NHS
East of England
Clinical Senate

Suffolk Mental Health Alliance: mental health and wellbeing services in East and West Suffolk.

Report of the Clinical Senate independent review panel held on 10 December 2019.

england.eoeclinicalsenate@nhs.net

Glossary of abbreviations used in the report

CCG	Clinical Commissioning Group
CYPF	Children and Young People
IAPT	Improving Access to Psychological Therapies
ICS	Suffolk & North Essex Integrated Care System
INT	Integrated Neighbourhood Teams
IT	Information Technology
LDA	Learning Disability and Autism
PCN	Primary Care Networks
STP	Sustainability and Transformation Partnership
SMHA or the Alliance	East and West Suffolk Mental Health Alliance
24/7	24 hours a day, seven days a week.

Table of Contents

EXECUTIVE SUMMARY

The panel supported the direction of travel and agreed that the breadth of the Alliance partnership was impressive. The Alliance team had shown a genuine commitment to work together, acknowledging what was not currently working for users and carers and the need to work together to develop services appropriate for the users' needs. The panel felt that the Alliance should be congratulated in bringing the system together and putting in place a structure around that in a relatively short space of time.

The panel was impressed by the genuine approach taken by the Alliance to co-production, using its local population to develop a strategy for mental health and wellbeing, and with user groups able to challenge the commissioners and providers to think differently about the strategy and future service models appropriate for the local population. The #averydifferentconversation approach had become a movement for mental health and wellbeing in Suffolk and strongly supported Alliance's co-production approach.

The panel supported the intention to adopt a needs-based model of care, from a diagnostic threshold one, to reduce or even eliminate 'hand offs' to different agencies and services. It also supported the principle of the quadrant model as a basis to provide a seamless care journey for the user. In both instances though, the panel agreed that unless the services were fully supported by a workforce with the appropriate skills and competencies with truly seamless communication, there was a risk that the user could get 'stuck' in one of the quadrants and would not move through to other quadrants (or indeed be discharged if appropriate) as intended.

The panel felt that the Alliance had not yet fully explored the potential opportunities of the future model in general or with the specific workstreams but accepted that this may be something that will be worked through as detail developed.

The panel made a number of recommendations, those that applied across all work streams are summarised below. The full version of recommendations one to six and

the recommendations for each of the four workstreams can be found in full in Section five of the report.

Recommendation 1 – The Alliance should define and articulate a clear vision for Mental Health and Wellbeing Services.

Recommendation 2 – The Alliance should balance the desire for a rapid pace of change with ensuring there is sufficient time to mobilise and implement changes safely and smoothly.

Recommendation 3 – The Alliance should develop clear and robust outcome measures and an approach to the evaluation of the changes to service models.

Recommendation 4 – The Alliance should plan to roll out the early adopter sites to gain further knowledge and make further refinements before full roll out.

Recommendation 5 – The Alliance should ensure full alignment of the health and care system including incorporating the Primary Care Networks.

Recommendation 6 – The Alliance should continue with the early development of ICS system wide Information Technology systems to support seamless care.

The recommendations above should be read in the context of the broader findings of the clinical review panel as laid out in the key findings section of this report.

End.

1. Foreword from Clinical Senate Review Panel Chair

The Clinical Senate was delighted to support the Suffolk Mental Health Alliance in the early phase of their development of plans for mental health services for East and West Suffolk with an independent clinical review panel of their plans at this stage.

Mental health and wellbeing are critically important to all of us. Many of us will experience mental health illness at some point in our lives, all of us will be affected by relatives, friends and colleagues who suffer from mental ill-health. In addition, we know that NHS and Social Care as well as other services require significant resources to support those with mental health problems. We also know that mental health can significantly impact on the outcomes for those with long-term conditions and other illnesses. Finally, there is significant evidence of huge health inequalities between those with significant mental health conditions and learning difficulties with respect to their physical health outcomes including their life expectancy.

The NHS long-term plan quite rightly contains a significant section and tasks the NHS to, amongst other things, provide integrated primary and community health care, expand IAPT services, ensure that NHS 111 provides a single point of access for those with mental health difficulties, provide a mental health transport service and enhanced mental health liaison services in acute hospitals.

The Alliance, made up of NHS Trusts, Community services, Primary Care, Clinical Commissioning Groups, Social Care services, Third Sector providers, Charities, and patient and community support groups, demonstrated significant evidence of collaborative working. In addition, it was clear that they were open and honest regarding the fact that despite the best intentions, services had not been delivering what service users, families and carers and the public would rightly hope for and expect. The Alliance recognised the significant scale of the challenge. There was also very clear and positive evidence of active engagement

with services users, their families and support groups through their engagement campaign #averydifferentconversation. The panel recognised the clear desire to deliver a high-quality service and to rebuild confidence in the service provided by both service users and the public.

A strong case for change was presented and an overview of initial plans for the transformation of all mental health services in Suffolk with the focus however on four priority areas. These priority areas were Children, Young People and Families, Crisis, Community (including IAPT and Wellbeing) and Learning Disabilities and Autism.

I would like to thank all members of the Alliance who engaged with the Clinical Senate, prepared their evidence and presentations, responded to the Key Lines of Enquiry identified through our pre-panel teleconference and responded openly and honestly to questions from the panel on the day.

I would also like to thank all of the Clinical Senate's review panel members for engaging in such an active way with the process, asking searching questions and contributing with their wide and varied expertise and of course in giving up their time.

We wish the Alliance well with its ongoing work and hope we can assist them again in the future as it continues its work to transform services.

Dr Bernard Brett

East of England Clinical Senate Chair and clinical review panel Chair

2. Review background and scope.

2.1 East of England Clinical Senate was approached in July 2019 with a request to undertake an early stage review of the high level proposals for mental health and emotional well-being services in East and West Suffolk.

2.2 Ipswich and East Suffolk, West Suffolk and North East Essex Clinical Commissioning Groups (CCG) together with NHS Trust providers, local authorities and other statutory and non-statutory providers, partners and regulators, are part of an Integrated Care System (ICS) formed in line with national policy to provide placed based care appropriate for the needs of its local population.

2.3 The ICS has developed an Alliance approach to develop common strategies across services, share resources and decision making. It is within this Alliance context that mental health and emotional wellbeing services in East and West Suffolk are being developed and driven forward. For the purposes of this review, and report, the Alliance in question is referred to from now on as the Suffolk Mental Health Alliance (SMHA or the Alliance).

2.4 The background to the review is complex: despite the best intentions and hard work of many people, the system for mental health and emotional wellbeing in Suffolk is failing; even with increased investment it has been recognised that the outcomes for people are not yet good enough. The SMHA recognises that the design of the current system does not meet the changing needs of its population and needs to change.

2.5 The main provider of mental health services in Suffolk is the Norfolk and Suffolk NHS Foundation Trust (NSFT). In February 2015 NSFT was placed in Special Measures[1] by the Care Quality Commission (CQC). The Trust came out of Special Measures in October 2016 but placed back into Special Measures again in October 2017 and is currently rated as 'Inadequate'. To address the concerns documented by the CQC, the two Suffolk Alliances (East and West) came together to have a #averydifferentconversation.

[1] https://www.cqc.org.uk/sites/default/files/special_measures_guide.pdf

2.6 The Alliance put in place an engagement process to develop a Mental Health and Wellbeing Strategy '**#averydifferentconversation for the future of Suffolk**[2]**'**. A series of co-produced engagement events were run inviting individuals and organisations to take part in the conversation to co-produce a new mental health and wellbeing strategy for Suffolk.

2.7 A Suffolk Alliance Mental Health Transformation Programme was established to support the design and implementation of a new all age mental health and wellbeing model for the population of East and West Suffolk supported by an Alliance programme team to deliver the programme. The programme is being delivered via four Priority Groups:

- Children, Young People and Families (0-25)
- Crisis
- Community (including IAPT and Wellbeing) and
- Learning Disabilities and Autism.

2.8 The programme plans to mobilise services from September 2020, this date having been committed to the Secretary of State. The mobilisation phase will require formal contracting arrangements to be developed and agreed.

2.9 The scope of this review is limited to the proposed service changes for mental health and wellbeing services in East and West Suffolk. Those proposals are still at a high level, with detailed pathways, workforce etc still in development. It is likely that Clinical Senate will be asked to look at the more detailed proposals later in 2020. The outcome and recommendations from this review will help to shape that detail.

2.10 Clinical Senate is not being asked to review any changes to the service model or delivery of mental health care by Norfolk and Suffolk Foundation Trust in any other geographical areas (i.e. Norfolk). Nor is it asked to review future workforce or demand models at this stage.

[2] https://www.westsuffolkccg.nhs.uk/get-involved/averydifferentconversation/

3. Methodology and Governance

3.1 Clinical review panel members (Appendix 2) from within and outside of the East of England and patient representatives (experts by experience) were identified by their clinical expertise and background and invited to join the review panel. All panel members signed conflict of interest and confidentiality declarations (Appendix 3).

3.2 Terms of Reference for the review were agreed between Dr Bernard Brett, Chair of East of England Clinical Senate and Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation, Ipswich and East Suffolk, West Suffolk and North East Essex Clinical Commissioning Groups (Appendix 1).

3.3 The evidence, received on 13 November 2019, was discussed at the pre-panel teleconference on 3 December 2019 to prepare panel members and discuss potential key lines of enquiry.

3.4 The clinical review panel took place on 10 December 2019. The SMHA team gave an overview and context setting presentation to the panel. The proposals were discussed with the panel in more detail, the SMHA team responding to questions providing further supporting and contextual detail.

3.5 Sections of the draft report were sent to clinical review panel members for review and confirmation of accuracy and to SMHA team for review for points of accuracy on 20 December 2019.

3.6 The final draft of the report was submitted to a specially convened meeting of the East of England Clinical Senate Council on 14 January 2020. Senate Council agreed that the clinical review panel had fulfilled the Terms of Reference for the review and confirmed the report.

3.7 East of England Clinical Senate will publish this report on its website at the appropriate time as agreed with the sponsoring organisation.

Summary of key findings: General and overarching

4.1 The panel thanked the team for its presentation and open and honest approach in response to the questions from the review panel. The Alliance team were obviously well prepared and had provided the panel with a comprehensive evidence set. The team was also thanked for its prompt and comprehensive response to the key lines of enquiry raised by the review panel on its pre-panel call on 3 December 2019. The panel acknowledged that the proposals before it were still at the high level and that further detail would be developed and brought to Clinical Senate at a later date.

4.2 The panel agreed that the breadth of the partnership (Alliance) was impressive. The Alliance team had shown a genuine commitment to work together, acknowledging what was not currently working for users and carers and the need to work together to develop services appropriate for the users' needs. The panel agreed that the Alliance should be congratulated in bringing the system together and putting in place a structure around that in a relatively short space of time.

4.3 The panel was impressed by the genuine approach to co-production as demonstrated by the numbers of users and groups involved in the process so far. The Alliance had used its local population to develop a strategy for mental health and wellbeing, with user groups able to challenge the commissioners and providers to think differently about the strategy and future service models appropriate for the local population. The panel heard how the #averydifferentconversation approach had become a movement for mental health and wellbeing in Suffolk and strongly supported Alliance's co-production approach. The Alliance team advised the panel that the next step was to go out to the harder to reach groups that it hadn't yet been able to engage with but acknowledged it would be a challenge. The panel encouraged the Alliance to continue to grow their engagement to maintain confidence with users and stakeholders as the detail around future service models and pathways were developed.

4.4 The review panel fully supported the direction of travel; it agreed that the 'East and West Suffolk Mental Health & Wellbeing Strategy 2019-2029' document was comprehensive. Through its population health based approach, the Alliance demonstrated a good understanding of the current and future demand and the work that needed to be done to meet that. The panel agreed that whilst it strongly supported the population health based approach, the Alliance should also ensure that the specialist provision was also strengthened so that people with severe mental illness received the same support as those with mild / moderate illness.

4.5 The panel agreed that the document clearly laid out the case for change, aims and intent. The panel supported a 'left-shift' more preventative focus but felt that it was (too) strongly focused on the model for services for low levels of ill-health with less focus on those with more severe mental illnesses. The panel further agreed that there needed to be a clear overall vision of what the Alliance wants to achieve for services and users. It strongly recommended that, as a priority, the Alliance define its vision that captures the range of mental health and wellbeing services in Suffolk. The panel was of the opinion that having a clear vision would help the Alliance refine its clinical model and clarify and define intended outcomes. (Reference recommendation 1)

4.6 The Alliance had gone some way to addressing the panel's question about outcomes for users and services through its response to the key lines of enquiry, advising that local outcomes would be co-produced with partners. The Alliance advised the panel that it was engaging with University of East Anglia to develop a research project, although the panel was not clear whether this would contribute to the development of any measurable outcomes. The panel recommended that data should start to be collected and analysed now to both provide a baseline for comparison and also to help develop the most appropriate indicators for future measurement. (Reference recommendation 3)

4.7 During discussion, the panel heard that other elements of mental health and wellbeing were covered in different work programmes (for example primary

care, older people / frailty and end of life care). Whilst it appreciated that it was not appropriate to review other work programmes, the panel felt that an overview of where the mental health strategy was aligned in the overarching long term plan for the Suffolk and North Essex Integrated Care System (SNEE ICS) would have been helpful.

4.8 The panel were supportive with the principle of the quadrant model as a basis to provide a seamless care journey for the user. The panel though did agree that unless the services were fully supported by a workforce with the appropriate skills and competencies with truly seamless communication, there was a risk that the user could get 'stuck' in one of the quadrants and would not move through to other quadrants (or indeed be discharged if appropriate) as intended. The panel felt that this particularly applied to the learning disability cohort (further in para 4.38).

4.9 The panel supported the approach to a needs-based model of care, from a diagnostic threshold one, and supported the commitment to reducing or even eliminating 'hand offs' to different agencies and services. Although it was not clear to the panel how that would work in practice in the new model, the panel accepted that the detail may be available as the model developed. Members of the panel highlighted that a needs-based model can sometimes be difficult for users to access if staff at the first point of contact did not have the appropriate knowledge, experience or competencies to appreciate the individual's personal situation, particularly for children, young people, learning disability and autism users who may not be so articulate as some other users. This could particularly apply at a time of user crisis contact.

4.10 Whilst it heard that the Alliance had made a clear commitment to the Secretary of State for Health to improve mental health and wellbeing services for Suffolk and mobilise a new model by September 2020, the panel agreed that the timeline was extremely ambitious. Whilst supporting the desire to improve services with sufficient pace, the panel cautioned that the proposed very rapid pace of change did not appear to offer opportunity to assess the efficacy or appropriateness of services, offered little time for any

required upskilling and development of the workforce and could put users, carers, services, and staff at risk. (Reference recommendation 2)

4.11 There was also a risk that rapid, simultaneous mobilisation of multiple services could undermine the confidence and support of the service users and groups and staff involved in the co-production. User confidence was viewed by the panel as of critical importance after a challenging time for services.

4.12 The Alliance team advised the panel of its early adopter site in Haverhill, in particular a two-week pilot using link workers to triage all mental health presentations. The data from the pilot showed that a large percentage of those individuals did not require an onward referral to secondary (mental health) services, and that many of the issues and concerns that contributed to the individual presenting themselves stemmed from a variety of social and environmental elements including housing, work, relationships and finances. The Alliance team explained that it was trying to understand how the information from the pilot could be used to start to model managing demand and workforce in a different way (with the caveat it was a very small sample in a short period of time).

4.13 The panel suggested that it might be helpful to extend the earlier adopter pilot to a small number of other sites. (Reference recommendation 4)

4.14 The panel agreed that to appropriately manage demand and bring the context of mental health into the health and care system, there did need to be clear alignment of the mental health agenda between primary and secondary care**,** ensuring there was a joined up clinical pathway conversation. The Alliance advised the panel that there would be a lead mental health GP identified in each practice and each GP practice would have a multi-disciplinary team (MDT) meeting that would include a psychiatrist and the link worker. (Reference recommendation 5). The panel agreed that it would also be necessary for clarity on how the pathways linked with the criminal justice system, including probation services, for these users.

4.15 The Alliance advised the panel that currently across the system a number of different information technology (IT) patient information systems were used. Most GP practices in Suffolk used SystmOne and work was underway to understand the wider IT requirements and how the different systems could interface in future. (Reference recommendation 6). The panel learned that the Suffolk User Forum was involved in the development of online platforms and 'apps' and heard of two examples that had been developed.

4.16 Whilst workforce *per se* was not within the scope of this review, the panel discussed the need for appropriate competencies and supervision of staff in the new model, so that the user received the right access, journey and treatment at the right time by staff with the appropriate skills and competencies. The governance arrangements to support multi-agency, multi-specialty involvement in patient pathways needed some careful focus. The Alliance advised the panel that there had been a shift from a traditionally medical care model to more Advanced Nurse Practitioner roles and that a system had been put in place for rotation of posts so that the workforce gained experience in different areas.

4.17 The panel felt that the Alliance had not yet fully explored the potential opportunities of the future model in general or with the specific workstreams, but accepted that this may be something that will be worked through as detail developed.

4.18 Children & Young People and Families workstream (CYPF)

4.19 The panel supported the proposal for CYPF services to cover 0-25 years. However, it cautioned that services should be available to age-specific sub-groups to ensure appropriateness, and that there should be a mechanism for seamless transition for the users between the services for all the age groups.

4.20 The panel commented that although the co-production approach had engaged significant numbers of individuals and groups, it should have sought clarification whether this had included CYPF specific user groups and carers.

4.21 The Alliance team explained that the Integrated Neighbourhood Teams (INT) were working well across Suffolk and were at present more developed than

the (newer) Primary Care Networks (PCN). They further explained that the geographical boundaries between the two did not always align. Following a pilot scheme which showed positive results, a Mental Health Schools Team will work closely with schools. Further pilots were due to take place in 2020.

4.22 The panel felt that the detail of interaction with CYPF and their families through schools needed further development along with more detail around how the CYPF specialist social workers, school teams and community paediatricians would be an integrated part of the CYPF mental health and wellbeing service to ensure seamless care for CYPF.

4.23 The panel felt that the crisis pathway for CYPF in particular needed to have more clarity as there appeared to be cut-offs at different ages. The panel also agreed that there were user groups that should have been included for example perinatal, eating disorders and suicide risk in the younger people group.

4.24 Crisis workstream

4.25 The panel heard that there would be 24-hour seven day (24/7) mental health care available in the emergency department of both West Suffolk and Ipswich Hospitals. The Alliance advised the panel that it recognised that 'crisis' was different for every individual and so wanted user crisis to be determined by the user and not defined by a generic threshold model (via NHS111 option 2). The Alliance advised the panel that the NHS 111 option 2 24/7 workforce would offer generic support but would have access to specialist staff.

4.26 The Alliance recognised that a 24/7 crisis model would be a challenge from a workforce perspective but advised that a number of new staff had been recruited in the last twelve months who were all keen to be part of the new models.

4.27 The panel agreed that whilst there were still some areas that lacked detail or clarity from the evidence and/or discussion, this should come later.

4.28 The panel was supportive of the proposal for third sector provision of some services but was unclear of the interface with statutory provision and other third sector provision and how the risk would be managed (e.g. how the crisis café connected with the contact centre / NHS 111 / option 2, and other statutory services).

4.29 Community workstream and wellbeing

4.30 The panel had been advised through the response from the key lines of enquiry that the IAPT service was addressing integration of mental and physical health for patients with long term conditions and that patients with serious mental illness were offered physical heath checks.

4.31 The Alliance advised that the Wellbeing service was functioning well and provided interventions for mild to moderate conditions.

4.32 The panel agreed that the community offer appeared to focus on IAPT (Improving Access to Psychological Therapies) and the mental health link workers who sat within the Wellbeing service and were attached to a (or several) GP practice/s. The full role of the link workers though was not clear to the panel, especially around what services, therapies or interventions they would be able to offer themselves, nor their skill level competencies. (Note: the panel had learned about the pilot at Haverhill - see para 4.12 above).

4.33 The panel was of the opinion that overall the approach to wellbeing could be much more holistic and comprehensive than the current IAPT service but acknowledged that it had not fully explored detail of the provision. For example, promoting healthier lifestyles, communities, workplaces and educational environments including a significant focus on mental health has been one approach taken in other areas.

4.34 The panel did agree that the Alliance needed to strengthen its community offer. Whilst it understood that some of the user groups were covered in other work programmes outside of the mental health Alliance work, the panel suggested that the integration was cross referenced so that these user groups were not excluded from the service model as it developed. This included the following groups: Older people, those requiring end of life care,

drug and alcohol users, individuals with a personality disorder and seriously mentally ill patients along with marginalised and vulnerable groups (refugee, homeless, travellers).

4.35 Learning Disability and Autism (LDA)

4.36 The Alliance advised that the majority of people with learning disability or autism should be able to access mainstream (mental health) services. There would be a specialist LDA complex community team in the new model to support those with the most complex needs and provide interventions specific for those users for whom mainstream services were not appropriate.

4.37 The panel agreed that whilst its questions were answered well on the day, the proposals for LDA appeared to be less advanced than, and were not entirely consistent with, the proposals for the other priority workstreams.

4.38 The panel agreed that there was a greater risk of LDA users getting 'stuck' in the quadrant (model of care) than other users and that there needed to be clarity on how LDA users would be holistically managed across several different services to enable a better lifestyle rather than a focus on functional mental health. There appeared to be no detail about how the physical health of those with moderate to severe learning disabilities would be integrated with their mental health or any specific detail about how the health inequalities for LDA would be addressed.

4.39 The panel considered that it would be helpful to have clarity on the support for those with epilepsy and where that sat in the model, also specific end of life care for the LDA group.

4.40 The panel suggested that needs for people with learning disability vary across the range of disability and it would be helpful to have a gap analysis to understand where the gaps were at various tiers of services.

End of section.

5. Conclusion and recommendations

5.1 In conclusion and to set the context of the recommendations, the clinical review panel made the following response to the questions asked of Clinical Senate which were:

a) Do the proposed high-level models indicate the provision of safe, accessible mental health care for service users in Suffolk? and

b) Would the model improve service user confidence in provision and accessibility of mental health services in Suffolk?

5.1.1 The clinical review panel was very supportive of the huge amount of work that had been undertaken and the direction of travel. It was obvious to the panel that the range of organisations contributing to the Alliance had all strived to work collaboratively using co-production methodologies to improve services for the future.

5.1.2 In response to question a) the panel agreed that the high level models at this stage, with some refinement, had the potential to deliver safe, accessible mental health services but this would require further development, specific pathway development and well-managed implementation plans.

5.1.3 In response to question b) the panel felt that the collaborative approach with engagement with services users and a clear commitment to co-production should instill confidence and this must be followed through with the development of detailed plans and careful implementation plans. Early positive developments should also help further build confidence going forwards.

5.2 Recommendations

5.2.1 The recommendations below are in separate parts: recommendations one to six below are generic and apply across the programme to all priority workstream areas, followed by recommendations specific to each of the four workstreams.

5.3 Recommendation 1 – The Alliance should define and articulate a clear vision for Mental Health and Wellbeing Services.

5.3.1 The panel recommended that, as a priority, the Alliance define its vision for mental health and wellbeing services in Suffolk. The panel felt that having a clear vision would help the Alliance refine its clinical model and develop intended outcomes for users and services.

5.4 Recommendation 2 – The Alliance should balance the desire for a rapid pace of change with ensuring there is sufficient time to mobilise and implement changes safely and smoothly.

5.4.1 The panel recommended that careful consideration be given to the proposed rapid pace of change, whilst supporting a desire to improve services at a reasonable pace. The Alliance should continually assess that the pace was balanced with assurance that the right change, to the right degree was applied and that there was no undue risk to users, carers and families, services and staff.

5.5 Recommendation 3 – The Alliance should develop clear and robust outcome measures and an approach to the evaluation of the changes to service models.

5.5.1 The panel recommended that a set of clearly defined and measurable outcomes be developed that included hard outcomes, nationally set measures and service user experiences. These should include physical outcomes including life expectancy for those with severe mental health disorders and mental health outcomes for those with long-term conditions. Appropriate data items needed to be identified, collection to commence as soon as possible to enable analysis to help further refine the appropriate priority outcomes and to act as a baseline.

5.5.2 The panel recommended that a system of evaluation needed to be established to assess each pilot / new service model or new pathway in turn to determine how well they were working and whether they needed to be rolled out. The whole process should ideally be evaluated on an ongoing basis so that the Alliance could understand how it was performing as a system (including national and local priorities and health and social care measures) and so that it could help inform service redesign across the NHS.

5.6 Recommendation 4 – The Alliance should plan to roll out the early adopter sites to gain further knowledge and make further refinements before full roll out.

5.6.1 The panel recommended that the Alliance considered extending the pilot site to a small number of other sites across Suffolk to test the results of early pilots in Haverhill and to test further pilots of the new model when appropriate.

5.7 Recommendation 5 – The Alliance should ensure full alignment of the health and care system including incorporating the Primary Care Networks.

5.7.1 The panel recommended that the Alliance considered utilising the local Primary Care Networks as well as the more established Integrated Neighbourhood Teams to support the alignment of the mental health agenda across primary and secondary care to enable joined-up, seamless care for users and carers.

5.8 Recommendation 6 – The Alliance should continue with the early development of ICS system wide Information Technology systems to support seamless care.

5.8.1 The panel further recommended the continuing focus as an important priority on developing ICS wide IT systems that enabled health, social care and third sector workers to access appropriate levels of information to support patients

and care users, and also to enable more patient and user access to information to support their care.

5.9 Recommendations for the Children and young people and families (CYPF) workstream

5.9.1 **Recommendation 1 (CYPF)**: The panel recommended that a plan was developed to reduce adverse childhood experiences and to help those who had suffered from them.

5.9.2 **Recommendation 2 (CYPF)**: The panel recommended that the crisis pathway for CYPF in particular needed to have more clarity as there appeared to be cut-offs at different ages.

5.9.3 **Recommendation 3 (CYPF)**: The panel recommended that the Alliance worked to ensure seamless multi-agency communication with appropriate governance to support patient pathways for those under the age of 25.

5.9.4 **Recommendation 4 (CYPF)**: The panel supported a needs-based approach, but recommended care was taken to ensure that this did not become a means of restricting access to services.

5.10 Recommendations for the Crisis workstream

5.10.1 **Recommendation 1 (Crisis)**: The panel recommended that the make-up, working arrangements, governance, roles and responsibilities of the 24/7 first responder (i.e. NHS 111 option 2) service be clarified to ensure that patients receive the right care and interventions in a timely manner. Where possible, most patients should be offered face to face support.

5.10.2 **Recommendation 2 (Crisis)**: The panel recommended that the Alliance carefully considered how Crisis Cafes, Crisis Houses and / or Crisis

Sanctuaries were incorporated and integrated safely into pathways, with a view to reducing referrals into secondary care emergency departments.

5.10.3 **Recommendation 3 (Crisis)**: The panel further recommended that there was careful consideration for managing the high-risk groups including those living with personality disorders, living with eating disorders and those with drug and alcohol problems, with plans developed to reduce the risk of crisis in these groups.

5.10.4 **Recommendation 4 (Crisis)**: The panel recommended that there was a focus on certain groups who may find it more challenging to access help and support such as adults with learning disabilities and vulnerable groups such as the homeless.

5.11 Recommendations for the Community workstream

5.11.1 **Recommendation 1 (Community)**: The panel recommended that the link worker role should be clarified to define their skills, responsibilities and interventions the link workers could offer. Defining the vision for the service should enable a better understanding of the desired role / function of the link worker.

5.11.2 **Recommendation 2 (Community)**: The Alliance should also ensure that the specialist provision was strengthened so that people with severe mental illness received the same support as those with mild / moderate illness.

5.11.3 **Recommendation 3 (Community)**: The panel recommended that the role of the Primary Care Networks and how they fit into the Mental Health and Wellbeing strategy be carefully considered to ensure appropriate connection and inclusion.

5.11.4 **Recommendation 4 (Community)**: The panel recommended that the Alliance adopted a more holistic approach to improving mental wellbeing, linking with other ICS workstreams to encourage healthy lifestyles and workplaces.

5.12 Recommendations for the Learning Disability and Autism (LDA) workstream

5.12.1 **Recommendation 1 (LDA)**: The panel recommended that the Alliance develop robust proposals to ensure that the physical health of those living with learning disabilities or autism was optimised to reduce health inequalities.

5.12.2 **Recommendation 2 (LDA)**: The panel further recommended that there should be sufficient support for those living with learning disabilities or autism who may find it difficult to access mainstream services.

End of section.

APPENDIX 1: Terms of Reference for the review

NHS
East of England
Clinical Senate

Independent clinical review of proposals for mental health and wellbeing services in East and West Suffolk for Suffolk Mental Health Alliance

10 December 2019

Terms of Reference

(NB graphics removed to reduce file size)

CLINICAL REVIEW: TERMS OF REFERENCE

Title: **Richard Watson**, Deputy Chief Executive and Director of Strategy and Transformation. Ipswich and East Suffolk, West Suffolk and North East Essex Clinical Commissioning Groups

Sponsoring organisation: **Suffolk Alliances** (Ipswich and East Suffolk CCG, West Suffolk CCG, East Suffolk and North East Essex Foundation Trust, West Suffolk Foundation Trust, Suffolk GP Federation, Suffolk County Council, Norfolk and Suffolk Foundation Trust, Suffolk Family Carers, Suffolk User Forum, Suffolk Family Carers and ACE Anglia.

Terms of Reference agreed by: Suffolk Alliance Mental Health Implementation Group

Signature

And

Dr Bernard Brett, clinical review panel chair and East of England Clinical Senate Chair, on behalf of East of England Clinical Senate

Signature

Date: 25 November 2019

When is the advice required by? Please provide any critical dates	The advice is required by 20th January 2020. The overall programme milestones are: • February 2020: Completion of the detailed pathways (senate advice will be required in advance of this to incorporate feedback) • April 2020: Completion of the Service Specifications • May 2020: Service and Provider re-alignment • July 2020: Completion of due diligence and assurance • August: Contracts awarded • September 2020: Mobilisation
What is the name of the body / organisation commissioning the work?	Suffolk Alliances (Ipswich and East Suffolk CCG, West Suffolk CCG, East Suffolk and North East Essex Foundation Trust, West Suffolk Foundation Trust, Suffolk GP Federation, Suffolk County Council, Norfolk and Suffolk Foundation Trust, Suffolk Family Carers, Suffolk User Forum, Suffolk Family Carers and ACE Anglia.
How will the advice be used and by whom?	The advice received from the NHS England Clinical Senate on the four High Level Models will help shape the detailed pathways that will be developed to underpin the models. The pathways will form the new mental health model that will implement the Suffolk Mental Health and Emotional Wellbeing 10 year Strategy. The advice will be provided to the SROs of the four priority groups. These groups will develop the pathways.
What type of support is Senate being asked to provide: a) Assessment of clinical services b) Early advice to inform a clinical service model c) Review of proposed clinical model /s d) Support for case for	c) Review of proposed high level model for mental health services for Suffolk

change, including the appraisal of the clinical evidence within e) Informal facilitation to enable further work f) other	
Is the advice being requested from the Senate a) Informal early advice on developing proposals b) Early advice for Stage 1 of the NHS England Assurance process c) Formal clinical review to inform Stage 2 of the NHS England Assurance process and/ or your Consultation Business Case d) Other	a) Informal early advice on developing proposals
Does the matter involve revisiting a strategic decision that has already been made?	No.
Is the matter subject to other advisory or scrutiny processes?	Yes. The programme will be subject to formal scrutiny from all provider boards, the Health and Overview Scrutiny Committee and NHS Procurement.

Clinical review panel members

Each review panel has a bespoke membership, brought together to provide the Senate with expert opinion from a range of clinical and patient \ carer perspectives. Members of the clinical review panel sit in their own personal or professional capacity; they do not represent the opinion of their employing or professional body. All clinical review panel members sign an agreement of confidentiality and declare any potential interests. Membership of this panel is given below:

Clinical review panel members		
Name	**Area / organisation**	**Role / area of expertise**
Dr Bernard Brett – Chair	Clinical Senate Chair	
Aly Anderson	Cambs, Peterborough & South Lincolnshire MIND	CEO (non clinician) Expert by Experience
Dr Rachna Bansal	Essex Partnership University NHS Trust (EPUT)	Consultant Psychiatrist (Adult)
Natasha Dominique	(EPUT)	Operational service manager for Older Adult inpatient Services and care homes
~~*Dr Ana Draper~~	~~Tavistock & Portman NHS Trust~~	~~Systemic Psychotherapist~~
Owen Fry	Hertfordshire Partnership University NHS FT	MH Nurse, Senior Service Lead LD
Clare Mundell	Cambridge & Peterborough NHS FT	Chief Pharmacist
~~*Diane Palmer~~	~~EPUT~~	~~Veterans MH Lead~~
Dr Arrthi Pangaytselvan	Cambridge	Public Health Specialty Registrar
Dr Indermeet Sawhney	Hertfordshire Partnership University NHS FT	Consultant Psychiatrist Adult LD, Clinical Director Essex
Annemarie Smith	Hertfordshire	Expert by Experience
~~*Matthew Sparks~~	~~East London NHS FT~~	~~Professional lead, CAMHS, MH Nurse~~
Dr Emma Tiffin	Cambridgeshire and Peterborough	GP, Cambridgeshire &Peterborough CCG Adult Clinical Mental Health Lead, National Adviser on the Expert Reference Group for development of the National Community Mental Health Pathway
Dr Suzanna Watson	Cambs & Peterborough NHS FT	Consultant Clinical Psychologist CAMHS
Lynn Williams	EPUT	Advanced Nurse practitioner
Dr Greg Wood	EPUT Senate Council member	Consultant Clinical Psychologist
Prof Asif Zia	Hertfordshire Partnership University NHS FT Senate Council member	Executive Director Quality and Medical Leadership and Consultant Psychiatrist LD

* **Note updated at 12 December 2019: members withdrew** End.

Aims and objectives of the clinical review

Despite the best intentions and hard work of many people, the system for mental health and emotional wellbeing in Suffolk is failing; despite increased investment, the outcomes for people are not yet good enough. The design of the current system does not meet the changing needs of our population.

The main provider of mental health services in Suffolk is the Norfolk and Suffolk NHS Foundation Trust (NSFT). In February 2015 NSFT was placed in Special Measures[3] by the Care Quality Commission (CQC). The Trust came out of Special Measures in October 2016 but placed back into Special Measures again in October 2017 and currently rated as 'Inadequate'. To address the concerns documented, the two Suffolk Alliances (East and West) have come together to have a #averydifferentconversation.

Suffolk has seen a genuine and concerted effort to shift the conversation around mental health services over the last year. At the heart of this has been the pioneering engagement process to develop a Mental Health & Wellbeing Strategy #averydifferentconversation for the future of Suffolk[4]. A series of co-produced engagement events saw a broad range of organisations and individuals taking part in the conversation to co-produce the new strategy. To help ensure that the ambitions of the strategy are achieved in any new services designed, the Suffolk Alliance Mental Health Transformation Programme was established. The Suffolk Alliance Mental Health Transformation Programme will support the design and implementation of a new all age mental health model for the population of East and West Suffolk. This model will be ready to start being delivered from September 2020.

To deliver the programme an Alliance Programme Team was established. The Programme Team members moved away from their existing jobs in the Alliance organisations to form this new team. The programme is being delivered via four Priority Groups:

1. Children, Young People and Families (0-25)
2. Crisis
3. Community (including IAPT and Wellbeing)
4. Learning Disabilities

[3] https://www.cqc.org.uk/sites/default/files/special_measures_guide.pdf
[4] https://www.westsuffolkccg.nhs.uk/get-involved/averydifferentconversation/

Each Priority Group has a Senior Responsible Owner (SRO) and a team of implementation leads from across the Alliance partners that do not form part of the Alliance Programme Team.

The Alliance Programme Team is supporting the four established Priority Groups to understand the current mental health services and support the co-production of four (draft) high level models. This is the current stage of the programme and will be the basis of the evidence for the review by Clinical Senate on 10 December 2019.

The Priority Groups will then co-produce an explanation of how the proposed services will work (detailed pathways) and this will provide more information about the higher level model. The Alliance Programme team will support this work by providing information about how many people will use the services, the numbers of staff that will be needed to run the services safely and effectively, the IT systems needed, the finances needed, the risks that need to be managed and the governance arrangements that will be place to ensure that things are being done safely and lawfully.

All of this information will be used to create service specifications that will explain exactly how each service will look, how people will use it and how much it will cost.
During this process the current provider contract with NSFT will be reviewed. The new models may indicate that the services need to be delivered by a different, or multiple different, providers. In June 2020 the formal Due Diligence process will commence with the current providers of Suffolk mental health services (those that make up the Suffolk Alliance). This will be led by the two CCGs (Ipswich and East and West Suffolk). The document that will form the basis of the Due Diligence is the Assurance Framework. The Assurance Framework is a set of 'Key Lines of Enquiries' (KLOEs). These KLOEs are structured as questions, which will establish the risk profile and other parameters of the complex requirements.

The programme plans look to mobilise services from September 2020, this date having been committed to the Secretary of State. The mobilisation phase will require formal contracting arrangements to be developed and agreed.

Scope of the review

The scope of this review is limited to the proposed service changes for mental health care in East and West Suffolk. These proposals are still at a high level, with detailed pathways, workforce etc still in development. It is likely that Clinical Senate will be asked to look at the

more detailed proposals later in 2020. The outcome and recommendations from this review will help to shape that detail.

Out of scope

Clinical Senate is not asked to review any changes to service model or delivery of mental health care by Norfolk and Suffolk Foundation Trust in any other geographical areas (i.e. Norfolk).

The Senate is not asked to review future workforce, demand or financial models at this stage.

Purpose of the review

Clinical Senate is asked to review the available evidence, discuss with the members of the programme and make appropriate recommendations from its findings.

The central questions Clinical Senate is being asked to address in this review are:

a) **Do the proposed high level models indicate the provision of safe, accessible mental health care for service users in Suffolk?**

b) **Would the model improve service user confidence in the provision and accessibility of mental health services in Suffolk?**

When reviewing the case for change and options appraisal the clinical review panel (the panel) should **consider whether these proposals deliver real benefits to patients. The panel should also identify any significant risks to patient care in these proposals.** The panel should consider benefits and risks in terms of:

- Clinical effectiveness
- Patient safety and management of risks
- Patient experience, including access to services
- Patient reported outcomes.

The clinical review panel is not expected to advise or make comment upon any issues of the NHS England Assurance process that will be reviewed elsewhere (e.g. financial elements of risk in the proposals, patient engagement, GP support or the approach to consultation). However, if the panel felt that there was an overriding risk this should be highlighted in the panel report.

Questions that may help the panel in assessing the benefit and risk of the proposals include (but are not limited to):

- Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g., sustainability of cover, clinical expertise)

- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Will the proposals reflect further the delivery of the NHS Outcomes Framework?
- Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
- Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. five years)?
- Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?
- Do the proposals demonstrate good alignment with the development of other health and care services, including national policy and planning guidance?
- Do the proposals support better integration of services from the patient perspective?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

The clinical review panel should assess the strength of the evidence base of the case for change and proposed models.

Timeline

The clinical review panel will be held on 10 December 2019.

Reporting arrangements

The clinical review panel will provide a report to the Clinical Senate Council which will ensure the panel met the agreed Terms of Reference, agree the report and be accountable for the advice contained in the final report.

Methodology

The review will be undertaken by a combination of desk top review of documentation, a pre panel teleconference to identify the key lines of enquiry and a review panel meeting to enable presentations and discussions to take place.

Report

A draft report will be made to the sponsoring organisation for fact checking prior to publication.

Comments/ correction must be received from the sponsoring organisation within **ten working days**.

Final report will be submitted to Clinical Senate Council (on 14 January 2020) to ensure it has met the agreed Terms of Reference and to agree the report.

The final report will be submitted to the sponsoring organisation following the Council Senate Council meeting of 14 January 2020. The sponsoring organisation forthwith becomes the owner of the report.

Communication, media handling and Freedom of Information (Act) requests

Communications will be managed by the sponsoring organisation. Clinical Senate will publish the report once the service change proposal has completed the full NHS England process, or at a time that is appropriate to the proposals. This will be agreed with the sponsoring organisation. The sponsoring organisation, as the owner of the report and any evidence and or data provided for the review, will be responsible for handling any formal requests for information under the Freedom of Information Act 2000, irrespective of whether the request is received by either the Clinical Senate or sponsoring organisation. (note: NHS England is the statutory body with responsibility for FOI requests received either directly or by the Clinical Senate and will be advised of all such requests received directly by the Clinical Senate and confirmation that the sponsoring organisation will be responding to the request).

Resources

The East of England Clinical Senate will provide administrative support to the clinical review panel, including setting up the meetings and other duties as appropriate.

The clinical review panel may request any additional existing documentary evidence from the sponsoring organisation. Any requests will be appropriate to the review, reasonable and manageable.

Accountability and governance

The clinical review panel is part of the East of England Clinical Senate accountability and governance structure.

The East of England Clinical Senate is a non statutory advisory body and will submit the report to the sponsoring organisation, who are the owners of the final report.

The sponsoring organisation remains accountable for decision making but the clinical review panel may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

Functions, responsibilities and roles

The **sponsoring organisation** will

i. provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. Background information may include, but is not limited to:

- relevant public health data including population projections, health inequalities, specific health needs
- activity date (current and planned)
- internal and external reviews and audits
- relevant impact assessments (e.g. equality, time assessments)
- relevant workforce information (current and planned)
- evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Long Term Plan, NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG plans and commissioning intentions, STP implementation plans).

The sponsoring organisation will provide any other additional background information requested by the clinical review panel.

ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy

iii. undertake not to attempt to unduly influence any members of the clinical review panel during the review

iv. be responsible for responding to all Freedom of Information requests and

v. arrange and bear the cost of suitable accommodation (as advised by Clinical Senate support teaml) for the panel and panel members.

Clinical Senate Council and the sponsoring organisation will

i. agree the Terms of Reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate Council will

i. appoint a clinical review panel this may be formed by members of the Clinical Senate Council and Assembly, external experts, and / or others with relevant expertise. It will appoint a Chair of the review panel

ii. endorse the Terms of Reference, timetable and methodology for the review

iii. consider the review recommendations and report (and may wish to make further recommendations)

iv. provide suitable support to the panel

v. submit the final report to the sponsoring organisation and

vi. forward any Freedom of Information requests to the sponsoring organisation.

Clinical review panel will

i. undertake its review in line the methodology agreed in the Terms of Reference

ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies
iii. submit the draft report to Clinical Senate Council for comments and will consider any such comments and incorporate relevant amendments to the report. The panel will subsequently submit final draft of the report to the Clinical Senate Council and
iv. keep accurate notes of meetings.

Clinical review panel members will undertake to

i. Declare any conflicts of interest and sign a confidentiality agreement prior to having sight of the full evidence and information
ii. commit fully to the review and attend all briefings, meetings, interviews, panels etc that are part of the review (as defined in methodology)
iii. contribute fully to the process and review report
iv. ensure that the report accurately represents the consensus of opinion of the clinical review panel and
v. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the Chair of the clinical review panel and the Head of Clinical Senate, any conflict of interest that may materialise during the review.

Appendix A – key dates schedule

Action	Date (no later than)	Who
1. Terms of Reference for review completed, agreed and signed off	**14 November 2019**	**SMHA** team and Senate
2. All panel members identified and confirmed, confidentiality agreements and declarations of interest signed	**14 November 2019**	Sue Edwards
3. All papers and evidence for the review panel to be with Sue Edwards	**21 November 2019**	**SMHA** team
4. Panel papers etc to panel members	**25 November 2019**	Sue Edwards
5. Pre panel teleconference call	**3 December 2019**	Panel members only – **SMHA** not involved-
6. Lines of Enquiry / Agenda for Clinical Panel review day issued	**5 December 2019**	SE to ALL
7. Clinical Panel Review	**10 December 2019**	ALL – panel members & **SMHA** team (max 5)
8. Draft report to **SMHA** lead for points of accuracy	**18 December**	SE/Chair
9. **SMHA** response on points of accuracy	Note to SMHA we usually say five days for response but given the Christmas break, it would seem sensible to extend this to around **8 January 2020**	**SMHA** response
10. Clinical Senate Council consider report	**14 January 2020**	Clinical Senate Council

APPENDIX 2: Membership of the clinical review panel

Clinical Review Panel Chair:

Dr Bernard Brett
Dr Bernard Brett, Chair of East of England Clinical Senate, is Deputy Medical Director and a Consultant in Gastroenterology and General Internal Medicine based at the Norfolk and Norwich University Hospitals NHS Foundation Trust, and also works at the James Paget University Hospitals NHS Foundation Trust.

Bernard has held several senior management posts over the last fifteen years including that of Medical Director, Responsible Officer, Deputy Medical Director, Divisional Director, Director of Patient Flow and Appraisal lead. He continues with an interest in Appraisal and Revalidation. Bernard has spoken at regional and national meetings on the topic of 7-day working and been an invited speaker on the topic of improving colonoscopic adenoma detection rates.

Panel Members:

Aly Anderson
Aly Anderson is CEO of Cambridgeshire, Peterborough and South Lincolnshire (CPSL) Mind. Aly has worked in a variety of roles in the mental health sector for the past 15 years and within the Mind network for more than a decade.

Aly is an experienced mental health trainer/speaker, delivering the internationally recognised Mental Health First Aid (MHFA) and Applied Suicide Intervention Skills Training (ASIST). She has also been very actively involved in the wider collaborative work around suicide prevention across Cambridgeshire and Peterborough, including the development of the award winning STOP Suicide campaign.

Aly has championed the move towards asset based approaches to building community resilience/wellbeing and led the development of CPSL Mind's new strengths-based 'Good Life' service which has just been commissioned across Cambridgeshire and Peterborough.

Dr Rachna Bansal
Dr Rachna Bansal is a Consultant Psychiatrist and has been working with EPUT for 11 years and as a Consultant for five years. She works in General Adult Psychiatry and other than the MRCPsych, has done a Diploma in Medical Sciences in Clinical Psychiatry from University of Nottingham in 2007 and Diploma in CBT in 2008. Rachna currently works between two teams - Access and Assessment service - where she does initial screening of referrals received from primary care and other healthcare agencies. She also works in the Specialist Psychosis Team looking after patients with a primary diagnosis of psychosis. Rachna is the SAS Tutor for the trust and has been in this role for eight years. She also wears other hats e.g. Specialty Lead for SAS doctors in Psychiatry for the whole of Eastern Deanery, Regional representative of the Royal College of Psychiatrists and Clinical Senate member.

Natasha Dominique
Natasha is an operational service manager for Older Adult inpatient Services and care homes for Essex Partnership University Trust. Natasha joined the Trust in 2002. Natasha has been an inpatient manager in the Older Adult setting for over 7 years, where she has gained experience and qualifications in leadership, patient safety and clinical effectiveness. She is an Accreditation for Inpatient Mental Health Services Assessor (AIMS) which involves

reviewing and supporting mental health inpatient wards to self-review their services and achieve the accreditation status.

Owen Fry
Owen is currently Head of Service for Specialist Health Learning Disability Services in Essex. These services have begun a county wide transformation to a new model of care lead by Hertfordshire Partnership Foundation Trust in Partnership (HPFT) with Essex Partnership University Trust and Anglia Community Enterprise. Owen held a similar role in Norfolk and Forensic Services on behalf of HPFT and prior to that a commissioning role for East of England Specialised Commissioning Group. Owen has worked in the mental health and learning disability health services for over 30 years as a nurse, manager and commissioner.

Clare Mundell
Clare is Chief Pharmacist at Cambridgeshire and Peterborough NHS Foundation Trust and Senior Responsible Officer for the OneVision project. Clare has 23 years of experience in the NHS working in community, acute and mental health pharmacy. After specialising as a clinical mental health pharmacist for a number of years working for Addenbrookes NHS Trust, she became Chief Pharmacist of the Cambridgeshire and Peterborough Mental Health Trust in 2003. Clare has also been a member of the College of Mental Health Pharmacy Council and is now responsible for pharmacy services that span mental health, community and children' universal services within Cambridgeshire and Peterborough. Recently, Clare has taken on a wider role with responsibility for the implementation of the OneVision project, delivering SystmOne as a replacement electronic patient record for mental health services within CPFT.

Dr Arrthi Pangayatselvan
Dr. Arrthi Pangayatselvan undertook her pre-clinical medical training at The University of Cambridge and her clinical training at University College London. She went on to complete her foundation training in the South Thames region. She completed an MSc in Public Health at the London School of Hygiene and Tropical Medicine after which she entered the Public Health Training scheme. She is currently working at Public Health England as a Specialty Registrar in Public Health.

Dr Indermeet Sawhney
Dr Sawhney is a Consultant Psychiatrist in Intellectual Disability Psychiatry & Clinical Director at Hertfordshire University Foundation Trust. She gained her MRCPsych in 2004 and went to do her higher training in Oxford. She has done her Masters in Mental Health Law from Northumbria University and has a certificate in Expert Witness from University of Cardiff.

She sits as a medical member of the Mental Health Tribunal (first tier) and on the Mental Health Act approval panel for Midlands and East of England. She has published widely in peer reviewed journals She has led on several quality improvement projects at a local and national level. She is an executive member of the Royal College of Psychiatry Faculty of Intellectual Disability. She has been the editor of the newsletter of the Eastern Division of Psychiatry.

Her clinical work entails looking after mental health and behavioural issues in people with learning disability. She is also involved in overseeing the care of epilepsy in people with learning disability.

Anne-Marie Smith
Member and past Acting Chair of HPFT MH Trust Carers Council and also sits on the Patients Care and Environment Committee for Lister Hospital, N.&E. Herts Acute Hospital. She sits on a committee for NHS England and trains the new Leadership on patient and carer issues in the Nye Bevan initiative. A member of the Citizens' Senate for East Anglia.

Annemarie has an interest in Research and involved in joint projects with Cambridge University and Anglia Ruskin and Hertfordshire University where she teaches as an expert by experience. Sits on the validation committee for the new nursing degree and on the NHS Health Committee for smoking cessation for Britain. A stakeholder member of Healthwatch Hertfordshire and also undertakes other voluntary work.

Dr Emma Tiffin
A practising GP in Cambridgeshire and has a weekly radio show "Health Matters" on BBC Radio Cambridgeshire. Emma is the Cambridgeshire and Peterborough STP Clinical Mental Health Lead. She has worked in mental health clinical leadership roles for over 17 years. Local focus has been on developing a sustainable integrated community-based service model for both planned and unplanned mental health care.

In 2016 Emma was awarded the Health Education England "East of England Leadership Award for Service Improvement and Innovation" and in November 2017 was awarded "Healthcare Leader of the Year" at the national General Practice Awards.

During her career, Emma has had national advisor roles including development of the Community Mental Health Framework, Adult Eating Disorder and Coproduction guidance (2019).

Dr Suzanna Watson
Dr Suzanna Watson is a Consultant Clinical Psychologist who leads the paediatric neuropsychology services for children in CPFT at Addenbrooke's Hospital and in the community. She works across acute and community services in the East of England: She is an NIHR CLAHRC Fellow and has published research in paediatric acquired brain injury. Before moving to Cambridge, Suzanna was employed by the Helicopter Emergency Services and CAMHS in East London.

Lynn Williams
Lynn has been working in community mental health for the past 36 years. She is the Advanced Nurse Practitioner for the Home Treatment Team at the Linden Centre in Chelmsford and has been in this role for the past four years. Prior to this Lynn was the supported discharge coordinator for the Mid home treatment team, and interfaced with both private and NHS hospitals as part of her role.

Previous to this Lynn worked in a home treatment team as a senior nurse, and managed various community mental health teams as a senior manager. She has worked in primary care as a nurse therapist and has a Masters degree in Sociology & Community Mental Health. Lynn also holds a diploma in Psychodynamic psychotherapy and most recently has been working with individuals who have mental health issues that would like to take up sport or athletes that are already participating in sport who have mental health issues.

Dr Greg Wood
Greg is a Consultant Clinical Psychologist with over 20 years experience of treating people with physical health problems and severe mental health conditions. He worked as a health activist in South Africa, helping shape prevention and treatment for HIV/AIDS in KwaZulu-Natal and the National AIDS Programme before joining the NHS in 1997 to work in Bedfordshire and Essex.

In 2016 Greg became Chief Psychologist at South Essex MH Trust, and helped manage the merger with North Essex Trust, becoming Clinical Director of Psychological Services at Essex Partnership University Trust where he has Clinical and Operational responsibility for Psychology, Psychotherapy and IAPT services. Greg is a Senate Council member.

Prof Asif Zia
Prof. Asif Zia is Director Quality and Medical Leadership at HPFT and is responsible for medical leadership in the Trust, research and development, clinical effectiveness, pharmacy and medicines management. Asif joined HPFT in 2012. He has worked as a consultant psychiatrist for learning disabilities both in the community and on acute assessment and treatment units. Asif has been involved in service development and quality improvement activities in his psychiatrist career and was appointed to his current role in 2017.

Asif has been a Senate Council member since 2013.

Clinical Senate Support Team:

Sue Edwards	East of England Head of Clinical Senate, NHS England
Brenda Allen	East of England Clinical Senate Senior Project Officer

APPENDIX 3: Declarations of Interest

All panel members were required to declare any interests.

Aly Anderson, Chief Executive of Cambridgeshire, Peterborough & South Lincolnshire (CPSL) MIND declared a potential indirect non-pecuniary conflict owing to the close working links of her organisation to Suffolk Mind. CPSL Mind is to roll out Suffolk Mind's Waves Personality Disorder Service across Cambridgeshire in the near future. Ms Anderson would withdraw from the panel if she considered that the discussion could skew her opinion.

Dr Gregory Wood wished to declare his employment with Essex Partnership United NHS Trust (the declaration does not raise any conflict of interest).

The remaining panel members claimed not to have any a) Personal pecuniary interest b) Personal family interest c) Non-personal pecuniary interest or d) Personal non-pecuniary interest.

However, the Head of Clinical Senate, Susan (Sue) Edwards and Lizzie Mapplebeck, Director, Suffolk Alliance Mental Health Transformation Programme East and West Suffolk Alliances made known to panel members and the Alliance team that they had a familial relationship. This relationship does not give any cause for conflict as Sue Edwards is not a panel member nor decision maker for the review.

APPENDIX 4: Review panel agenda

A G E N D A

Independent clinical review of proposals for mental health and wellbeing services in East and West Suffolk for Suffolk Mental Health Alliance

Date: Tuesday 10 December 2019. **Time:** 09.15 to 16.30hrs for panel members & 09.50hrs to 13.00 hrs (& lunch) for Suffolk Mental Health Alliance team

Venue: Abington Room, Granta Centre, Granta Park, Cambridge CB21 6AL

Clinical Senate is asked to review the available evidence, discuss with the members of the programme and make appropriate recommendations from its findings on the high-level proposals for mental health and wellbeing services in East and West Suffolk.

The central questions Clinical Senate is being asked to address in this review are:

c) **Do the proposed high-level models indicate the provision of safe, accessible mental health care for service users in Suffolk?**

d) **Would the model improve service user confidence in the provision and accessibility of mental health services in Suffolk?**

Time	Item
09.15 – 09.30	Registration & arrival – panel members
09.30 - 09.50	Welcome, introductions & outline of the proceedings for the review panel from panel chair Dr Bernard Brett
09.50 – 10.00	Suffolk Mental Health Alliance team (Alliance team) welcome & introductions
10.00 - 10.30	Overview presentation 30 mins by Alliance team to the panel
10.30 – 11.15	General questions from the panel to Alliance team
11.15 – 11.30	Short break
11.30 – 13.00	Panel questions & discussion with Alliance team
13.00 – 13.40	Lunch (panel and Alliance team) Alliance team depart after lunch.
13.40 – 16.00	a) Confidential Panel discussion b) Panel summary – key findings and recommendations (to include working break as appropriate)
16.00 - close	Panel summary – key findings and recommendations

Next steps – information for clinical review panel members:

1) A draft report will be sent to the Alliance team and clinical review panel members for points of accuracy check no later than 18 December 2019 for response by 8 January 2020 turnaround for panel members and 3 January 2020 for Alliance team.

2) Final draft report will be provided for specially convened Clinical Senate Council meeting on 14 January 2020 for Council to confirm that the clinical review panel met the Terms of Reference for the review (NB Council cannot make any material changes to the report or its recommendations but may make additional comment or recommendations).

Final report provided to SMHA team by 16 January 2020.

KEY LINES OF ENQUIRY

The clinical review panel discussed the evidence on a 'pre-panel' call and identified some key areas of enquiry (shown below) it would like to pursue with the Alliance team on the panel day. Discussion on the day though will not be limited to these areas.

General and applies to all workstreams

Outcomes:

- Is there an intention to develop local as well as national (i.e. must do) indicators to measure success for services and patients? How will appropriate feedback from clients, families and carers be gathered?

Cross linking:

- How will the different work-streams cross link e.g. if LD and A are to access more mainstream services how does each work stream accommodate them (generally and workforce specific).

- There is a focus (in the evidence) on health for demand, but does the Alliance consider there is enough focus on complex secondary care? Much of the data in the case for change is secondary care based but there is less focus on the workstreams.

- Physical health and poor physical outcomes: how will the integration of physical with mental health be addressed?

Workstream specific

Children & Young People workstream

- Clarity around ante and post-natal mental health services and how they link in with early childhood etc.
- Will there be adequate specialist CYPF social workers available to support the services?

Crisis workstream

- Who will be the gatekeeper for inpatient beds?
- The panel sought some clarity on some aspects of the crisis pathway:
    - How does the patient navigate back through the pathway if necessary?
    - How does crisis café link to the wider crisis pathway?
    - How will the system ensure that the individual components work in a seamless way and patients are not just moved from one team to another?
    - Detail of the link with A&E beyond MH liaison services.

Community workstream

- What will be the expected waiting time for referral to the community team and who will hold the patient while waiting?
- Is the NHS111 data an appropriate and adequate indicator of possible demand given that mental health patients tend not to call NHS111 but may do in the future with a fully functioning service?
- How / where will the justice system fit into the pathway (released prisoners and those still in prison)?
- How will other marginalised groups be accommodated in each workstream (particularly those that do not access a GP i.e. travellers, homeless) including those in the marginalised and vulnerable adults service, BAME, gender reassignment etc?

Learning Disability and Autism

- Clarity on what will be different in the 'to be' from the 'as is' – all current services appear to be still in there with little change.
- How will those with less severe disorders be supported to access mainstream service?
- How will you ensure that a limited skilled workforce isn't diluted (by spreading them into too many different services)?
- Are the predicted numbers of the patients that can access mainstream services and the amount of support they might need realistic (modelled)?

End.

Clinical Review Panel members		
Name	**Area / organisation**	**Role / area of expertise**
Dr Bernard Brett – Chair	Clinical Senate Chair	
Aly Anderson	Cambs, Peterborough & South Lincolnshire MIND	CEO (non-clinician)
Dr Rachna Bansal	Essex Partnership University NHS Trust (EPUT)	Consultant Psychiatrist (Adult)
Natasha Dominique	(EPUT)	Operational service manager for Older Adult inpatient Services and care homes
~~**Dr Ana Draper~~	~~Tavistock & Portman NHS Trust~~	~~Systemic Psychotherapist~~
Owen Fry	Hertfordshire Partnership University NHS FT	MH Nurse, Senior Service Lead LD
Clare Mundell	Cambridge & Peterborough NHS FT	Chief Pharmacist
~~**Diane Palmer~~	~~EPUT~~	~~Veterans MH Lead~~
Dr Arrthi Pangaytselvan	Cambridge	Public Health Specialty Registrar
Dr Indermeet Sawhney	Hertfordshire Partnership University NHS FT	Consultant Psychiatrist Adult LD, Clinical Director Essex
Annemarie Smith	Hertfordshire	Expert by Experience
~~** Matthew Sparks~~	~~East London NHS FT~~	~~Professional lead, CAMHS, MH Nurse~~
Dr Emma Tiffin	Cambridgeshire and Peterborough	GP, Cambridgeshire and Peterborough CCG Adult Clinical Mental Health Lead, National Adviser on the Expert Reference Group for the development of the National Community Mental Health Pathway
Dr Suzanna Watson	Cambs & Peterborough NHS FT	Consultant Clinical Psychologist CAMHS
Lynn Williams	EPUT	Advanced Nurse practitioner
Dr Greg Wood	EPUT Senate Council member	Consultant Clinical Psychologist
Prof Asif Zia	Hertfordshire Partnership University NHS FT Senate Council member	Executive Director Quality and Medical Leadership and Consultant Psychiatrist LD
In attendance		
Brenda Allen	NHS England \ NHS Improvement	Clinical Senate Senior Project Support
Sue Edwards	“	Head of Clinical Senate

** Note: withdrew, did not attend

Suffolk Mental Health Alliance team members **Panel Members**		
Name	**Role**	**Organisation**
Clare Kingaby-Lewis	User by Experience	Suffolk Parent Carer Network
Rebecca Pulford	Priority Two: Community & Programme Clinical Lead	East Suffolk North East Essex Foundation Trust
Richard Watson	Chair	Suffolk Clinical Commissioning Groups
Dr Roz Tandy	GP Representative	GP
Stuart Richardson	Priority Three: Crisis & Priority Four: Learning Disabilities and Autism	Norfolk and Suffolk Foundation Trust
Observers		
Allan Cadzow	Priority One: Children, Young People and Families	Suffolk County Council
David Pannell	Priority Two: Community	Suffolk GP Federation
Dr Jenny Axford	Consultant Psychiatrist	Norfolk and Suffolk Foundation Trust
Lizzie Mapplebeck	Programme Representative	Suffolk Alliance
~~**Rowan Procter~~	~~Priority Three: Crisis~~	~~West Suffolk Foundation Trust~~
Wendy Scott	Priority Four: Learning Disabilities and Autism	Suffolk Clinical Commissioning Groups

** Note: withdrew, did not attend

APPENDIX 5: Summary of evidence set provided

Ref	Evidence	Explanation
01	Suffolk Mental Health Strategy	Sets out the background to Suffolk's Mental Health offer and the aims and objectives for the mental health offer over the next 10 years
02	Framework Process and High level milestones	Milestones that detail the process from now until mobilisation. Includes the due diligence process
03	Communications and Engagement Plan	The plan that details who we are going to engage with, how and why
04	Structure including governance and risk reporting	Breakdown of what current mental health services are allocated to the priorities and how the risk and governance process flows
05	Priority One CYPFF High Level Template	Sets out the objective, benefits, outcomes, risks, milestones, national must dos and high level model for CYPFF
06	Priority Two Community High Level Template	Sets out the objective, benefits, outcomes, risks, milestones, national must dos and high level model for Community
07	Priority Three Crisis Level Template	Sets out the objective, benefits, outcomes, risks, milestones, national must dos and high level model for Crisis
08	Priority Four Learning Disability and Autism High Level Template	Sets out the objective, benefits, outcomes, risks, milestones, national must dos and high level model for LD and ASD
09	Response to the key lines of enquiry sent following panel member pre-panel teleconference on 3 December 2019	

End of report.