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 panels held in November 2020.

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EXECUTIVE SUMMARY

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 Clinical Governance: The Alliance should develop a robust and effective clinical governance and risk management framework, including detail regarding how this worked for front-line services, supported by a system wide information technology.

Recommendation 2 Pace of change: The Alliance should ensure it balances the pace of change with a seamless transition, ensuring the safety of service users and its workforce.

Recommendation 3 Workforce: The Alliance should undertake workforce modelling as soon as possible, and develop a workforce strategy that includes recruitment (including new roles), retention, training, development and clinical supervision

Recommendation 4 Outcomes: The Alliance should develop outcome measures that clearly describe what it is trying to achieve and what good will look like.

Recommendation 5 The Alliance needs to ensure that it puts all necessary measures in place to ensure service user and staff confidence in the single trusted assessment. The Alliance should develop very clear protocols for who undertakes and has clinical accountability for the trusted assessment, how it is used and forwarded on through the THRIVE model to ensure that service users do not fall through gaps or have long waits for referrals.

Recommendation 6 Information sharing: The Alliance should ensure that staff are able to access service user trusted assessments and all other important clinical information.

Recommendation 7 Illustrative pathways: The Alliance should develop a range of illustrative pathways pathways to demonstrate to service users, carers, the population and all relevant stakeholders what the new models would look and feel like and how they would be different to those service users currently experience.

Recommendation 8 System capacity and demand modelling to understand workforce and system capacity to deliver timely needs-led care including the initial 'double running' of services during mobilisation.

Recommendation 9 Estates: The Alliance should give consideration to the estate capacity to ensure it has a range of suitable environments.

Recommendation 10 Staff engagement and clinical leadership. The Alliance should ensure that it has a clear and robust plan to deliver an appropriate level of staff engagement and develop clinical leadership capacity to finish developing and implement and deliver its ambitious plan.

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 Suffolk Mental Health Alliance has been working on their ambitious project to improve Mental Health and Wellbeing services in Suffolk. The Alliance recognise, and have been open about, shortcomings of the services in the region in the past and have taken a collaborative, multi-stakeholder coproduction approach to significantly improve their services for the future.

Mental Health services across the country need improvement to deliver better mental health for the population. The COVID pandemic has exacerbated the situation with an increase in demand and greater challenges in providing the appropriate capacity to support service users.

The Alliance has to be commended on its clear desire and enthusiasm to improve services for their population. The panels were impressed with the degree of engagement which has continued despite the COVID pandemic. The panels were also impressed with how well the various partners within the Alliance appeared to be working together as a collaborative team.

The Alliance continues to have significant challenges ahead. These challenges include: the ambitious timescales; ensuring the governance on the ground as well as at a higher more strategic level are robust and clear; ensuring the communication and engagement continues into the implementation phase and reaches all stakeholders including staff on the ground; delivering a reliable and safe trusted assessment process and overcoming the potential for information gaps as a result of different IT systems and different levels of authorised access to information.

I would like to thank all the panel members for giving up their time and offering their expertise and concentrated focus on reviewing the Alliance's plans. I would also like to thank Sue Edwards and Brenda Allen for their hard work in arranging the whole process and preparing the report.

There is no doubt that there is a real desire from the whole Alliance team to improve the mental health of their population and a real desire to ensure that all stakeholders and service users are involved in shaping the future. We would like to thank the Alliance team for the significant work undertaken to develop services and in preparation for this independent review by Clinical Senate. In addition, I would like to thank them for their openness and responsiveness to questions and queries from the panel.

We wish them every success with their ongoing work, we hope this report assists them with their important aims and would be happy to support the Alliance again in the future.

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 undertook a review for the Suffolk Mental Health Alliance (SMHA or the Alliance) in December 2019 on its high-level proposals for mental health and emotional wellbeing services in East and West Suffolk.

2.2 Since that review, the Alliance has developed its proposals and sought a further review from Clinical Senate on the more advanced and detailed proposals.

2.3 The more detailed background to the proposals can be found in the report of the Clinical Senate's review panel for the Alliance held in December 2019.

2.4 As with the previous review, the scope of this review is limited to the proposed service changes for mental health and wellbeing services in East and West Suffolk. 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).

3. Methodology and Governance

3.1   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 2).

3.2   Review panel members (Appendix 3) from within and outside of the East of England and experts by experience were identified and invited to join the review panel. All panel members signed conflict of interest and confidentiality declarations (Appendix 4).

3.3   Due to the COVID pandemic and the requirement for social distancing, the decision was made to conduct the review panels virtually by MS Teams. So that the review was manageable through that medium and for the comfort of panel members, it was agreed that a series of review panels would be held focussing on the respective priority workstreams, with a presentation panel for all members prior to those and an 'overarching' panel to bring the key findings from each of the review panels into one panel.

3.4   The report provides a summary of the findings of each of the respective priority workstream review panels and the overarching panel. It should be noted that the limitations of running Clinical Senate review panels through Teams did not do justice to the significant amount of work that the Alliance had undertaken since the review panel in December 2019.

3.5   The presentation took place on 4 November 2020, with the SMHA team giving an overview and context setting presentation to the panel. The respective workstream panels took place on 10, 11 and 12 November with a more detailed presentation specific to the workstream and the overarching panel on 18 November 2020.

3.6   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 9 December 2020.

3.7   The final draft of the report would normally be submitted to a meeting of the East of England Clinical Senate Council for it to consider whether the clinical review panel had fulfilled the Terms of Reference for the review and confirmed the report. However, responding to, and managing, the unprecedented and continued demand placed on services due to the COVID pandemic, Clinical Senate activity was suspended in January 2021. Therefore, in order to ensure that the Alliance received a final report in a reasonable time, Chairman's action was taken to sign off the report which was provided to the Alliance on 12 January 2021.

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

4. Summary of general and overarching key findings

4.1 The panel thanked the Alliance teams for their presentations, the comprehensive and detailed evidence set and response to panels questions. The panel fully supported the intention and aspirations of the Alliance and agreed that the Alliance had a good understanding of the needs of its population and users with a clear case for change and was rightly placing the service user at the centre of its model.

4.2 The review panels had all commented and agreed that the vision, enthusiasm and commitment to improving mental health and wellbeing services in Suffolk was clear on the part of all partners. The Alliance had been open and honest with the panels about the case for change and some of the current issues for service users, some of which were demonstrated through a case study (in the Children, young people and families and Crisis review panels).

4.3 The panel welcomed the Alliance's intention to shift to community and preventive mental health models and away from more traditional clinical diagnostic models with the requirement to meet access criteria (threshold) to enter the service, although the Alliance did not explain how this would operate should demand increase to a point where it exceeded capacity. The panel agreed that this was progressive and congruent with national drivers.

4.4 It was clear to the panel that the Alliance was addressing mental health and wellbeing services in Suffolk as a system and had recognised the importance of relationship building and the softer enablers that make things work. The panel congratulated the Alliance on its genuine commitment to work together in partnership and especially its approach to engagement and co-production with service users, carers, voluntary and community organisations and the public. The panel were impressed with the clear collaborative teamworking from Alliance partners. The panel heard that the Alliance would actively continue with this level of engagement and that co-production partners would be involved in the development of service user outcome measures and the evaluation of services.

4.5   The panels agreed that the aspiration was ambitious, particularly as the Alliance was trying to change and implement new services during an unprecedented pandemic situation.

4.6   The panel raised some concern that as the immediate and long-term impact on service demand due to COVID was still not known, this could jeopardise what was already a very tight and perhaps over-ambitious timescale for the implementation and mobilisation of new services.   Although the panel did not raise the issue of COVID impact with the Alliance, it had subsequently received information from the Alliance that it had the support of a public health epidemiologist who was leading on Suffolk COVID data. They were supporting the demand and capacity modelling and so able to draw in population level COVID related data into the modelling to inform the increased demand on mental health services. The COVID pandemic was clearly impacting on the workload and capacity of current staff in the system and their ability to engage with new development and undertake relevant training.

4.7   The panel understood that there would not be a formal open procurement process for delivery of the new mental health and wellbeing services in Suffolk; but, supported by a clear framework for decision making, the Alliance would undertake a formal process to determine which of the Alliance partners were best placed to take a lead on the specific services, followed by a period of due diligence to test that further. A formal open procurement process would however take place should appropriate delivery partners not be identified from among the Alliance partners.

4.8   This approach had made it difficult for the Alliance team to explain in detail how services would be delivered as that would be determined through the new service specifications and agreed with the service providers once known. The panel did agree that even though it was not able yet to describe what the services would look like the Alliance should have been able to describe what good would look like, as this would be fundamental to setting ambition and outcomes for services. Furthermore, the panel was of the clear view that describing and defining the expected outcomes would be a key element to helping ensure service specifications were fit for purpose.

4.9   The panel heard that once the new pathways had been formally agreed, service specifications would be developed supported by demand and capacity and workforce modelling. The Alliance had in place a framework for development of detailed key performance indicators and outcome measures which would include individual service user outcomes, service / system outcomes and population-based outcomes. Local defined outcomes for each service specification would be developed with the service provider along ten domains that had been co-produced with Alliance partners (Appendix 1.) These would sit alongside nationally defined outcomes.

4.10   The panel felt that the timeline and complexity of approach for the formal award of services to providers, followed by development of service specifications and outcomes, workforce modelling, recruitment and subsequent workforce training and development to the new way of working was extremely challenging even with the plans to phase changes over several years.

4.11   The panel agreed that there needed to be more clarity around timescales, particularly given the size and complexity of the proposals. The panel heard that the Alliance was now two years into an initial ten-year programme but with an expectation that the roll out of the new model would be completed within the next five years. The panel also heard that services would be phased in, with some 'double running' rather than a 'big bang' approach. It felt that without a clearly defined timeline it would be difficult to understand the level of progress and success against any defined outcome measures.

4.12   Whilst the panel strongly supported the intention to move away from current silos of care, it was concerned that the system would not have the capacity to cope with demand following the introduction of a needs led access to service and could easily become overwhelmed. Similarly, although supporting the Alliance's aspiration to move away from a diagnostic model, the panel agreed that it was likely to be difficult to achieve in practical terms and did not get a clear picture of how, without any thresholds or diagnosis, users would be able to quickly and easily access and move through appropriate services once the trusted assessment had been completed.

4.13   All panels had discussed the clinical governance arrangements for services and the Alliance as a whole, and none of the panels had a clear picture of what that would look like. The Alliance did provide the overarching panel with more information on the plan for the development of governance arrangements, and, although it did provide some clarification, it did not allay all the concerns of the panel. The panel did appreciate the clear commitment for all partners to work together to overview governance in a collaborative manner but found it more difficult to see how this would be translated into seamless and safe governance on the ground.

4.14   The panel heard that an Alliance Board would receive risk and incident reports that would be used for future learning, although there was no detail on whether the Alliance, or that board would have any degree for accountability or management of risk. The Alliance is not a statutory body but made up of multiple providers, each having its own clinical governance framework and processes, which were unlikely to have common, or similar, governance arrangements. The panel did not have an understanding of how risks and reporting would be managed either within or across services or partner organisations or who would have ultimate accountability, or how shared learning would be embedded across the Alliance partners. The panel was concerned that some incidents and / or reporting might be contained within a single organisation and risks not managed appropriately.

4.15   The panel agreed that the absence of a clear clinical governance framework and Alliance-wide agreed approach to the management and accountability of service risk was the greatest risk to the Alliance's programme and urged that this be given additional early consideration.

4.16   During its discussion the panel also raised concern about the management of service user risk in voluntary and community sector (VCS) organisations. The panel supported the approach for more step-down service capacity within VCS organisations and provision for those with earlier stage or more minor mental ill health. The panel was concerned that as full service user records and information could not always be shared with VCS organisations, service users supported within or by VCS organisations, and their staff in them, could be put at risk. Similarly, the panel could not see how robust

clinical governance principles and management could be applied to service users in those organisations without an appropriate, well managed, clinical governance framework in place.

4.17 Sharing of patient information would be fundamental to seamless care, and the panel heard that although most Suffolk primary care practices used SystmOne electronic patient record system, other Alliance partners used alternative systems (EMIS being the most widely used). The Alliance advised it would have in place (by mid-2021) a Health Integration Engine (HIE) system for information sharing. Through the HIE, the most recent patient information was 'grabbed' and converted into a viewing portal so that the health or social care professional could see the service user's most recent clinical contact if that had been entered into a different electronic patient record system other than that used by their own organisation. The panel heard that although sharing of patient records with social care systems would be the next phase of roll-out, it was more difficult to provide this to other external providers due to their contractual nature – this included drug and alcohol services. The Alliance was aware this was an issue it was seeking to overcome.

4.18 The panel agreed that in principle this was an excellent way forward and had heard that there was an Information Sharing Agreement signed by all partners. However, the panel felt that the Alliance should put in place a contingency plan for the occasions when this approach might not work due to either a service user not agreeing to sharing of their information or reluctance or indeed legal inability of the health care professional to share sensitive information. Similarly, the system should be sufficiently secure to ensure access.

4.19 The Alliance advised that it was still developing a workforce model and did not yet have the bigger picture of the workforce required to deliver the new model of care. The panel heard that the Norfolk & Suffolk NHS Foundation Trust (NSFT) had an ageing workforce and although recruitment to the Trust had improved recently, there were a number of vacancies (across the Trust) it was struggling to fill.

4.20   The Trust understood that in order to attract potential staff earlier in their career it would need to look at ways of being able to offer positions before registration and needed to ensure that it provided high quality, enjoyable student placements. The Trust was working with local Higher Education Institutions to support local post registration recruitment.

4.21   The panel heard that the Alliance was developing a workforce strategy designed to grow and develop the current workforce. It had a five-year rolling programme of training on the THRIVE model of care for the entire Alliance workforce, this would include a train the trainer element to enable a more rapid cascade. The programme of training would also provide basic mental health awareness for staff in primary care, secondary care, the ambulance trust, voluntary and community sector organisations, police and staff working in emergency departments. The panel heard that this training would not be mandatory. While the panel recognised that this could be a real challenge to get agreement, suggested that the Alliance should work with partner organisations and encourage them to recognise the benefits of having mental health awareness as a mandatory element of their ongoing training and development. The panel suggested that the Alliance should also look to work with local Higher Education Institutions to build this into pre-registration training programmes.

4.22   Specialist training would also be provided on areas such as eating disorders, personality disorders, suicide prevention and children's mental health. The Alliance was aware that primary care needed increased support to deliver the new models of care and was looking at new roles such as clinical associate and non-medical prescribers to support this. The Alliance recognised the need for good clinical supervision across the workforce, and particularly as it recruited to new roles, although the panel did not hear of any plans for clinical supervision training.

4.23   The LDA panel had raised concerns around the need for the recruitment and / or training of specialist workforce including clinical psychologists with learning disability and autism and Asperger's experience and allied health professionals, particularly occupational therapists, to support some of the

physical health needs of individuals with learning disabilities (e.g. aspiration for those with dysphagia).

4.24   The panel fully supported the Alliance's intention to value professional uniqueness and expertise whilst trying to increase a range of generic competencies to support service delivery and recognised the challenges in getting this balance right.

4.25   The panel recommended that the Alliance should look to more innovative ways to retain, attract and recruit clinical and non-clinical staff.

4.26   The panels had each discussed with the Alliance the issue of demand and capacity and particularly in relation to the shift towards a needs-led model away from threshold criteria to access services, eliminating the need for the service user repeating their story multiple times to different parts of the system.

4.27   The panels heard that there would be a single trusted assessment as the user entered the service. However, one review panel heard that the trusted assessment would be carried out in a central team by a qualified clinician but the crisis panel heard that as most service users entered the system through primary care, the trusted assessment would usually be carried out by a GP or primary care practice nurse.

4.28   The panel heard that the Trusted Assessment template was already in place in the acute Trusts' emergency departments and used by the First Response service and Crisis Resolution Team for service users entering the service in crisis. The Alliance clarified for the panel that the initial trusted assessment may well be expanded with more detailed clinical information as the user moved through their pathway and, if necessary, accessed more specialised services and clinicians.

4.29   The panel did not explore with the Alliance whether when a service user, who may have been discharged from the service, needed further support and tried to re-enter the service would need to undertake another trusted assessment or whether the initial assessment would stand and be added to. The learning disability and autism workstream review panel did however

understand that this cohort of service users would have add-on assessments and not need to have new or repeated trusted assessments.

4.30   The service user's care pathway would be through the THRIVE[1] framework, a model for needs led mental health services recommended in the NHS Long Term Plan. The model, supported by multi-professional and multiorganisational training across all Alliance partners and staff, should form the basis for a common language for all partners in the Alliance. The panel supported the approach but acknowledged that it was likely to take some time before there was absolute confidence and trust by all clinicians in the Trusted Assessment and THRIVE model of care. The panel was advised that this would be built through a learning set approach that had already been adopted (for other services) in primary care practices; reflecting back on (some assessments and subsequent care pathways) learning what had happened in a non-confrontational way to establish best practice.

4.31   The panel heard that currently a service user may wait up to a month for a crisis referral to be taken up and that system and pathways needed to become more agile and flexible as this was clearly not acceptable or safe. The Alliance recognised that provision of immediate access to specialist advice and guidance for GPs and primary care was essential, particularly for service users who were in a crisis situation and seeking support from primary care. The panels had heard that there were currently just four Primary Care Network Mental Health Practitioners (Link workers) across Suffolk, the Alliance was working towards enhanced mental health link workers for all primary care practices and quicker access to Psychiatrists and Psychologists.

4.32   The Alliance was open with the panel that across Suffolk GPs there was varied level of support for the proposals. It advised the panel that Suffolk had successfully used positive peer pressure to improve performance in other areas, around physical health for example, and was confident that it could be successfully applied in gaining wider support and buy-in for the changes to mental health. The panel recognised that any proposals that placed a greater workload into primary care, without adequate and appropriate support, including additional

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[1] https://www.annafreud.org/mental-health-professionals/improving-help/thrive-framework/

training and backfill, and additional staff, considering the everyday pressures in primary care - compounded this year by the COVID pandemic, would not be welcome by GPs - irrespective of any amount of peer pressure. The panel recognised that whilst peer pressure-led change can be very effective, it also usually takes time. There was therefore a danger that without clear and positive clinical leadership in primary care, the new model would not be properly taken up and service users could continue to have long waits for referrals or fall through the system completely.

4.33   The Alliance advised the panel that it was aware there was currently a hidden unmet need for mental health and wellbeing services, although it had no clear idea of what the scale of this looked like. The move to a needs-led system could well reveal some of that demand. The crisis priority workstream review panel had heard that the Alliance planned to move to national demand and capacity modelling tool with more up to date data than it was currently able to apply to modelling. By moving to a monthly review, the Alliance felt that the modelling should be able to provide more reliable prediction of demand and that it would be able to mitigate this through a flexible workforce.

4.34   The panel agreed that despite the work focused on this issue, it was still not clear how the Alliance would understand the level of demand for services once thresholds were removed and so have in place the appropriate level of capacity and support to ensure service users were able to access appropriate services in a timely way and not fall through the gaps.

4.35   The panel supported the move to needs-led service and agreed that earlier access into the service resulting in earlier diagnosis would prevent many service users developing more serious mental health issues and moving into higher thresholds, potentially requiring greater intervention. However, it felt that although the Alliance recognised there was a high likelihood of increased demand, it did not appear to have a clear plan for how it would manage that. The panel recognised that the Alliance was trying to build flexibility in the system but agreed that had not yet been tested to understand if it would be sufficient to cope with any unprecedented demand, nor had it been informed through workforce modelling.

4.36   The panel agreed that there needed to be more detail on how physical and mental health services would link. The community panel had acknowledged that this was the biggest gap in care of older people, and it was particularly apparent in the LDA panel.   The workstream panels also felt that there had been a lack of detail in the Alliance's response to questions on mental health access and care for other groups including pre- and post-natal mothers and some of the less easy to reach groups such as substance users and homeless.

4.37   The panel heard how the LISTEN values were being applied in the crisis pathway, although there had been no reference to these in other panels. The panel agreed the values should be adopted across new and existing mental health and wellbeing services in Suffolk and incorporated into staff training, development and recruitment. The panel also suggested that the Alliance consider incorporating the LISTEN values into the new service specifications.

4.38   The panel commented that a single Alliance branding (including the THRIVE model and LISTEN values) would help to indicate to service users that their care was being delivered as a joined-up service and help to eliminate any confusion with service users receiving correspondence from different organisations.

5. Conclusion and recommendations

5.1 Conclusion

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

(to the overarching clinical review panel)

a) Does the evidence show that proposed pathways are likely to provide seamless joined up mental health services for all ages and across all transition points to provide safe, accessible mental health care for service users in east and west Suffolk?

(to the respective priority workstream clinical review panels)

b) Do the proposed pathways indicate the provision of safe, accessible mental health care for service users in east and west Suffolk?

c) Is it likely that the new pathways will improve service user confidence in the provision and accessibility of mental health services in east and west Suffolk?

5.1.1. The clinical review panels were all supportive of the Alliance's direction of travel and agreed that the collective and individual enthusiasm and drive to improve mental health and wellbeing services in Suffolk was very clear. It was obvious that there was a genuine commitment to collaborative working and the Alliance was to be congratulated on the degree of service user, carer and voluntary and community engagement and involvement in co-production.

5.1.2 In response to question a) the overarching clinical review panel agreed that it had heard evidence that the Alliance was heading in the right direction but felt there were some areas that required more thinking through and development. The panel agreed that the proposals needed further detailed work, evaluation and testing before they would be ready for mobilisation.

5.1.3 In response to questions b) and c) again the panel agreed that proposals had the potential to provide joined up, safe services and accessible services but the detail of how that would be delivered across all ages and for all services needed further development. The panel was aware that the Alliance

intended to continue with its co-production approach but agreed that the further development of the proposals should include more staff engagement and clinical leadership to build confidence in the development and implementation of the proposals.

5.2 Recommendations

5.2.1 The recommendations below apply across the programme to all priority workstream areas, recommendations specific to the four priority workstream areas can be found in the respective key findings sections that follow.

5.3 Recommendation 1 Clinical Governance: The Alliance should develop a robust and effective clinical governance and risk management framework, including detail regarding how this worked for front-line services, supported by a system wide information technology plan.

5.3.1 The panel understood the Alliance's plans and due process for contracting of services but agreed that the Alliance had a long way to go to develop a robust and effective clinical governance and risk management framework that would be thorough and safe both for service users and multi-agency, multi-disciplinary staff.

5.3.2 The panel recommended that the Alliance develop and agree, as a priority, a clear, robust clinical governance and risk management framework and process from service user facing staff to overarching system overview. This should apply to and cover all service delivery partners (including primary care, social care and voluntary and community services) and clearly lay out where the clinical management responsibility and accountability was held within the organisations and across the Alliance as a whole.

5.3.3 The agreed framework and process should include the support for community and voluntary sector organisations and ensure that service user risks are managed seamlessly across the THRIVE model and service delivery partners.

5.3.4 The clinical governance framework and processes should ideally be developed and agreed by the Alliance prior to the award of service delivery

contracts so that service providers can demonstrate how they will meet the requirements as part of the consideration of award of contract.

5.3.5   The Alliance should ensure that the clinical governance and risk framework is supported by system wide information technology that provides appropriate levels of access and an audit system that would allow all the Caldicott regulations to be cross checked for compliance.   Challenging elements to address and build into the framework includes:

- Developing a genuine no blame culture within and between organisations to ensure system-wide learning
- Ensuring appropriate information sharing whilst reducing risk – how can an organisation hold a risk if they do not have access to the confidential information that provides detail around the risk?
- Ensure that clinical responsibility and risk is appropriately and seamlessly passed between organisations delivering different elements of a care and recovery pathway.

5.3.6   In order to illustrate governance processes, examples of complex multiagency pathways should be developed and described (see recommendation 6 below)

5.4   Recommendation 2 Pace of change: The Alliance should ensure it balances the understandable desire for pace of change with a seamless transition, ensuring the safety of service users and its workforce

5.4.1   The panel understood that the Alliance is keen to bring about change at some pace to improve services and access for service users, their carers and families. However, the panel strongly recommended that the Alliance carefully balances the pace of change with the need to implement and mobilise new services seamlessly and safely by a workforce that is fully trained and equipped to deliver services through the THRIVE model.

5.4.2   The panel unanimously agreed that the COVID pandemic must have had an impact on the progress the Alliance has been able to make, and what progress is realistic in the next few months and that this should be considered in a review of timescales. The panel was of the view that the

clinical pressures on the ground are likely to negatively impact on the ability of staff to engage with the development and implementation of the proposals and access the relevant training required.

5.5   Recommendation 3 Workforce: The Alliance should undertake workforce modelling as soon as possible, and develop a workforce strategy that includes recruitment (including new roles), retention, training, development and clinical supervision

5.5.1   The panel recommended that the Alliance should undertake high level workforce modelling as soon as possible and refine that as the service specifications were developed. The panel agreed that any delay in workforce modelling would not only impact upon recruitment of specialist staff or new roles that were required to deliver the THRIVE model but also impact on staff not being in the right place or teams once the services went live.

5.5.2   The panel had heard that there were significant vacancies in the community services and recommended that the Trust and Alliance look at more innovative ways to attract staff and fill vacancies before attempting to move to the new models.

5.5.3   The panel recommended that the Alliance ensure it had support and buy in across primary care for the new model and identified clinical leaders to help drive the implementation. The Alliance look carefully at additional support for primary care services and fully assure itself that the support in primary care was adequate and robust before the new model was fully implemented across Suffolk.

5.5.4   The panel recommended that the Alliance have appropriate arrangements for clinical supervision of all staff, particularly as it brought in staff in new roles.

5.5.5   The Alliance should have a clear timeline and plan for training and development to ensure all staff are competent in the THRIVE model and values, and all appropriate staff achieve the required competencies for the Trusted Assessor role and are familiar with how service users should move

through the THRIVE model during their care pathway without undue delay or falling through the gaps.

5.5.6   The workforce modelling must take account of the initial need for the parallel running of some old services alongside new services.

5.5.7   The training of the workforce must take account of which elements of training can and will be mandatory and which elements will be optional and how to ensure that sufficient staff undertake both elements.

5.6   Recommendation 4 Outcomes: The Alliance should develop outcome measures that clearly describe what it is trying to achieve and what good will look like.

5.6.1   The priority workstream panels and the overarching panel all agreed they did not get a sense from the Alliance of what good would look like, the outcomes it aspired to as part of its vision and how it would measure success either as a system or a programme.

5.6.2   The panel agreed that the Alliance need to better describe the outcome measures that will be used to demonstrate that it has achieved what it wished to deliver.

5.6.3   The panel was supportive of the plan to develop outcome measures at three different levels – individual (service user) experience, service and strategic level outcomes and population-based outcomes. The panel was also supportive of the use of the co-produced DIALOG+ [2] as a key element of their individual outcome measures. The DIALOG+ scale however may not assess the seamlessness of the service and with a wider range of individuals and organisations delivering elements of the pathway could cause confusion (with question 11 'How satisfied are you with your meetings with mental health professionals?').

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[2] DIALOG+ is an app-based therapeutic intervention incorporating the DIALOG scale. It aims to improve the communication between a health professional and a patient and, through that, outcomes of mental health care. It combines assessment, planning, intervention and evaluation in one procedure

5.6.4   DIALOG+ will clearly need to be integrated with the Alliance provider's IT systems.

5.6.5   The Alliance had advised that all outcome measures would be agreed and documented in the formal service specifications, and that it would continue to measure the appropriate outcomes within the NHS National Outcomes Framework. The panel was very clear that a range of hard, clear-cut end points should be agreed.

5.6.6   The panel agreed that the Alliance should develop and agree some of the outcome measures prior to the service specifications to help drive the development of the service specifications to lay out what the new service models were intended to achieve for the service user, the service, the system and the population.

5.7   Recommendation 5 The single Trusted Assessment: The Alliance needs to ensure that it puts all necessary measures in place to ensure service users and staff confidence in the single trusted assessment.

5.7.1   The single Trusted Assessment is a key element in the Alliance's plans, and it is essential that this is undertaken in a consistent, competent and timely manner with appropriate communication. The panels heard conflicting information in respect of who would undertake the service user's trusted assessment (i.e. a central team or a GP or nurse if accessed through primary care or both) and recommended that the Alliance have very clear protocols for who undertakes and has clinical accountability for the trusted assessment, how it is used and forwarded on through the THRIVE model to ensure that service users do not fall through gaps or have long waits for referrals.

5.7.2   The panel agreed that trust and confidence in the Trusted Assessment would need to be built across professional and organisational boundaries to ensure that it is undertaken and used as intended. The panel recommended that the Alliance include competencies in its training programme that covered the application of the Trusted Assessment.

5.8 Recommendation 6 Information sharing: The Alliance should ensure that staff are able to access service user trusted assessments and all other important clinical information

5.8.1 The panel recommended that the Alliance test and ensure that staff working in Alliance partner organisations to deliver care have access to the service users' trusted assessment and other important clinical information. The Alliance must identify and address any reasons why staff are unable to access or utilise information via their electronic patient record system or the Health Integration Exchange system, either due to training problems, culture or IT issues.

5.8.2 The panel also recommended that the Alliance undertake regular evaluations of the uptake and access of the Health Integration Exchange to assess the level of utilisation across all Alliance partner organisations.

5.9 Recommendation 7 Illustrative pathways: The Alliance should develop a range of illustrative pathways

5.9.1 The panel recommended that the Alliance develop a range of illustrative pathways to demonstrate to service users, carers, the population. staff and stakeholders what the new models would look and feel like and how they would be different to those service users currently experience.

5.10 Recommendation 8 System capacity and demand modelling to understand workforce and system capacity to deliver timely needs-led care including the initial 'double running' of services during mobilisation

5.10.1 The panel recommended that the Alliance carefully assesses what current and anticipated demand is likely to be and how this can be met with the initial double running of some services and the need to develop and train the workforce.

5.11   Recommendation 9 Estates: The Alliance should give consideration to the estate capacity to ensure it has a range of suitable environments

5.11.1   The panels recognised that estates did not play a significant part in the information provided by the Alliance, the presentations they gave to the panels, the key lines of enquiry or indeed the questions from the panels. The overarching panel identified that consideration should be made to ensure that there was provision of a range of suitable environments for the new workforce including meeting rooms for multi-disciplinary team meetings, especially in the community and primary care, whilst utilising new ways of working, particularly virtual working where relevant and effective.

5.12   Recommendation 10 The Alliance should ensure that it has a clear and robust plan to deliver an appropriate level of staff engagement and develop clinical leadership capacity to finish developing and implement and deliver its ambitious plan.

5.12.1   The panel, whilst agreeing the Alliance had done a great deal of engagement work which had impressively continued despite the pandemic, still needed to do more to ensure key staff, especially those in primary care, are involved in the planning, implementation and delivery of the programme.

5.12.2   The panel further recommended that going forward, there would be the need for greater clinical leadership across the Alliance to drive the safe implementation of the new services.

6. Key Findings: Learning Disability and Autism priority workstream review panel

6.1 The panel congratulated the Alliance Learning Disability and Autism (LDA) team on their obvious individual and collective enthusiasm and keenness to improve services. They were clearly proud of their community focus, the level of public engagement and co-production approach.

6.2 The panel heard that the system recognised that there needed to be significant change to improve services for users, particularly the community services for Learning Disability and Autism (LDA) service users. The Alliance team were very open about some of the challenges and advised the panel that learning from internal and external reviews (since 2015) had been particularly helpful in understanding the areas that needed to improve and that it was applying that learning into the new services.

6.3 The Alliance team emphasised that the LDA service should be an 'as well as' service not an 'instead of service', and recognised that integration of, and coordination between, all health and social care services and providers for the cohort was fundamental to achieving this. The panel supported the idea of an 'as well as' service but agreed it had not been able to grasp what the this would look like, or how different the end result would be for the service user and one or more examples would have been helpful to illustrate the planned services(s).

6.4 The panel heard that although there were joint plans across the Suffolk system, currently this did not always translate into joint working. However, the need to work differently due to the COVID pandemic had highlighted for the Alliance that colleagues did not necessarily need to be in the same place to work well together. Joint cross-organisational working and colleague relationships had come on significantly in the last few months.

6.5   The panel agreed that it would have been helpful to have an example of how the various teams and individuals within organisations had recently achieved this and how that integration would develop and continue to deliver LDA services across Suffolk.

6.6   The panel heard that as part of the *#verydifferentconversation* public engagement programme a bespoke session was recently held for LDA service users and carers. Around 45 LDA users and carers joined the session and put forward their questions and ideas about how services could be different or improved.

6.7   The Alliance advised that it was aware of the majority of individuals in the community with learning disabilities and / or autism but acknowledged that there were a minority of individuals who were known to primary care and were well supported by their families but may not be known to social services. The Alliance did not consider that the level of demand from this cohort would increase.

6.8   The panel was advised that a meeting to discuss those on the Dynamic Support Register was held weekly to help better respond to incidents and events that required an increased support approach to prevent admission to hospital.

6.9   The panel heard that as a result of intensive work in the system, there had been only one (LDA) admission to a specialist bed in Suffolk since December 2019. The Alliance team made clear though that the system had more work to do, particularly on improving discharge from hospital which was frequently outside of the 12-week target. Although this was often due to limited social care resources to support the discharge from hospital, the Alliance acknowledged that it was a system problem and not solely a social care one.

6.10   The Alliance recognised that it needed to develop clear post discharge pathways. The panel felt that the strength, or lack of, links with GP and primary care and post discharge care-coordinators had not been demonstrated and would have found some detail around that helpful.

6.11   The Alliance advised that it was looking to work in collaboration with neighbouring areas at the support for high intensity service users including highly functioning individuals with autism or Aspergers who did not present with any learning disability. Although these service users were relatively small in number, they were resource intensive service users and Suffolk currently lacked available expertise to fully support these individuals.

6.12   The panel was disappointed with the response to a question on carer support and assessments; it was advised that carer assessments were carried out by the local authority as defined the 2014 Care Act. The panel felt that the response lacked any depth, it did not hear any reference to how the carer assessment was used to support carers and service users nor how it was integrated into service user support.

6.13   Recommendations

6.13.1 **Recommendation A 'As well as' service: The panel recommended that to support the vision of being an 'as well as' service the Alliance describe, with examples what this would look like for users, carers and families, and how LDA services integrated with physical, mental health and social care services enabling users to receive   seamless care across the health and care system.** The Alliance was aware that it needed to develop and have in place clear post discharge plans that needed to be fully supported by primary care, community and social care services. The panel suggested that the development of the discharge plans could be incorporated into the examples of the 'as well as' service to demonstrate full integration.

6.13.2 **Recommendation B Reasonable adjustments: The panel recommended that the development of the toolkit and training plan to support staff to deliver Reasonable Adjustments for service users and carers should be development, agreed and implemented as a priority.**

The LDA panel had heard that Alliance partners were slow to roll out Reasonable Adjustments across all services, although some progress had been made for LDA specific services. The panel had learned from the crisis

panel that a toolkit to support all services to embed Reasonable Adjustments and upskill all staff in awareness and understanding was in development. The panel recommended that this be given priority so that Reasonable Adjustments could be implemented as swiftly as possible in all existing services as well as the new services.

7. Key Findings: Communities, Children and young people and families priority workstreams review panel.

7.1 As the two priority workstreams had been brought together in a single review panel the discussion was not specifically separated out between the two. The more general comments below refer to both priority workstreams as often one also related to the other. On reflection, the panel agreed that it would have been more beneficial to spend time separately with each of the workstream teams to better understand the plans for each of the workstreams.

7.2 Again, the panel were struck by the enthusiasm of the Alliance team and their determination to improve services for users. The panel heard from service user and carer group members of the Alliance team how they had genuinely been engaged with from the start including co-producing the outcomes and proposals.

7.3 The panel heard that there were four multi-agency, multi-professional community teams that would deliver the THRIVE model across community services for all ages. The Children, Young People and Families service would cover 0-25 years, although there was a lack of clarity around the age of access to the IAPT service for young people. The Alliance advised that mental health teams were embedded in school teams.

7.4 The panel heard that children and young people needing to access mental health services would also follow the single trusted assessment model, although the Alliance advised it was aware that younger people particularly tended not to access primary care for mental health services

7.5 The Alliance talked the panel through a case study of a young person's recent pathway in mental health services. The panel agreed that although the example had highlighted the difficulties for users in moving through the service, it would have been helpful to have had the new pathway described alongside the old one to demonstrate how many of the challenges would be

removed and how the learning was feeding back into improved service delivery and access.

7.6   The panel had asked for some detail on later life services and heard that although Suffolk performed relatively well, the Alliance recognised that it needed to work on joining physical and mental health care for this service user group.

7.7   The panel heard that currently there were more barriers to getting service users back into a regular normal life from secondary care than there should be. The Alliance recognised that it needed to provide more secondary care expertise into primary care settings to support GPs and primary care services.

7.8   The Alliance team explained how an early adopter Primary Care Network site in Haverhill was using a Primary Care Network Mental Health Practitioner (Link worker) model that was proving successful with GP. In this model primary care remained the 'gatekeeper' for mental health care with integrated mental health nurses working with the more severe cases. The Alliance was looking at developing mental health champions for each practice; it acknowledged that this would be challenging, and it had a long way to go to get there, particularly as currently there was a very limited number of metal health nurses in post and significant number of vacancies.

7.9   The panel asked about links with Learning Disability and Autism priority workstream and services and dependency services and heard that "bridges needed to be built"; work was taking place through the early adopter sites, although the panel was not provided with details. The Alliance was aware that managing service users with complex needs required specialist resources to support primary care and that is was working towards a more coordinated, needs led, approach.

7.10   Similarly, in response to a question about pre- and post-natal mental health, the panel was advised that a midwife should be able to access mental health services through the respective integrated neighbourhood teams and GPs.

The panel felt that there was not a clear pathway for pre and post-natal mental health needs.

7.11 Recommendations

7.11.1 The panel agreed that due to having combined the two workstreams into one panel resulting in limited time for discussion with the Alliance, it had not really managed to get a grasp of what the new proposals would look like, how they would be different to the current position, how the workforce would support the new model or how users, particularly Children and young people, would move across the THRIVE model and pathways.

7.11.2 The panel agreed that it would have been helpful to have further detail on how and where children and young people particularly access mental health services and how pathways of care moved across the THRIVE model without falling through gaps, particularly if moving from one agency to another, for example if they did not access services through primary care.

7.11.3 The majority of the panel recommendations have been covered in the overarching recommendations. The panel though had particular concerns around workforce capacity, recruitment and training and the impact on primary care and GPs in particular. It recommended that the Alliance includes clear plans for how specialist mental health support will be available to primary care services and GPs.

7.12 **Recommendation C Workforce: The panel recommended that detailed specific workforce plans are developed the describe who primary care will be supported to deliver the new services, including how specialist mental health support will be provided.**

8. Key Findings: Crisis priority workstream review panel

8.1   The Alliance team explained that the Crisis priority workstream was slightly ahead of other workstreams with some changes already in place. It was trying the build on what is already there but with a different approach and working to bring different teams together. The Alliance recognised that accessing mental health services in Suffolk was often confusing and difficult for the service user and particularly difficult trying to access services for the first time.

8.2   The aim of the crisis service was to have a clear front door (to access mental health services) for all ages with one trusted assessment so that the user's story did not need to be repeated in different parts of the system. The individual would self-define their (own) crisis, a move away from the traditional approach whereby a service user not meeting defined threshold criteria could be turned away or face long and unacceptable delays to care and support.

8.3   Alliance partners recognised that emergency departments were not a suitable place for those struggling with their mental health, particularly if they did not have a physical health emergency. It did though acknowledge that for many service users it had been the only, or last, option as a means of accessing mental health support and services.

8.4   The Alliance had in place a 24/7 telephone crisis telephone number although this was not currently NHS 111/2. The panel heard that it was planned to move to NHS 111/2 by December 2020, but this had been delayed owing to lack of provider capacity (due to COVID demand). Although the provider was aware that callers should be referred onto the NSFT 24/7 phone number the Alliance was aware that this did not always happen (and this was clearly demonstrated in the case study heard by the panel, see below).

8.5   The panel heard that the Alliance planned to open two Crisis Cafes, although this had been delayed due to COVID restrictions. These Crisis Cafes sat alongside the First Response Service as a 'front door close to home'. The panel supported this

approach although suggested that siting the Crisis Cafes in the two main Suffolk towns made it difficult for those in the more rural parts of the county to access easily.

8.6   With its voluntary sector partners, the Alliance was developing a framework for Community hubs to be able to build local community support. Recognising the significance of social factors contributing to mental health, the Alliance wanted to support prevention through local understanding, working with Primary Care Networks and Integrated Neighbourhood Teams, the panel heard that the Alliance had recently joined as a partner on the local authority Housing Board for supported accommodation.

8.7   The Crisis panel talked through a very recent actual case of a patient in crisis trying (unsuccessfully) to access services through a number of routes. The panel thanked the Alliance for sharing this and agreed this was an extremely powerful illustration and that not only did it highlight the challenges that service users have in accessing mental health services, it showed the many challenges that the service itself is up against and trying to improve. Not least amongst these challenges are the joining up of services and need to raise awareness and understanding of mental health needs and how to access care.

8.8   The panel did agree though that it was not clear how the described service user's outcome or pathway would be any different in the new model as this was not explained and felt that this was a missed opportunity on the part of the Alliance.

8.9   The panel heard that the First Response service was originally intended to be a resource for crisis and emergency presentations. Whilst an increase in demand had been expected once the self-referral model was implemented, the original plan had moved from a crisis resource to an all service resource. Staffing had recently been doubled and, learning from the increased demand that has arisen through the COVID pandemic, flexibility had been built-in to enable other staff to be brought in to support the service.

8.10   Recommendations

8.10.1. The majority of the panel's recommendations have been incorporated into the recommendations in section five of the report. The panel recommended that the Alliance illustrate how the crisis interventions and care pathways integrated with the community services and service users were able to move across, and within, the THRIVE model according to their level of need.

8.10.2 Recommendation D: The panel recommended that the Alliance illustrate how the crisis interventions and care pathways integrated with the community services enabling service users to move across, and within the THRIVE model according to their level of need.

End of section.

Glossary of abbreviations used in the report

CYPF	Children and Young People and Families
HIE	Health integration Engine
IAPT	Improving Access to Psychological Therapies
IT	Information Technology
LDA	Learning Disability and Autism
NSFT	Norfolk & Suffolk NHS Foundation Trust
SMHA or the Alliance	East and West Suffolk Mental Health Alliance
VCS	Voluntary and Community Services
24/7	24 hours a day, seven days a week.

APPENDIX 1: Suffolk Mental Health Alliance locally defined outcomes – extract from draft service specification.

The service provider will work with Alliance partners to agree plans to routinely collect local outcome data.

Domain	Description	Applicable
One	**Access** I. 'I want to access services which meet my needs.' II. 'I want to access services in a timely manner.'	1.I 1.II
Two	**Support in the Community** I. 'I want to access services in the community and closer to home.'	2.I
Three	**Information and Signposting** I. 'I want to access information to support my emotional health and wellbeing and understand what services are available and how to access them.'	3.I
Four	**Continued Support** I. 'I want to be supported to stay healthy, especially when discharged from services.'	4.I
Five	**Listened and Understood** I. 'I want services to be compassionate, to listen to me and my family/parents/ carers.' II. 'I and my family/carers want to be involved in deciding how services are planned for me.'	5.I 5.II
Six	**Integrated Care** I. 'I want services to work together to better meet my overall needs.' II. 'I don't want to fall between different services.'	6.I 6.II
Seven	**Support for Carers** I. 'I want the needs of carers to be a priority for services.'	7.I
Eight	**Digital Support** I. 'I want to be able to access services online and though apps.' II. 'I want support to be available online and through other digital means.'	8.I 8.II
Nine	**Schools** I. 'I want schools to prioritise and support my emotional health and wellbeing.'	9.I
Ten	**Transition** I. 'I do not want to fall between child and adult services.'	10.I

APPENDIX 2: (Summary document only) Terms of reference for the review

NHS
East of England
Clinical Senate

Independent clinical review of proposals for mental health services in Suffolk for Suffolk Mental Health Alliance

04 November 2020

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
Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation Suffolk and North East Essex CCGs, on behalf of Suffolk Mental Health Alliance

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: 21 October 2020**

When is the advice required by? Please provide any critical dates	The advice is required by 4 January 2021. The overall programme milestones are: • 30/10/20 – Workforce and Public Engagement Completes • 30/11/20 – Demand and Capacity Models Complete • 31/01/21 – Updates made to pathways based on engagement feedback, clinical reference group feedback and clinical senate feedback • 31/01/21 – Service Specifications Complete • 28/02/21 – Services aligned to providers • March-May 21 – Due Diligence / Assurance • June 21 -Contracts signed and Mobilisation Commences
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 detailed pathways will enable changes to be made to reflect best practice and advice. 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 make changes to the pathways and develop service specifications based on these 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 change, including the appraisal of the clinical evidence within e) Informal facilitation to enable further work f) other	c) Review of proposed detailed pathways for mental health services for East and West Suffolk

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	c) Formal clinical review to inform new models for implementation Note: Formal assurance is not required
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, the Mental Health Alliance Clinical Reference Group and NHS Procurement process (due diligence).

Clinical review panel members

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).

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)

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

2. Crisis

3. Community (including IAPT and Wellbeing)

4. Learning Disabilities

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 has supported the four established Priority Groups to understand the current mental health services and develop four high level model which were presented to the Clinical Senate for review late 2019.

Following this the Priority Groups have co-produced an explanation of how the proposed services will work (detailed pathways) which provides more information about the higher-level model. The Alliance Programme team are supporting 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. Public and workforce engagement on this detail commenced on 14 September and looks to complete 30 October 2020. This is the current stage of the programme and will be the basis of the evidence for the review by Clinical Senate during November 2020.

Using the feedback from the Clinical Senate, along with feedback from our public and workforce engagement, the detailed pathways will be updated early in 2021. The pathways along with the above 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. During spring and summer 2021 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 Crisis Priority is currently progressing through this Assurance Process.

The programme plans look to mobilise services from June 2021 (earlier for Crisis), 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 include detailed pathways, the 'needs typing' of the service users and the draft workforce implications. Exact workforce requirements will be detailed based on the outcome and recommendations.

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).

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 question/s Clinical Senate is/are being asked to address in this review are split into two sections:

Section One (Overarching):

    d) **Does the evidence show that proposed pathways are likely to provide seamless joined up mental health services for all ages and across all transition points to provide safe, accessible mental health care for service users in east and west Suffolk?**

Section Two (Priority Specific)

    e) **Do the proposed pathways indicate the provision of safe, accessible mental health care for service users in east and west Suffolk?**

    f) **Is it likely that the new pathways will improve service user confidence in the provision and accessibility of mental health services in east and west 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 panels will be held on:
- 4 November 2020, Overview presentation to all panel members
- 10 November 2020, Learning Disabilities and Autism
- 11 November 2020, Community and Children Young People and Families
- 12 November 2020, Crisis
- 18 November 2020 Overarching review panel

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 1 December 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 1 December 2020. The sponsoring organisation forthwith becomes the owner of the report.
*NB: as detailed at paragraph 3.7 of this report, due to the COVID pandemic, Chairman's action was taken in January 2021.

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.
    v. arrange and bear the cost of suitable accommodation (as advised by clinical senate support panel) 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 and
    v. submit the final report to the sponsoring organisation
    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.
    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

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 3: Membership of the clinical review panels

Clinical Review Panel – Learning Disability & Autism priority workstream 10 November 2020:

Clinical Review Panel Chair: Dr Andy Morris

A Consultant specialising in anaesthetics and intensive care since 1999, my previous roles include Associate Medical Director, Group Director and Clinical Director at Barts Health and Whipps Cross and most recently five years as Chief Medical Officer at The Princess Alexandra Hospital, Harlow. I have worked across East London and the East of England for over 30 years and during my career have been involved in many significant change programmes for clinical pathways, be that part of service development, reconfiguration or mergers.

I joined the West Suffolk NHS Foundation Trust as a locum Consultant Anaesthetist following retirement in July 2020, after having supported NHS England & NHS Improvement East of England as clinical lead during the height of the COVID-19 pandemic.

A member of the EoE Clinical Senate Council since 2017.

Panel Members:

Dr U A Tanvir Alam

Following primary medical education in India with a Bachelor's degree (MBBS) from Manipal Academy of Higher Education and then a Master's Degree (M.S. in Orthopaedics), I worked in the Middle East briefly before moving to the UK working in Orthopaedics, Neurosurgery and Accident & Emergency before going into General Practice training culminating in the MRCGP.

Since qualifying, I have worked in multiple roles in Primary care, Urgent care and Mental health. Presently I'm the Clinical Director for Primary care network Clacton, a GP partner at East Lynne Medical Centre, Clinical Consultant for iC24 (Level 8 - 111/CAS) and a Lead GP for Southern Hill Hospital (acute mental health services)

I'm also the Chairman of the GP Training Forum - providing free teaching to GP registrars for the CSA component of the MRCGP examination for which there is a significantly lower pass rate for BAME and International Medical Graduates.

Sharon Allison

Sharon is a Consultant Clinical Psychologist and is the Head of the Aspergers and Learning Disability Psychology Services, and the lead for paediatric psychology services within EPUT. Having qualified as a clinical psychologist in 1993 she has worked in a range of services for both children and adults within the NHS since this time. In her current role she provides specialist assessments and interventions for adults with Autism Spectrum Disorders as well as clinical input into services for adults with learning disabilities; managing psychologists, occupational therapists and behaviour therapists in these teams. She provides training to staff within the Trust around Autism Spectrum Disorders and sits on the All Age Autism Network and the Autism Partnership Board in Essex.

Jon Cullum

I have worked in NHS funded healthcare for the majority of my working life, training as learning disability nurse, working in in patient community and secure services, in criminal justice and prison services and currently as a Non-Medical Prescriber for Substance Misuse.

Monika Samuels

I have worked for the NHS as an Occupational Therapist for the last 30 years, specialising in services for Adults with Learning Disabilities. Initially I was practicing as a clinician, with my career developing into managing Therapy services, including Physiotherapy, Speech and Language Therapy and Occupational Therapy provisions. Staff development and support has been a strong focus of my practice, believing that skilled and confident staff can provide the best services possible. I strongly believe that managing services and staff effectively is a key to providing services that meet the needs of their users, with a focus to being person centered and empowering.

Since retiring last year, I have continued to work in a part-time role, supporting staff in AHP mental health services using coaching approaches. I am dedicated to health care services provided by the NHS and strive to make a difference to their provisions.

Jonathan Wells

Jonathan Wells is now retired from a career in mental health services as social worker, manager, commissioner and senior leader. He is a carer who supports and represents other carers through Rethink Carer Support. He is also chair of The SUN Network a local mental health voice organisation and a Director of Healthwatch Cambridgeshire and Peterborough.

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 KwaZuluNatal 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.

Clinical Review Panel – Communities, Children, Young People & Families priority workstreams. 11 November 2020: Clinical Review Panel Chair: Joanna Douglas

Chief Executive Officer, Allied Health Professionals Suffolk CIC

Led the service throughout its journey to form a social enterprise. She is a Chartered physiotherapist and continued with an element of clinical practice until recently. She has 35 years of NHS experience and has senior management level experience within the NHS for the past 15 years, working in a variety of clinical and organisational settings. Jo has been a Clinical Senate Council member since 2013.

Panel Members:

Alison Clark

Alison is a paediatric nurse with 33 years' experience. She is currently working as the Lead Nurse for the East of England Paediatric Critical Care Operational Delivery Network and works with 17 hospitals across the region, supporting with the delivery of care to children requiring high dependency and intensive care

Alison trained at Great Ormond Street Hospital and moved to CUH as a junior nurse on the paediatric wards. She then spent 11 years in Paediatric Intensive Care where she became a junior sister and then a clinical educator. Alison moved back to the ward in 2004 to take up the role of Senior Sister where she worked until 2019. She has focused her post graduate studies on healthcare leadership, completing her Masters with the NHS Leadership Academy in 2015.

Louise Connolly

A senior allied health professional working in a large Community NHS Trust. She is an Occupational Therapist specialising in Neurological Rehabilitation with over nineteen years of operational management experience managing a range of specialist and generalist multidisciplinary teams.

Having completed her MSc in Senior Healthcare leadership at the NHS Leadership academy, she is currently Clinical Quality Lead in Herts Community NHS Trust facilitating the continued embedding of evidence-based practice into front line community teams and supporting the strategic development of Community and Rehabilitation Services. Louise has also been leading Discharge Home to Assess pathways during the pandemic and working on the implementation of new COVID system wide pathways.

Debra Quartermaine

Debra has been a qualified nurse for 32 years and has worked in a multitude of different care settings, including hospitals, GP practice's, prisons and the community. Debra has experience in a variety of specialties including general medicine, care of the elderly, learning disabilities and mental health. Over the last 11 years she has specialised in the area of falls prevention and management; her role is to lead, inspire, motivate and influence multidisciplinary teams to help them to develop quality improvement and patient safety within the area of falls prevention and management.

Debra is a registered nurse and holds a BSc [Hons] in Health and Social Studies, a Post Graduate Certificate in Medical and Health Education and a Post Graduate Certificate in Falls and Osteoporosis. She is also trained in root cause analysis, human factors and is an after-action review conductor.

Dr Rachel Tait

I have practised as a GP in East Norfolk for a decade, and prior to that worked in Central London. I have previously undertaken a role as a Principal Medical Officer in Malawi with Voluntary Service Overseas (VSO); this involved an emphasis on capacity building and change management.

I have a strong interest in education and am an Honorary Senior Lecturer and GP Tutor at the University of East Anglia (UEA), and an Associate GP Trainer. I am currently The Coastal Partnership's lead for Children and Women's Health.

Ann Walker

Ann has worked for the NHS within maternity services as a midwife for the past 34 years. Over the last 10 years of her career, Ann progressed into midwifery management, where she became involved in service redesign and transformation. She succeeded in achieving a Masters in Leading Innovation for Clinical Practitioners. Her role as Deputy Head of Midwifery at the NNUH involved leading the governance and risk management strategy. She became skilled at reviewing serious incidents and report writing. Since September, she has retired from this role to join a medico legal company as a Maternity Litigation Expert.

Simon Warren

Simon Warren is a qualified social worker with over 20 years' experience of working within psychiatric services for both local authorities and the NHS. The majority of this time has been spent working in central London as an Approved Mental Health Practitioner and a manager of adult services. He has worked in a variety of sectors including homeless, forensics, primary care and perinatal.

Currently Simon is an area service manager in Milton Keynes for CNWL NHS Trust developing primary care services in partnership with service users, carers and GPs and other stakeholders.

Clinical Review Panel – Crisis priority workstream 12 November 2020:
Clinical Review Panel Chair: Dr Ellen Makings

Dr Ellen Makings MBBS, FRCA, FFICM, RCPathME is the Regional Medical Examiner for the East of England and Lead Medical Examiner at the Royal Papworth Hospital. She has been a Consultant in Anaesthetics & Intensive Care for 15 years at Mid Essex Hospitals NHS Trust where she was then appointed as Medical Director in 2017. Her areas of interest in Critical Care are patient safety and recovery from critical illness. She has been a Medical Examiner at Mid Essex for 8 years, one of the original Department of Health pilot sites for the Medical Examiner system.

In 2019 she was appointed as Regional Medical Examiner. She is passionate about the Medical Examiner process and its contribution to patient safety. She is a member of the Faculty of the Royal College of Pathologists providing the training of future medical examiners.

During the Coronavirus pandemic, she has been supporting Critical Care as the Clinical Lead for the Covid-19 Critical Care Cell NHSI/E East of England.

Dr Gillian Bowden MBE
A Clinical Psychologist working with the University of East Anglia as a Clinical Lecturer. Her interests are in primary and community mental health services and in developing and researching new approaches to service delivery which engage with people in the context of their communities. Gillian is also interested in wellbeing at work and how people manage demanding aspects of work and which factors they find rewarding or protective against stress. Gillian worked in various NHS mental health and learning disability services since 1984 initially in South London and moving to Norfolk in 1998. She recently retired from her position as a Consultant Clinical Psychologist and Lead Clinician with Norfolk and Suffolk NHS Trust. Awarded an MBE for services to mental health in Norfolk in 2009.

Ann Carter
Head of Primary Care Psychological Therapy Services, Essex Partnership University NHS Trust (EPUT).

I have worked for 20 years delivering psychological talking therapy services in primary care settings across Essex and outer London as a clinician, clinical supervisor and as a senior manager. Since 2009 I have been in senior mangement roles delivering the Improving Access to Psychological Therapies (IAPT) programme in South Essex. I also have experience of delivering training and education in further and higher education institutes.

In addition to my role within EPUT's IAPT services, I am strategically involved with the transformation and integration of primary care services to design and deliver health care services to the community, liaising with all sectors of the wider health and social care system across Mid, South and North Essex.

As Chair of the Psychological Wellbeing Practitioner (PWP) Apprenticeship Trailblazer, I have worked alongside other professional colleagues and the Institute for Apprenticeships and Technical Education (IfATE) to develop the first psychological therapy apprenticeship which was approved for delivery in March 2019. The aim of this apprenticeship is to widen participation and access to training to assist with recruitment and retention within the mental health workforce.

Jon Cullum As above.

Dr Megan Gingell
Dr Megan Gingell is a Specialty Registrar in Public Health Medicine, based within the East of England deanery. She has a medical background. She spent the initial years of her Public Health training based within a Local Authority and is currently working with the Public Health England Healthcare Public Health team within the East of England.

Emma Lally
I have been a qualified paediatric nurse for twenty years. Working in London, Norfolk and then Cambridge. My roles have been on paediatric wards and as a Clinical Nurse Specialist for Cystic Fibrosis.

For the last three years I have been the Senior Sister on a busy ward at Addenbrookes. I am passionate about delivering the best care for children and their families. I have an interest in the provision of Mental Health care for children and work as a Consultant trainer for We Can Talk.

Dr Rhiannon Newman
I am a consultant in Liaison Psychiatry and medical education, employed by Cambridgeshire and Peterborough NHS Foundation Trust at Hinchingbrooke Hospital. Throughout my training, I have spent significant amounts of time working in acute mental health wards, crisis teams and community mental health teams before specialising in liaison psychiatry. Working in a split clinical and academic post, I am completing the final year of my master's degree in medical education at the University of Cambridge and run foundation doctor training days for the local deanery. I am a strong advocate for patient centred care and fully integrated MDT working.

Professor Jill Robinson
Jill Robinson is an accredited Cognitive Behavioural Psychotherapist, a Registered Nurse in Mental Health and has a PhD in Education. She currently runs her own small private practice offering CBT and EMDR and is also an Independent Chair for NMC Fitness to Practice panels.

She has a background in nurse education, health professional regulation and research and in the past has held senior roles in three different Universities, the most recent being Executive Dean and Professor of Healthcare Practice at the University of Suffolk. Her recent clinical practice in the NHS included working as a High Intensity Psychological Therapist in three different IAPT services in London and East Anglia. In the past she has been a NonExecutive Director on the Boards of two different NHS Trusts.

Annemarie 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.

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.

Overarching Clinical Review Panel: 18 November 2020
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: (biographies as above)

Dr Andy Morris	Jo Douglas	Dr Ellen Makings
Louise Connolly	Jon Cullum	Annemarie Smith
Ann Walker		

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 4: Declarations of Interest

All panel members were required to declare any interests.

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.

End of report.