate specialist beds in one place

Proposed Bed Impact
Norfolk & Waveney CCG areas (excluding dementia)

Norfolk and Suffolk NHS
NHS Foundation Trust

'To Be' Beds – March 2016

Location	Type	Number	Total beds
Gt. Yarmouth & Waveney	Acute	20	
	Complexity in later life	*3*	
	Alternative to admission	9	
	Substance misuse	*2*	34
Central Norfolk	*Complexity in later life*	*5*	
	Acute	40	
	Psychiatric intensive care	*10*	
	Alternatives to admission	15	
	Substance misuse	*2*	72
West	Acute	14	
	Alternative to admission	6	
	Substance misuse	*2*	
	Complexity in later life	*2*	24
NW	*Children*	*8*	*8*
TOTAL			**138**

Sections noted in italics are now or could in future be hosted in one location in order to concentrate specialist beds in one place

Proposed Bed Impact Norfolk & Waveney CCG areas – dementia

Norfolk and Suffolk NHS
NHS Foundation Trust

'As Is' Beds Position

Location	Type	Number
Gt. Yarmouth & Waveney	Acute dementia	12
	Continuing Care Dementia	36
Central Norfolk	Acute dementia	22
	Continuing Care Dementia	24
West Norfolk	Acute dementia	18
TOTAL		**112**

Proposed Bed
Impact Norfolk & Waveney CCG areas - dementia

Norfolk and Suffolk NHS
NHS Foundation Trust

'To Be' Beds

Location	Type	Number
Gt Yarmouth & Waveney Gt. Yarmouth & Waveney	*Acute Dementia*	3
	Alternative to Admission	4
	Continuing Care Dementia	36
Central Norfolk	*Acute dementia*	8
	Alternative to Admission	7
	Continuing Care Dementia	24
West Norfolk	*Acute Dementia*	4
	Alternative to Admission	2
TOTAL		**88**

Sections noted in italics are now or could in the future be hosted in one place in order to concentrate specialist beds in one place

Proposed Bed Impact Suffolk CCG areas

Norfolk and Suffolk NHS
NHS Foundation Trust

'As is'

Location	Type	Number	Total
East	Adult acute	42	63
	Older people's acute	10	
	Dementia	11	
West	Older people's acute	10	58
	Adult acute	41	
	Dementia	7	
East and West	*Psychiatric Intensive Care*	*10*	29
	Learning Disability	*19*	
TOTAL			**150**

Sections noted in italics are already or could be in the future hosted in one location in order to concentrate specialist beds in one place

Proposed Bed Impact Suffolk CCG areas

Norfolk and Suffolk NHS
NHS Foundation Trust

'To be'

Location	Type	Number	Total
East and West	Adult acute	62	100
	Dementia and Complexity in Later Life	38	
	Psychiatric Intensive Care	*10*	23
	Learning Disability	13	
TOTAL			**123**

Sections noted in italics are already or could be in the future hosted in one location in order to concentrate specialist beds in one place

Proposed Impact on workforce - Norfolk and Waveney - 010313

Band	Type	Staff in Post @ 31st January 2013	Vacancies @ 31st January 2013	Establishment @ 31st January 2013	To Be @ Mar-16	Total gross reduction / (increase) in WTE (Establishment)	Total gross reduction / (increase) in WTE (Staff In Post)
		[a]	[b]	[c] = [a] + [b]	[d]	[e] = [c] - [d]	[f] = [a] - [d]
1+2	AFC	37.58	4.88	42.46	56.31	-13.85	-18.73
3	AFC	249.69	17.30	266.99	238.49	28.50	11.20
4	AFC	176.63	3.31	179.94	131.74	48.20	44.89
5	AFC	179.61	55.05	234.66	195.80	38.86	-16.19
6	AFC	339.54	29.60	369.14	281.40	87.74	58.14
7	AFC	126.61	4.69	131.30	99.00	32.30	27.61
8a	AFC	51.01	9.29	60.30	36.40	23.90	14.61
8b	AFC	37.17	-0.41	36.76	31.20	5.56	5.97
8c	AFC	3.95	0.39	4.34	11.80	-7.46	-7.85
8d	AFC	6.67	0.00	6.67	6.63	0.04	0.04
9	AFC	0.37	0.00	0.37	1.37	-1.00	-1.00
SAS/Staff Grade	Medic	22.72	6.30	29.02	Under review	Under review	Under review
Consultant	Medic	52.45	4.45	56.90	Under review	Under review	Under review
Total		**1284.01**	**134.85**	**1418.86**	**1090.14**	**242.80**	**118.70**

Version (Feb-13)

Norfolk and Suffolk NHS
NHS Foundation Trust

Norfolk and Suffolk NHS
NHS Foundation Trust

Title of Report:	Norfolk and Suffolk NHS Foundation Trust (NSFT) Strategy 2012/13 to 2015/16 **Quality and Safety Measures**
Version:	1st March 2013

1.0 Quality Measures

Suffolk

1. Alleviate and prevent distress
2. Create safety for all
3. Promote recovery, autonomy and independence
4. Prevent deterioration
5. Support self-assessment and self-management, working with users and carers to create packages of care tailored to meet individual wishes and needs
6. Facilitate the least stigmatising approach
7. Increase the contribution of service users in the delivery of services
8. Provide equitable services across the county
9. Promote the use of personal budgets
10. Provide timely responses and interventions
11. Work with the 3rd sector and other partner agencies to provide access to safe, suitable alternatives to hospital admission
12. Provide or signpost to a wider and more comprehensive range of suitable interventions and resources
13. Reduce the need for inpatient admission
14. Improve vocational functioning
15. Increase access to acceptable services
16. Improve the experiences of our Service Users and their carers
17. Collaborate with commissioning groups to inform commissioning of appropriate and high quality services
18. Create a positive environment for staff to work in
19. Promote research and innovation
20. Reduce risks around transitions and gaps in services
21. Ensure that Services Users and their carers receive the right intervention and the right time and by the right staff
22. Promote the use of local resources where possible
23. Increased efficiency of our clinical practice

All pathways will use meaningful, qualitative and quantitative standardised and individualised measures to evaluate the above goals.

2.0 Norfolk and Waveney

	Wellbeing (IAPT)
P15	You will be able to work jointly with the Wellbeing Service to find out what you need. In most cases you won't have to wait for this as you can contact them by phone, email, website or post, but if you need to make an appointment to talk to someone face-to-face you'll wait no more than 10 days.
P15	When you have discussed your needs with us, if you need further support from the Wellbeing Service where possible we will start doing so immediately and you will never wait more than 2 weeks. You will have a choice of how to get this support through a variety of means including local wellbeing centres, telephone, text and web-based facilities.
P3	You will be supported in the community, avoiding where possible having to stay overnight and so helping you keep your links with your home and community. If you do need to stay overnight this will be in an informal and less serious or stigmatizing setting.
P1, P3	We will support you in making use of a comprehensive range of resources to assist you to stay in employment, education and stable accommodation and to play an active role in the life of your family and community.
P13	There will be a wide range of psychological therapies for you to choose from, whichever best meets your needs and wishes.
P5	If you are from a Black, minority or ethnic background, including those from Roma, gypsy and travelling backgrounds, and those who are refugees or asylum seekers, we will ensure that your cultural needs are met and that you know how and where to access mental health services.
P17, 18, 19	As well as considering your mental health we will also make sure your physical needs are not forgotten. For example, if you come into one of our hospitals we will make sure we know what physical problems you might have which might make you fall and be injured. Some types of dementia have physical causes, so we will help you identify and improve your physical health in order to avoid your condition getting worse.

	Children & young people will be supported to participate in the training, development and recruitment of mental health staff.
	We will offer a wide range of supportive interventions to families and care givers; including parenting support and family therapy.
	We will provide families and care givers high quality information via our updated website and sign post to other community resources when appropriate to do so.
	Professionals in the universal services such as teachers, health visitors, or school nurses also need to know how to access early

	support and to recognise when children are developing emotional and mental health problems, we will therefore provide consultation, liaison and training to improve their expertise, and work closely with other partner agencies to improve the wellbeing of all children & young people.
	We will provide families and care givers high quality information via our updated website and sign post to other community resources when appropriate to do so.
	Professionals in the universal services such as teachers, health visitors, or school nurses also need to know how to access early support and to recognise when children are developing emotional and mental health problems, we will therefore provide consultation, liaison and training to improve their expertise, and work closely with other partner agencies to improve the wellbeing of all children & young people.
P20, 21	If you need to be admitted to hospital it will be for the least number of nights possible.
P17, 18, 19	As well as considering your mental health we will also make sure your physical needs are not forgotten. For example, if you come into one of our hospitals we will make sure we know what physical problems you might have which might make you fall and be injured. We will help you identify and improve your physical health in order to avoid your condition getting worse.

	Children and young people
M	If you are a young person under 25 and need help with mental ill health there will be a specialist team available to support you.
P15	Once it has been agreed that you will need the support of the Youth Service Network we will start supporting your needs as soon as it is appropriate for you and definitely within 2 weeks.
	Our services will focus on helping young people to manage their health condition themselves, putting them in control.
	You will be able to choose where to see us, in places where you feel comfortable rather than embarrassed, making it easier and less stigmatizing for you to receive the help you need.
M P21 P3	If you have highly-specialist, serious needs connected to either a personality disorder, adult developmental disorder, learning disability or mental health problems connected to pregnancy or following birth, you will have access to a specialist team who will support you in the community, avoiding where possible having to stay overnight in hospital. If you do need to stay overnight we will make sure this is as short as possible and the hospital will be in Norfolk or Suffolk. All this is to help you keep your links with your community and family.
M P22	If you are between 14 and 35 and, for the first time, experiencing a psychotic illness (i.e. you can't tell the difference between your imagination and reality), where possible we will help you avoid having to stay in hospital. We will support you in the community, so you keep your social links.

M	If you are a young person under18 and it's necessary for you to come into hospital this will be a place especially for children and young people. To help you keep your ties with your family and friends this place will be in the Norfolk or Suffolk area.
M P21, 20, 15	You will be supported in the community, to avoid where possible having to stay overnight in hospital and so helping you keep your links with your home and community.
	We recognise the important job carers do supporting our service users. To support carers we will work with them to identify and provide the support that they need.
	There will be a wide range of different types of support for you to choose from, whichever best meets your needs and wishes.
	If you are eligible you will be given a personal budget. This is an agreement that sets out your needs, the amount of money available to meet those needs and how this money will be spent. You can then chose how this is spent, or work with the service to decide together how best to spend it. This puts you in direct control of your care.
P5	If you are a child, young person or family from a Black, minority or ethnic background, including those from Roma, gypsy and travelling backgrounds, and those who are refugees or asylum seekers, we will ensure that your cultural needs are met and that you know how and where to access mental health services.

	Adult
	We will work with you to identify what you hope to achieve with our support. The plan for supporting you will be built around this.
P15	Once it has been agreed that you will need the support of the Managed Care Network we will start supporting your needs as soon as is appropriate for you and definitely within 2 weeks.
	We will help service users and carers find out what they need and enable them get it quickly by creating a directory of the support available from ourselves, our partners and the wider community.
M P15 P21 P3	If you have highly-specialist, serious needs connected to either a personality disorder, adult developmental disorder, learning disability or mental health problems connected to pregnancy or following birth, you will have access to a specialist team who will support you in the community, avoiding where possible having to stay overnight in hospital. If you do need to stay overnight we will make sure this is as short as possible and the hospital will be in Norfolk or Suffolk. All this is to help you keep your links with your community and family.
M P3	You will be supported in the community, avoiding where possible having to stay overnight and so helping you keep your links with your home and community.
M	You will have a wide range of psychological therapies available to you, for you to choose whichever best meets your needs and wishes.
	If you wish, we will arrange support for you from someone who has already been through a similar experience.
	We will work with both you and your carer to develop an action plan

	specific to your situation which can be put into action in a crisis.
	We recognise the important job carers do supporting our service users. To support carers we will work with them to identify and provide the support that they need.
	If you are eligible you will be given a personal budget. This is an agreement that sets out your needs, the amount of money available to meet those needs and how this money will be spent. You can then choose how this is spent, or work with the service to decide together how best to spend it. This puts you in direct control of your care.
P5	If you are from a Black, minority or ethnic background, including those from Roma, gypsy and travelling backgrounds, and those who are refugees or asylum seekers, we will ensure that your cultural needs are met and that you know how and where to access mental health services.
P17, 18, 19	As well as considering your mental health we will also make sure your physical needs are not forgotten. For example, if you come into one of our hospitals we will make sure we know what physical problems you might have which might make you fall and be injured. We will help you identify and improve your physical health in order to avoid your condition getting worse.

	Dementia and complexity in later life
M P4	We will make every effort to identify and diagnose people with dementia as early as possible. This means we will be able to better support the person with dementia and any person caring for them, helping both maintain greater quality of life and independence for longer. This will include ensuring that all service users and carers receive information regarding lasting power of attorney and advance decisions.
M P15 P4	You will be able to work jointly with the service to find out what you need. You will have to wait no more than 8 weeks to have this discussion. Where possible we will do this in the community, so you avoid having to be in hospital and helping you keep your links with your home and community. If you do need to stay overnight you will only be away from home as long as is necessary to help you.
	We will give you access to therapy and, if appropriate, medication which has been proven to greatly increase and prolong the quality of life and independence of people with dementia, as well as reducing the impact of the illness on their carers.
M P3	You will be supported in the community so where possible you will avoid having to visit or stay in a hospital, helping you keep your links with your home and community and making it easier and less stigmatising for you to receive the help you need.
P1, 3	If you have complex needs because you have dementia but are in a regular hospital we will visit you there to discuss your needs. Before you leave hospital there will be a plan for managing your condition so you can leave earlier and your quality of life and independence is supported. This will be available to everyone in this situation by April 2013.

P17, 18, 19	As well as considering your mental health we will also make sure your physical needs are not forgotten. For example, if you come into one of our hospitals we will make sure we know what physical problems you might have which might make you fall and be injured. Some types of dementia have physical causes, so we will help you identify and improve your physical health in order to avoid your condition getting worse.
	We will work with both you and your carer to develop an action plan specific to your situation which can be put into action in a crisis.
M	We recognise the important job carers do supporting our service users. To support you we will work with you to identify and provide the support that you need. If you wish, this can include giving you training.
	If you are eligible you will be given a personal budget. This is an agreement that sets out your needs, the amount of money available to meet those needs and how this money will be spent. You can then chose how this is spent, or work with the service to decide together how best to spend it. This puts you in direct control of your care.
	We will ensure you have access to Cognitive Stimulation Therapy services in a wide variety of settings and that you will bale to access these types of services in the early stages of your illness.
P5	If you are from a Black, minority or ethnic background, including those from Roma, gypsy and travelling backgrounds, and those who are refugees or asylum seekers, we will ensure that your cultural needs are met and that you know how and where to access mental health services.

P refers to Payment by Results for nationally set Mental Health Quality and Outcome Measures.

2.0 Safety Indicators

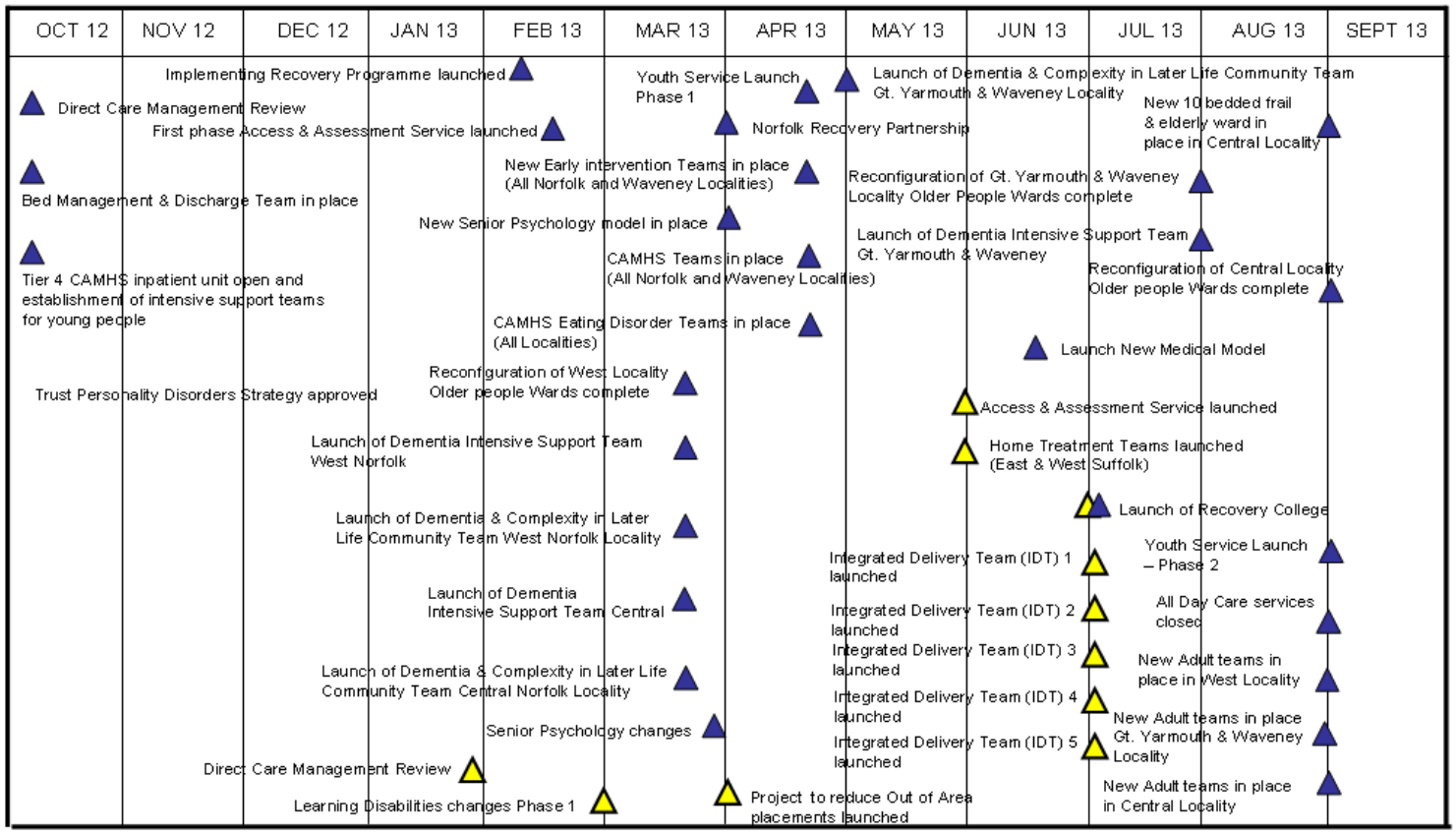
The Trust has developed a set of service safety indicators which it will use to formally monitor the safety of its services. These will work both during the change and while old and remodelled services are running normally. The indicators, which have been developed with input from senior clinicians, have been selected on the basis that they provide 'early warning' of a potential safety issue in a particular Locality or Service Line. These indicators will be monitored daily by the Executive Team (Director of Operations and Director of Nursing and Patient Safety). Where these indicators reveal 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 them. The safety indicators will be implemented by the end of February 2013. The Trust will share safety indicators with commissioners and report any issues identified and resulting action plans.

The indicators are as follows:

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 one 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 a standard to be agreed)
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 seven days following discharge
10. **Serious Incidents** - number of Serious Incidents 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.

Proposed Trust Service Strategy
High Level Milestones Plan Accelerated – Updated February 2013

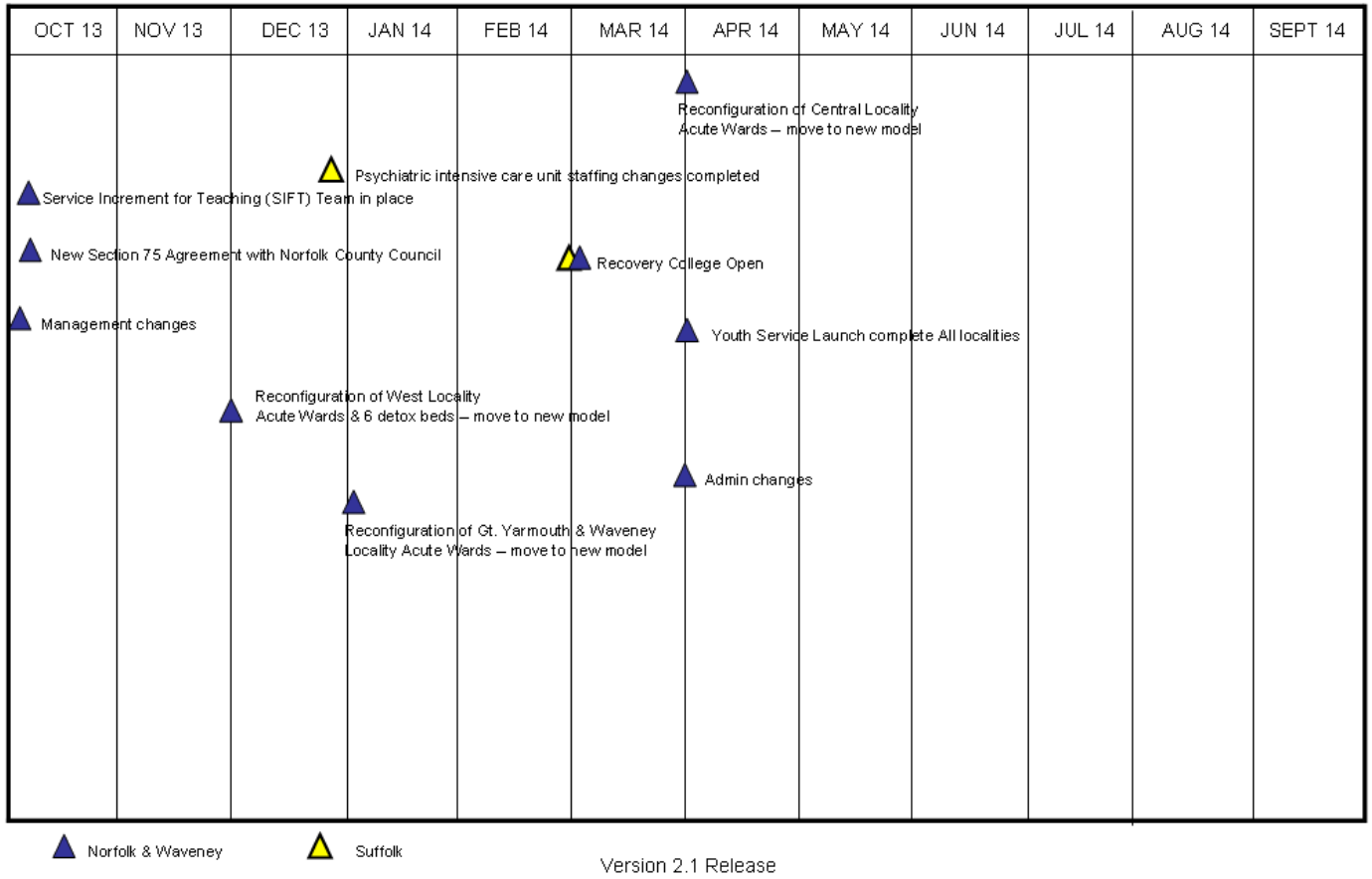
Please note this is subject to change



Version 2.1 Release

Proposed Trust Service Strategy
High Level Milestones Plan Accelerated– Updated February 2013

Please note this is subject to change



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High Level Milestones Plan Accelerated– Updated February 2013

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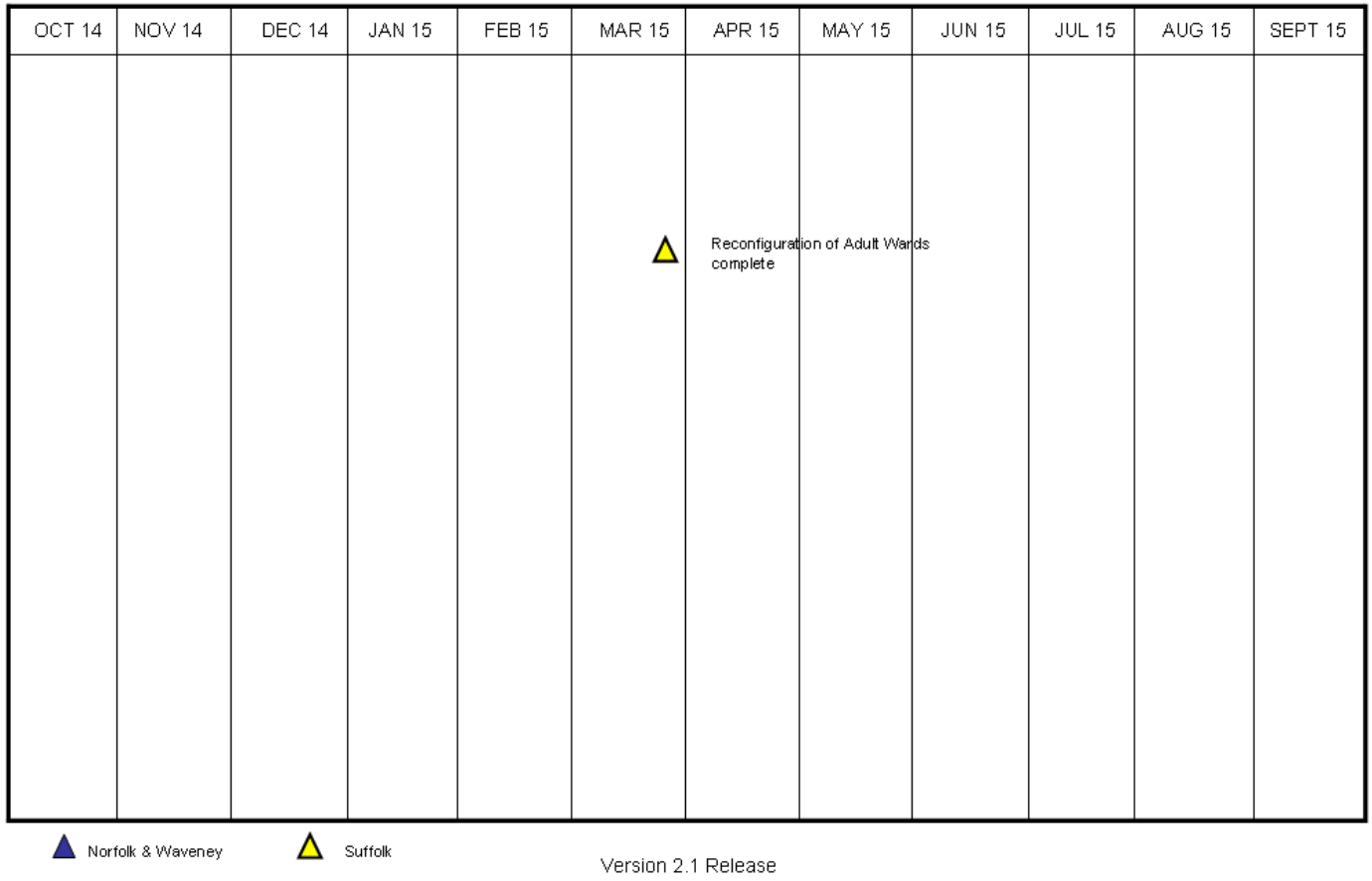

Version 2.1 Release

Norfolk and Suffolk NHS
NHS Foundation Trust

Title of Report:	Norfolk and Suffolk NHS Foundation Trust (NSFT) Strategy 2012/13 to 2015/16 **Individual staff consultation timetable**
Version:	1st March 2013
Notes:	Individual consultation with staff members potentially affected by a service change . The consultation duration is 30-45 days and occurs well in advance of actual service change.

Change	**Locality**	**Individual Staff Consultation begins**
Dementia and Complexity in Later Life	Central and West Norfolk	February 2013
Children and Young People	Norfolk and Waveney	February 2013
Dementia and Complexity in Later Life	Yarmouth and Waveney	April 2013
Access and Assessment Service	Suffolk	March 2013
Acute - Home Treatment Team	Suffolk	March 2013
Integrated Delivery Teams	Suffolk	April 2013
Adult community	Norfolk & Waveney	May 2013
Adult acute	Norfolk & Waveney	Sept 2013
Adult acute	Suffolk	December 2014

Norfolk and Suffolk NHS
NHS Foundation Trust

Title of Report:	Norfolk and Suffolk NHS Foundation Trust (NSFT) Strategy 2012/13 to 2015/16 **List of Third Sector Partners March 2013**
Version:	1st March 2013
Notes:	The Trust Service Strategy aims to deliver services in partnership with other providers including NHS, local authority, independent and third sector. This report lists third sector partners as at 1st March 2013.

Third sector partner	Service Line	Service delivered
Matthew Project	Norfolk Recovery Project	Drug and alcohol support
Rehabilitation for Addicted Prisoners Trust	Norfolk Recovery Project	Advice, counselling and treatment for addicted prisoners
Mancroft Advice Project	Norfolk Wellbeing Service	Counselling, advice and support for children and young people
Norwich and Central Norfolk Mind	Norfolk Wellbeing Service Suffolk Wellbeing Service	Counselling services Mental Health First Aid
Gt Yarmouth and Waveney Mind	Gt Yarmouth and Waveney Wellbeing Service	Support programmes for young people
Relate Norfolk and Suffolk	Suffolk Wellbeing Service Norfolk Wellbeing Service	Relationship counselling (Norfolk and Suffolk) Counselling for young people (Suffolk)
West Norfolk Mind	Norfolk Wellbeing Service	Counselling and Mental Health First Aid
Broadland Meridian	Gt Yarmouth and Waveney Wellbeing Service	Employment support
Stonham (Home Group)	Acute Service Norfolk and Waveney	Working in an integrated team with NSFT Acute Staff to facilitate discharge from the acute wards
Julian Support	Acute Service Norfolk and Waveney	Housing and social welfare advice and support to service users
VoiceAbility	Suffolk Wellbeing Service	Community development workers and support groups
4YP	Suffolk Wellbeing Service	Counselling services for young people
Stonham	Acute Service Suffolk	Alternatives to hospital
Suffolk Mind	Suffolk Wellbeing Service	Personality Disorder
Suffolk Family Carers	Suffolk Wellbeing Service	Family/carer support
Shaw Trust	Suffolk Wellbeing Service	Employment skills support
Mentis Tree CIC	Suffolk Wellbeing Service	Counselling

Norfolk and Suffolk Joint Scrutiny Committee on Radical Redesign of Mental Health Services
12 March 2013
Item no 6

Conclusion of the Joint Committee

Suggested approach by the Scrutiny Support Manager

Suggested arrangements for concluding the joint committee's work prior to the lead-in period to the County Council elections on 2 May 2013.

1. The joint committee's report

1.1 The joint committee was established on a task and finish basis 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 and to make a response to Norfolk and Suffolk NHS Foundation Trust (NSFT) and other appropriate agencies.

1.2 A six-week lead-in period to the County Council elections begins on 21 March 2013 and it is not possible for this joint committee to meet after that date. Should Norfolk Health Overview and Scrutiny Committee and Suffolk Health Scrutiny Committee wish to reconvene a Norfolk and Suffolk joint health scrutiny committee on radical redesign of mental health services after the elections on 2 May 2013, it would be necessary to establish a new joint committee under the new health scrutiny Regulations which come into effect on 1 April 2013.

1.3 Given the timescale involved, it is suggested that the Scrutiny Support Manager for the lead authority (Norfolk) drafts a brief report based on potential conclusions and recommendations agreed by the joint committee at today's meeting and circulates the first draft report to all Members for comment by 26 March 2013. The final report would be agreed by the Chairman and Vice Chairman, with re-circulation to Members as necessary, and forwarded to NSFT and other relevant agencies by 12 April 2013. Copies for information would be made available all who have given evidence to the joint committee.

1.4 The joint committee's report would also be presented to the next meetings of Norfolk Health Overview and Scrutiny Committee and Suffolk Health Scrutiny Committee for information.

2. Potential conclusions and recommendations

2.1 Members are asked to consider their potential conclusions and recommendations regarding NSFT's draft Service Strategy 2012/13 – 2015/16, based on the evidence heard at the two meetings of the joint committee, in relation to:-

- The extent to which the proposed changes 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

Members may also wish to 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.

2.2 The joint committee may also wish to make recommendations to Norfolk Health Overview and Scrutiny Committee and Suffolk Health Scrutiny Committee regarding the scrutiny or monitoring of the changes that NSFT proposes to make over the next four years.

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