Norfolk County Council
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Suffolk County Council

SUPPLEMENTARY AGENDA

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

Supplementary Item(s):

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

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

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

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

Date Agenda Published: 7 March 2013

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Norfolk and Suffolk NHS Foundation Branch 21111

Julian Hospital

Bowthorpe Road

Norwich

NR2 3TD

TO: Chairperson, Norfolk and Suffolk Joint Scrutiny Committee

5th March 2013

Dear Chairperson

UNISON asks Norfolk and Suffolk Health Overview Scrutiny Committee (HOSC) to consider the following information in their examination of the service changes proposed by Norfolk and Suffolk NHS Foundation Trust (NSFT).

We understand that NSFT will be presenting HOSC with updated staffing numbers. At the time of writing we have not had access to that information, so our comments are based on the best available evidence that we have. We will respond to updated figures when we give evidence on 12 March 2013.

We would firstly like to challenge the narrative of these service changes. Whether you euphemistically call it “Radical Pathway Redesign” or “Service Strategy” the reality is that this is a significant cut to local mental health services, and should be described as such. To not do so causes confusion and ambiguity in the minds of the public.

1. The proposed reduction of 502 whole time equivalent staff represents a reduction in 24% of front line clinical staff. The actual number of effected staff will be greater, as there are many part time workers within the workforce.

2. NSFT anticipate that the same number of patients will be seen by this 24% reduced clinical workforce.

3. We find it incredible that providing care to this number of people, with 24% fewer staff can be done in such a way that does not effect the quality or safety of patient care.

4. There is no evidence that teams or clinicians currently have 24% spare capacity, or that clinicians' time and skills are underutilised.

5. We believe that the actual reduction of staff could be even greater, given feedback from staff that maternity cover is either not provided, or not provided in a timely manner. This amounts to an additional 'hidden' cut.

6. We believe that the number of "frozen" or "vacant" posts have proven to be a false economy. Both in terms of the temporary staffing costs (at last report £17 million) and by increasing the workload of staff in services where there are vacant posts. This has led to a significant increase in workplace stress and staff mental illness within some clinical areas – a result of there simply being too many patients to see, and not enough time to see them. Staff are frequently distressed and overwhelmed by lack of resources, and some feel that they are not able to provide care to a standard that they are happy with.

7. There are currently 245 vacancies. There are an additional 102 fixed term posts. There will be a reduction of 103 posts following the Dementia and Complexity in Later Life reorganisation currently underway. This is a total of 450 posts. We therefore ask the question – is this 24% cut in staffing "front loaded". If so, is there a risk that further reductions will be needed in the following 3 years?

8. We consider that the risk register for the cuts is inadequate, and not sufficiently up to date. We suggest that the HOSC request to see the risk register, and any plans in place to mitigate against gaps in service provision and risks.

9. We share the concerns presented by both the RCN and BMA that the proposed measures for monitoring the risk of these changes focuses too heavily on "safety" rather than "quality".

10. We suggest that measures are introduced that take account quality of care are developed. This should include the average length of face-to-

11. face contact, and measures that take account of continuity of care, such as frequency of change of care co-ordinator/lead professional, or number of different practitioners seen by one person. We also suggest that the number of missed / did not attend appointments is monitored, as an increase could indicate a lack of satisfaction with care being offered. The number of appointments cancelled by clinician should also be monitored, as this could indicate clinicians needing to cancel routine visits to deal with an emergency or crisis, as there may be reduced capacity to do this due to increased caseloads.

12. Staff in some clinical areas are reporting pressure to provide telephone support rather than a face to face visit. We believe that this approach

is a false economy. So much of the care that we provide is based on face to face communication. A telephone call significantly restricts the ability to use clinical judgement and assessment skills. For example, assessing the risk of suicide and mental health is about more than words someone says to us. By visiting people at home clinicians are able to see how a person is managing their day to day life – is post unopened? is there food in the house? are they taking care of their hygiene? Are they vulnerable? is anyone coming to the house who may be exploiting them?. Early warning signs of relapse are much harder to detect on the telephone, and if people relapse or reach a crisis, the support needed to help them recover is more costly.

13. We will not comment further on dementia care services, as we believe this service line was adequately examined at the last HOSC.

14. We accept that some proposed changes are positive. The changes to the under 25 service in Norfolk do appear to have taken in to account both the evidence base, and views of young people. A move to earlier intervention is a positive step forward. However, the evidence does not support a move to this model at the cost of resources for people with enduring and chronic difficulties. Ideally the funding to such services would be reduced gradually, year on year, as the benefits of earlier intensive intervention take many years to be realised. In reality the U25 service is largely being funded by taking resources from recovery and CMHT services. We believe that there is not sufficient evidence available as to how the proposed service reorganisation will safely meet the needs of those who are over 25 with chronic and enduring difficulties, simply due to the speed of change and significant reduction in resources.

- We question how, if an evidence base has been at the centre of changes, Norfolk and Suffolk have developed such different models of care? We see no evidence that needs of the population of Suffolk and Norfolk are significantly different. We believe that NSFT is at risk of developing an internal post code lottery of services.

- In particular, members working in the CAMHS service have expressed concern that the proposed Suffolk model for children and families (U13s) will not provide safe, evidence based care for children. In particular they assert that children should been seen separately in a service staffed and suitable for their needs, and that such a team needs to be of a size that is viable professionally to provide the benefits of specialisation. They have raised concern about the ability of the LIDT to safely manage clinical risk and safeguarding issues in particular, due to the fragmentation of CAMHS practitioners across the locality. They are also concerned that this will impact negatively on the provision of Eating Disorder services. They consider the risks of proposed changes to be staff burn out, rising waiting lists, increase in tier 4 admissions, increase in serious untoward incidents. This is contrary to what is happening in Norfolk, where practitioners are being brought together to increase sharing of skills and expertise.

15. We are not confident that the Suffolk model will be compliant with the DOH policy implementation guidance for Early Intervention Services, and seek reassurance that young people in Suffolk with a first episode of psychosis will have access to the full range of evidence based interventions (ie. Intensive case management, CBT for psychosis, family intervention).

16. We consider that the risk register for the cuts is inadequate, and not sufficiently up to date. We suggest that the HOSC request to see the risk register, and any plans in place to mitigate against gaps in service provision and risks.

17. We believe that the plans have not adequately taken account of the wider context and impact of welfare reforms. We accept that many people who use our service prefer care at home rather than in hospital. In principle trying to support people at home is the right thing to do. However, a large number of people who access our service are at risk of being in an unstable living environment. The increase in shared or hostel accommodation for those under 35 as a result of the changes to housing benefit will mean that some people who access our service may not be in a safe or stable enough environment to provide treatment at home in a safe and dignified fashion. The "bedroom tax" will impact on a high number of people within our service, (Norfolk and Suffolk data available here:http://www.housing.org.uk/media/news/bedroom_tax_local_impact.aspx) putting them at increased risk of homeless, or increased debt – both of which are likely to have a significant detrimental impact on their mental health thus increasing need for support from our service.

18. We are unclear on the impact of the cuts to social care budgets in both counties. If there is a reduction in provision of other services that people access, this may have a knock on effect and further increase demand on mental health services.

19. Some partner agencies that we have successfully worked alongside are equally facing funding difficulties. If there is a reduction in the number of services that we can signpost people to, this again will have a knock on effect on mental health services. In particular we are noticing a significant reduction in availability of welfare rights advice, advocacy and representation. This has a significant detrimental impact on mental health, and adds to the workload as care co-ordinators attempt to support increasing numbers of service users facing such issues.

20. We accept that the Trust has attempted to consult with service users. We do not accept however that there has been wide enough consultation. We would like further information on what % of people who access our service have actually been consulted. Feedback from our members is that many people that they see are completely in the dark about the changes. Feedback from our members is that they find

it incredibly difficult to provide service users with accurate information, as they themselves are unclear. Their job is also at risk, so it is difficult to speak objectively about a process that is directly impacting on you personally.

21. We support the views submitted by the BMA (considered at the HOSC in February) that the consultation has been flawed. In addition to the BMA submission, people are having to apply for jobs where essential information is not available, for example the hours of operation of the service. Such information is vital, especially for those staff with caring responsibilities.

22. We dispute the assertion made at the last HOSC that previous redundancies as part of the "cost improvement process" were solely managerial or corporate services. Senior, experienced clinicians especially from a psychology/therapy background were lost. This has had an impact on the supervision and support available to remaining staff. These forthcoming proposed cuts risk further reducing the number of skilled, experienced staff who contribute to the development of more recently qualified staff, and help deliver safe and high quality care.

23. Morale of staff is low in many places. Members are reporting to us that they are distressed at not being able to give a good service. They chose to work in mental health to care, to build relationships with the people that they work with, and support them to make sense of their experiences and learn how to stay well. This takes, time, skill and experience – all of which are being reduced by the proposed cuts. Or, as one member put it "I feel like I've been trying to do my job with my hands tied behind my back for the last couple of years. Now they're trying to blindfold me as well".

24. Some members report feeling as though they are being reduced to administrators of care packages, dressed up as personal choice. This risks fragmenting care, increasing administration and bureaucracy, and increasing the number of different people and services for people to navigate.

25. We welcome the news that NSFT is working with commissioners to request transitional funding. We however remain fearful that this will not be sufficient to mitigate the risks.

26. We ask the committee to consider whether they accept the assurance that no beds will be closed until it is demonstrated there is no need for them. This will rely on a temporary increase of staffing within some areas. Is this realistically achievable within the significant reduction in front line staffing?

27. We support the BMA submission that Suffolk and West Norfolk commissioning groups have under-spent on mental health care compared to even the national average. We are unclear on what attempts have been made to bring their funding in line with, at the very

least, the national average, and what impact this would have on the need to make 20% cuts.

28. We are not convinced that the business model for the Tier 4 camhs unit is sound. A significant amount of money has been spent on capital costs, and we have seen no evidence that it has had the desired impact on reducing the spend on out of area beds. With the reconfiguration of U25s services, could these resources be better spent on providing intensive community based services? What are the risks to the service strategy, in light of the overspend and difficulties with the Tier 4 unit? Is there a risk of further reductions in other services to mitigate the costs associated with the Tier 4 unit?

29. Concerns about the delays and difficulties with mental health act assessments have already been raised by UNISON with the CQC. The HOSC may want to satisfy itself that these issues are being addressed  CQCamhpletter.doc (see attached letter on page A9)

30. We are concerned that there is no "plan B". We do not have clear information about what action will be taken if, as changes are made, significant harm emerges.

31. We call on the Trust to make a more honest and transparent description of the reality of the cuts that we are facing, and work with Trade Unions to lobby the Department of Health and local Members of Parliament, to be clear that this cut in funding cannot be implemented without a negative impact on the quality and safety of care.

On a more general note, we would like to remind the committee that Doctors and Nurses did not cause the financial crisis. The people who rely on our services most definitely did not, yet they are the ones who will find themselves at the sharp end of the consequences.

We find ourselves at odds with our employer over these cuts, when clearly we are at odds because of a failure of government to provide funding adequate to meet the basic needs of provision.

We will be attending HOSC on 12th March to answer any questions that the committee may have.

Yours truly

Branch Officers

UNISON Branch 21111

Norfolk and Suffolk Foundation Trust Branch
c/o 80 St Stephens Road
Norwich NR1 3RE

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

January 2013

Dear Sir / Madam

Re: Concerns regarding inadequate resources with reference to Mental Health Act assessments

I write to express concerns brought to our branch's attention by Approved Mental Health Professionals (AMHPs) in Norfolk. AMHPs have been raising these issues with the Norfolk and Suffolk NHS Foundation Trust for many months, but the situation does not appear to have improved. Our branch believes that all of these concerns relate to consequences of dangerous cuts in public spending.

Psychiatric in-patient bed shortages:

Frequently there are no beds available at the nearest hospital. This means that patients are often admitted to a hospital that is a very long way from their home. Sometimes there have been no available beds in the whole of Norfolk and Suffolk. This makes the prospect of psychiatric admission even more unappealing for patients who are often reticent about admission in any case.

When AMHPs visit someone in the community to carry out an assessment under the Mental Health Act (MHA), there has been an increased frequency of there not being a bed identified in advance for admission. If, as the outcome of assessment, admission is proposed – whether informally or formally – there is then a delay in arranging admission whilst a suitable available bed is identified. This delay often causes added stress to patients, their relatives/carers, and to the AMHP.

There have been occasions where patients have been admitted to a bed on a secure ward, when a bed on an open ward would have been more appropriate, but was not available. This is at odds with the least restriction principle of the MHA Code of Practice.

We note that in December 2012, Norfolk and Suffolk NHS Foundation Trust estimated that its bed occupancy was about 115%. Whilst this doesn't mean that patients were literally sharing a bed, it does mean that when a

patient went on overnight home leave, their hospital bed would be used to admit another patient. This raises the possibility that a bed might not then be available when the patient on home leave tries to return to the ward.

Inadequate support from other services:

When carrying out MHA assessments and arranging subsequent hospital admissions, AMHPs usually rely on support from other services e.g. the ambulance service and the police service. This usually relates to transporting / conveying the patient to hospital, executing warrants (under s135 MHA), preventing a breach of peace, restraining patients if they are violent, etc.

AMHPs are reporting that there are increasing levels of difficulties in getting timely support from these services, and we suspect that this is due to public spending cuts impacting on the ambulance and police services. The consequence can mean that MHA assessments are delayed, for instance if the AMHP believes that police attendance is necessary due to risk of violence. Another consequence is that after a decision has been made to admit a patient to hospital, there is considerable delay in the provision of transport. This often means the AMHP is left alone with the patient for an indefinite period of time waiting for transport, whilst the patient might be in an agitated, distressed state. It is not uncommon for AMHPs to report delays of three to six hours (and occasionally longer). This raises safety issues for patients and AMHPs. The patient, who needs to be in hospital, is not able to be admitted in a timely fashion, and their mental state may deteriorate further and their behaviour may increasingly place themselves or others at risk of harm (including family members, AMHPs, other professionals, and the general public). AMHPs report that, due to delays, many MHA assessments and admissions carry on way beyond the AMHP's usual working hours, leading to tiredness and mental exhaustion.

Inadequate alternatives to hospital admission:

One of the key roles of the AMHP is to consider whether there are viable alternatives to psychiatric admission. This often includes consideration of provision of additional services to the patient e.g. support from the Crisis and Home Treatment Team (CRHT) or a temporary period of support in a residential care home. However, due to cuts to the CRHT service, this option is much less viable: often CRHT are not available to participate in assessments, and also the intensity of support they offer has been greatly reduced. With regard to arranging an urgent residential care placement, this is made nigh on impossible by bureaucratic systems which require placements to be planned weeks in advance, with reports to be presented to a panel which will decide whether or not to approve a placement. (This arrangement, we suggest, effects a back-door rationing of service provision). Only rarely is it possible to obtain approval for emergency placements. Without adequate alternatives to hospital admission, it is inevitable that patients are more likely to be admitted to hospital.

AMHPs are wholly dissatisfied with this state of affairs and have great concerns about the health and safety risks that it exposes to patients, families, AMHPs, other professionals, and the general public.

We note that a recent National Survey of AMHPs carried out by Kings College, London (2012) reveals that a third of AMHPs would like to give up

their role of AMHP, citing the shortage of hospital beds as the main factor in pushing work stress levels beyond reasonable limits. The survey reveals very high stress levels among AMHPs with 41% of those surveyed disclosing symptoms indicative of clinical depression and anxiety.

We require action to be taken to reduce to acceptable levels the health and safety risks that patients, AMHPs and others are exposed to by the inadequacy of resources. We require adequate resources to enable AMHPs to offer viable alternatives to hospital admission, and adequate resources to enable AMHPs to arrange hospital admission without lengthy delays.

Yours sincerely

Kirsty Scales
UNISON steward

Cc:

- Lynn Wall, Unison NSFT Branch Secretary
- Service User Council, Norfolk and Suffolk NHS Foundation Trust
- Budge Ziolkowska, Social Care Lead, Norfolk and Suffolk NHS Foundation Trust
- Aidan Thomas, Chief Executive, Norfolk and Suffolk NHS Foundation Trust
- Andrea Wright, Head of Service (Mental Health), Norfolk County Council
- Harold Bodmer, Director of Adult Services, Norfolk County Council
- County Councillors, Norfolk County Council
- Clive Rennie, NHS Norfolk
- Sandra Flanagan, Deputy Chief Executive, Norwich and Central Norfolk MIND
- Shaun Hobbs, Norfolk Coalition of Disabled People
- Phil Gormley, Chief Constable, Norfolk Constabulary
- Norman Lamb MP and Minister of State for Care Services
- Richard Bacon MP
- Henry Bellingham MP
- Simon Wright MP
- Chloe Smith MP
- Elizabeth Truss MP
- Keith Simpson MP
- Brandon Lewis MP
- George Freeman MP

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

Proposed Impact on workforce - Suffolk - 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	125.89	12.65	138.54	32.94	105.60	92.95
3	AFC	114.27	20.06	134.33	205.95	-71.62	-91.68
4	AFC	79.93	12.51	92.44	76.20	16.24	3.73
5	AFC	143.85	20.25	164.10	156.60	7.50	-12.75
6	AFC	189.52	24.31	213.83	157.00	56.83	32.52
7	AFC	66.23	11.88	78.11	46.70	31.41	19.53
8a	AFC	20.92	9.28	30.20	35.90	-5.70	-14.98
8b	AFC	15.50	6.71	22.21	14.20	8.01	1.30
8c	AFC	11.55	1.01	12.56	9.10	3.46	2.45
8d	AFC	2.80	-0.06	2.74	2.00	0.74	0.80
9	AFC	0.00	0.00	0.00	0.00	0.00	0.00
SAS/Staff Grade	Medic	12.80	0.30	13.10	Under review	Under review	Under review
Consultant	Medic	38.06	4.80	42.86	Under review	Under review	Under review
Total		**821.32**	**123.70**	**945.02**	**736.59**	**152.47**	**33.87**

Version (Feb-13)

Norfolk and Suffolk NHS
NHS Foundation Trust

Proposed Impact on Workforce - Norfolk and Suffolk - 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	163.47	17.53	181.00	89.25	91.75	74.22
3	AFC	363.96	37.36	401.32	444.44	-43.12	-80.48
4	AFC	256.55	15.82	272.37	207.94	64.43	48.61
5	AFC	323.46	75.30	398.76	352.40	46.36	-28.94
6	AFC	529.06	53.91	582.97	438.40	144.57	90.66
7	AFC	192.84	16.57	209.41	145.70	63.71	47.14
8a	AFC	71.93	18.57	90.50	72.30	18.20	-0.37
8b	AFC	52.67	6.30	58.97	45.40	13.57	7.27
8c	AFC	15.50	1.40	16.90	20.90	-4.00	-5.40
8d	AFC	9.47	-0.06	9.41	8.63	0.78	0.84
9	AFC	0.37	0.00	0.37	1.37	-1.00	-1.00
SAS/Staff Grade	Medic	35.52	6.60	42.12	Under review	Under review	Under review
Consultant	Medic	90.51	9.25	99.76	Under review	Under review	Under review
Total		**2105.33**	**258.55**	**2363.88**	**1826.73**	**395.27**	**152.57**

Version (Feb-13)

Norfolk and Suffolk NHS
NHS Foundation Trust

Norfolk and Suffolk NHS
NHS Foundation Trust

Trust Service Strategy Financial Savings Plans

This paper shows by service area the changes that are planned to happen in the Service Strategy up to 2015/16.

This analysis aims to set out changes service by service.

The Strategy involves *redesign of services* as opposed to simple budget reductions for each service area, hence it is not possible to directly compare the finances 'before' and 'after'.

We have provided some notes to explain the differences between 'before' and 'after' for each service.

It is important to remember that, at the start of the redesign process in 2011, our clinicians were provided with savings targets of 20% for each of our 'before' services – ***this ensures that savings have been applied equally to each starting service and service user group (children, adult and older people)***.

It is also important to understand ***that the total number of service users in each group (children, adult and older people) does not change across the four years***.

This is because the Service Strategy is not a *commissioning strategy* – it is a strategy aimed at ensuring that the Trust can continue to see the same number of service users with 20% less income - as required nationally (NHS Operating Framework). We plan to achieve that by introducing a more efficient service design.

At a summary level savings are as follows:

Trust Total	**2012/13 Investment**	**2013/14 Saving**	**2014/15 Saving**	**2015/16 Saving**		**Starting Budget**
Planned change (£000)	232	-10,167	-17,551	-20,381		97,062

Norfolk and Waveney Services

Access and Assessment

'Before' – this work was completed by the various teams - acute, children, adult and older people.

'After' – a new service area, processing of referrals, liaison with referrer, appointments and assessment all now come under this service heading.

Assessments are still local and specialist, e.g. children's assessment will be different from dementia assessment.

Access and Assessment	2012/13 Investment	2013/14 Investment	2014/15 Investment	2015/16 Investment		Starting Budget
Planned investment (£000)	111	1,260	1,211	1,242		nil

Acute

These savings represent the changes associated with a reduction in the number of acute assessment beds for adults aged 18 and over with mental health problems (not dementia).

'Before'
- Inpatient services for people with age-related needs were part of our older people's (age 65 years and over) service.

'After'
- Inpatients services for people with age-related needs are included in this service
- The service still undertakes four hour urgent assessments.

Hence, the net saving appears to be less than the 20% required.

Acute	2012/13 Savings	2013/14 Savings	2014/15 Savings	2015/16 Savings		Starting Budget
Planned savings (£000)	-200	-164	-1,692	-2,236		13,370

Complexity in Later Life

'Before'
- Inpatients services for people with age-related needs were included in our older people's service
- People over 65 years in community were included in this service area.

'After'
- Inpatient services for people over 65 years will be part of our acute service area
- Only people over 65 years with age-related needs are seen in this service area
- Referral and assessment is now under Access and Assessment Service.

For this reason, the saving appears to be more than the required 20%.

Complexity in Later Life	**2012/13 Savings**	**2013/14 Savings**	**2014/15 Savings**	**2015/16 Savings**		**Starting Budget**
Planned savings (£000)	-18	-4,294	-5,264	-5,316		14,163

Adult

'Before'
- This service covered everyone over the age of 18 years including people with first episode psychosis and adult attention deficit disorder.

'After'
- This service will cover only adults from around the age of 25 years upwards (based on need) and excludes all adults with first episode psychosis and adult attention deficit disorder
- Referral and assessment is now under Assess and Assessment Service.

Adult	**2012/13 Savings**	**2013/14 Savings**	**2014/15 Savings**	**2015/16 Savings**		**Starting Budget**
Planned savings (£000)	65	-3,935	-6,248	-6,281		15,940

CAMHS and Young People

'Before'
- Children under the age of 18 years only.

'After'
- Children and young people up to the age of 25 years (based on need) and all service users with first episode psychosis and all service users with adult attention deficit disorder.

This service shows an overall investment rather than a saving.

CAMHS and Young People	**2012/13 Investment**	**2013/14 Investment**	**2014/15 Investment**	**2015/16 Investment**		**Starting Budget**
Planned investment (£000)	637	1,075	1,194	1,237		7,927

Suffolk Services

Access and Assessment

'Before'
- This work was completed by the various teams – acute, children, adult and older people.

'After'
- A new service area, processing of referrals, liaison with referrer, appointments and assessment all now come under this service heading.

Assessments are still local and specialist, e.g. children's assessment will be different from dementia assessment.

Access and Assessment	2012/13 Investment	2013/14 Investment	2014/15 Investment	2015/16 Investment		Starting Budget
Planned investment (£000)	nil	1,566	1,888	1,927		nil

Enhanced Wellbeing

'Before'
- These service users were seen in adult services.

'After'
- Service users, for example, those with mild and moderate conditions will be seen in this new service.

Hence this area shows an overall investment.

Enhanced Wellbeing	2012/13 Investment	2013/14 Investment	2014/15 Investment	2015/16 Investment		Starting Budget
Planned investment (£000)	nil	1,374	1,878	1,925		nil

Acute

These savings represent the changes associated with a reduction in the number of acute assessment beds for adults aged 18 and over with mental health problems (not dementia).

'Before'
- Inpatient services for people with age-related needs were part of our older people's (age 65 years and over) service.

'After'
- Inpatients services for people with age-related needs are included in this service.

Acute	2012/13 Savings	2013/14 Savings	2014/15 Savings	2015/16 Savings		Starting Budget
Planned savings (£000)	nil	-630	-1,240	-3,305		16,374

Complexity in Later Life

'Before'
- Inpatient services for people with age-related needs were included in our older people's service
- People over 65 years in community were included in this service area.

'After'
- Inpatient services for people over 65 years will be part of our acute service area
- Only people over 65 years with age-related needs are seen in this service area
- Referral and assessment is now under Access and Assessment Service.

Complexity in Later Life	2012/13 Savings	2013/14 Savings	2014/15 Savings	2015/16 Savings		Starting Budget
Planned savings (£000)	-31	-986	-1,294	-1,294		4,449

Adult

'Before'
- This service covered everyone over the age of 18 years including people with first episode psychosis and adult attention deficit disorder.

'After'
- This service will cover only adults from around the age of 25 years upwards (based on need) and excludes all adults with first episode psychosis and adult attention deficit disorder
- Referral and assessment is now under Access and Assessment Service.

Adult	2012/13 Savings	2013/14 Savings	2014/15 Savings	2015/16 Savings		Starting Budget
Planned savings (£000)	-84	-2,580	-3,371	-3,393		6,437

CAMHS and Young People

'Before'
- Children under the age of 18 years only

'After'

- Children and young people up to the age of 25 years (based on need) and all service users with first episode psychosis and all service users with adult attention deficit disorder.

CAMHS and Young People	**2012/13 Savings**	**2013/14 Savings**	**2014/15 Savings**	**2015/16 Savings**		**Starting Budget**
Planned savings (£000)	-55	-904	-1,165	-1,173		5,249

Neuro Developmental

These services are for children and adults with learning disability.

Neuro Developmental	**2012/13 Savings**	**2013/14 Savings**	**2014/15 Savings**	**2015/16 Savings**		**Starting Budget**
Planned savings (£000)	-40	-741	-1,368	-1,378		3,692

Other Changes

The savings target applied to management was higher than 20%.

Hence, overall management and admin shows a higher saving than the expected 20%.

Management and Admin	**2012/13 Savings**	**2013/14 Savings**	**2014/15 Savings**	**2015/16 Savings**		**Starting Budget**
Planned savings (£000)	-154	-1,206	-2,081	-2,338		9,462

Norfolk and Suffolk NHS
NHS Foundation Trust

HIGH LEVEL PROGRAMME RISK LOG EXTRACT AS AT FEBRUARY 2013

Attached is an extract of live risks from the high level programme risk log for the Service Strategy.

The programme risk log is reviewed monthly by the Trust Service Strategy Programme Board, the Trust's Audit and Risk Committee and the Board of Directors.

High level programme risk log extract as at February 2013;

Risk **(In order identified)**	Control and mitigation	Action	Progress to February
1. Risk of Trust distraction from service focus during consultation period and during implementation	1) Ensure adequate resources available for programme management 2) Plan and manage engagement events and meetings 3) Identify key reps. Review management burden	Agree Director responsible Agree resourcing Agree programme responsibility	Programme Management Structure agreed Director in place Appointments made to all but two key roles
2. Risk of service failure if a strategy to deliver savings not agreed with commissioners and implemented, risk of Monitor intervention and severe financial structure, arbitrary cuts would create serious pressures in services. Risk heightened by change in commissioning arrangements.	1) Continue and maintain discussion and negotiation including contract negotiation 2) Utilise arbitration, and appeal to CB, If necessary take legal advice on right of Trust to implement.	Establish and maintain clear early engagement with commissioners Establish clear negotiating position for contract Apply to commissioners for access to transitional funds to support programme cost of change including resource requirements	Letters of qualified support received from commissioners collectively. Negotiations continuing Positive discussion on transitional funding
3 Risk to service safety of cuts if service strategy not introduced - Trust would need to implement arbitrary cuts initially using vacancy reduction with direct impact on safety	Trust establish decision panel, and agree implementation plan	Develop safety monitoring measures Monitor situation with strategy progress Identify financial potential reserve to support	Strategy progress up to date and on time

4. Risk to financial and commercial viability of Trust if service strategy not agreed and implemented Trust in breach of terms of authorisation	Consult on and Implement strategy	Strategy timetable up to date	Continue with progress on strategy timetable
5. Risk of service failure as a result of loss of experienced staff during implementation	1) Continuous service safety monitoring including caseloads and agreed safety and quality list 2) Managed timing of changes to ensure core staff retained for periods to enable safe handover 3) Availability of transitional reserve for retention in key areas 4) Lack of availability of alternative posts in other Trusts 5) HR strategy to ensure maximum retention through reassurance and support and plan for retention during change 6) Avoid compulsory redundancies and manage redundancies around clear criteria valuing experience	Develop specific safety and quality measures. Monitor via service Governance DoN and MD and Board Retain reserve to ensure retention	Continuous service safety monitoring plan developed Discussion commenced with TUs over criteria for selection Discussions on transitional reserve and future use of CQINN in place with commissioners Proposals for retention and selection developing Reduction in level of loss of posts following consultation

6. Risk to service safety as a result of loss of continuity in specific services	1) Continuous service safety monitoring including caseloads and agreed safety list 2) Managed timing of changes to ensure core staff retained for periods to enable safe handover. 3) Double running where necessary	Develop safety and quality monitoring tools. Monitor via service Governance DoN and MD and Board and visits, Ensure staff aware of approach to continuity Retain reserve to ensure intervention, and double running if necessary	Safety and quality arrangements in place HR plan under development transitional funding under negotiation
7. Risk of service failure or service safety as a result of loss of senior clinical leadership	1) Review senior staffing levels looking at models elsewhere and in light of consultation, identify key leadership roles as we consult on each service. 2) Maintain continuous clinical engagement with continuous clinical review of service strategy during implementation. 3) Continuous service safety monitoring including caseloads and agreed safety list 4) Ensure regular frequent governance review of agreed safety list in place 5) Ensure response to regular frequent review of agreed safety list 6) Managed timing of changes to ensure key senior staff retained for periods to enable safe handover	Identify and support senior clinical leaders Monitor retention, and ensure continuity through appointment and if necessary temporary appointment. Identify pooling arrangements for clinical leadership, and implement as flexibly as possible.	Senior clinical staffing levels under review following consultation Potential Increase in staffing as result of negotiation with CCGs

8. Risk to external credibility if service strategy not agreed and implemented or is misrepresented	1) Ensure strategy is planned carefully Maximum engagement with service users and all partners 2) Retain open approach 3) Respond to press interest	Plan and implement stakeholder events and meetings for each pathway, and overall strategy. ensure early engagement with MPs and CB and key external agencies Ensure CCGs engaged Ensure engagement with patients, carers, and staff throughout process Respond openly to consultation outcome	Events/meetings all held and record of continuous events and feedback. Press responses available and or sent Response to Strategy consultation issued
9. Risk to service of failure in IT implementation	1) Limit selection of service systems to those already effectively in use elsewhere 2) Ensure adequate resourcing of IT strategy 3) Ensure clear governance in place over programme delivery	Identify programme support Secure system Establish programme timetable	Programme support in place Timetable being drafted
10. Risk to service and service safety of speed of transition in programme	1) Planned programme to ensure new arrangements in place wherever possible 2) Safety monitoring and intervention in place. 3) Potential Transitional funding to support change programme	Establish programme and timing Introduce safety monitoring and intervention approach Obtain transitional funding	Programme established Safety and quality monitoring schedule and “soft” info in place Negotiations underway for transitional funding

11. Risk to service of poor implementation	1) Ensure programme team adequately resourced and led 2) Ensure monitoring followed by governance team, executive team and Board 2) Ensure clear governance in place over programme delivery	Identify Director lead Identify and appoint programme team and programme governance structure Establish monitoring and reporting	Programme plan in place Leads identified Programme support identified
12. Social Care staffing requirement exceeds the S75 contractual value. May make social and health care packages to be unaffordable.	1) Work with Social Care to mitigate risk as S75 renegotiated 2) Negotiate reduction in bureaucracy	Negotiation of revised S75	New draft S75 under discussion with reduced bureaucracy and commitments to identify and address funding gaps