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

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

Members Present:

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

Witnesses Present:

Norfolk and Suffolk NHS Foundation Trust (NSFT)

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

Commissioners

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

Clinicians

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

Patient Representatives

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

Voluntary Sector Representative

Amanda Hedley	Norfolk MIND organisations

1. Election of Chairman

1.1 Alan Murray was elected Chairman of the Joint Committee.

2. Chairman's Announcements

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

3. Election of Vice Chairman

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

4. Apologies and Substitutes

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

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

5.1 No interests were declared.

6. Items of Urgent Business

6.1 There were no items of urgent business.

7. Terms of reference

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

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

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

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

RESOLVED

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

8. Background information and suggested programme of work

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

8.2 The Chairman noted that following points:

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

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

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

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

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

RESOLVED

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED

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

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

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

10. Future meeting date

RESOLVED

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

The meeting closed at 5:20pm.

IN TRAN
communication for all

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