Suffolk User Forum
The New Hollies, Unit 3,
Grange Business Centre,
Kesgrave, Ipswich, IP5 2BY
01473 907087
www.suffolkuserforum.co.uk
hello@suffolkuserforum.co.uk

11th July 2023

Dear SUF Community Member,

Here is my regular update from SUF, this month covering May and June.

Recruitment to our Healthy Together project

Last month we were pleased to welcome Sian Hanlon as a Peer Support Worker in our Healthy Together project which helps people with severe mental illness to access their physical health care entitlements.

Service user insights into discharge problems at NSFT

You may have seen recent press coverage of the review of the apparent high number of unexpected deaths at Norfolk and Suffolk NHS Foundation Trust (NSFT). The headlines in the press were actually rather misleading and NSFT have clarified what the numbers mean. However, their clarification did not have the same amount of publicity as the misleading headlines and so you may not have seen it. You can read NSFT's statement here. They explain that when NSFT is notified of a service user's death (from any cause) then they close the case record that day, but this does not mean that the person died on the day of discharge as was reported. You can also read the full report here.

The original review looked at how information is collected and analysed at NSFT, but it did not look at individual cases nor at clinical care. However, we know from service users that there has been a longstanding problem of poor discharge planning. Although the CQC did not pick up on this issue in their most recent inspection report (February 2023), service users had told SUF about the serious shortcomings in discharge planning that they had experienced.

We published our report summarising your feedback in September 2022. You can read our report here. It highlighted that discharges often took place without any planning and with little or no discussion with the service user or their family.

Our report concluded,

> "Mental health professionals must understand that discharge is a pivotal point in recovery and that when it is poorly managed it represents a high risk of harm and distress that can result in re-admission and re-referral back to secondary care services." (P.24)

Although NSFT talks a lot about valuing service user feedback, we have had no response to the recommended action points in our report on discharge planning. Actions speak louder than words and we hope that NSFT will respond to what service users say about this important aspect of clinical care.

If you have been affected by the NSFT Mortality Report, independent support is available through an organisation called Just B.

Just B is an organisation that has no connection with services across Norfolk and Suffolk, including Norfolk and Suffolk NHS Foundation Trust, and has been asked to support anyone, including staff who may be affected by the recently published report on mortality data and processes at Norfolk and Suffolk NHS Foundation Trust.

If you feel you may benefit from a confidential, supportive and compassionate space to talk through your emotions, please dial: 01423856799.

A friendly and listening ear will be available from 8am to 8pm, any day of the week.

This new support line is not able to discuss key findings within the report or provide any information about individual investigations. But it is available to provide support and listen if you feel this may be of benefit.

SUF's response to proposed police changes

You may have seen Jayne Stevens, SUF's chief executive, quoted in the East Anglian Daily Times (EADT) and Ipswich Star recently in their coverage of changes to the way the police respond to mental health issues. You can read the article here.

Our response to the EADT was not reproduced in full, and you may like to see a fuller version below:

"The model of 'Right Care, Right Person' means that the police will still attend calls where there is a risk of immediate risk to life or serious harm, and indeed under the Mental Health Act they have specific powers to respond and ensure vulnerable people are taken to a place of safety. Whilst service users often report the police as being kind and caring, others fear being criminalised by police intervention.

We know that our mental health and adult social care services have been struggling to keep up with demand. People have told us they have had to wait days or even weeks for a Mental Health Act assessment, as this will only take place if an inpatient bed is available. We also know that police officers have sometimes had to travel out of county to access a place of safety (known as a section 136 suite) as the ones in Suffolk are in use or unavailable. These delays when people are very unwell can have a shocking impact on individuals, and their families.

As a user led organisation, we know that the greatest risk, is a poor response to calls for help and poor risk assessment. These two factors cause greater distress to individuals and sadly can lead to the loss of life. These are not about funding issues. They are about staff responding to people in crisis by listening with a kind, compassionate approach. This together with a thorough risk assessment based on people's presenting needs, mental health history, and the involvement of family/parent carers is needed to deliver personalised crisis care."

That's all for this month. I will write again after our July board meeting. In the meantime, thank you for your continued support and please do keep giving us your feedback (good and bad) about your experiences of mental health services.

Yours sincerely

Guenever

Guenever Pachent
Chair of Trustees