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

Minutes of the Meeting Held on Tuesday 12 March 2013 at 1pm at Suffolk County Council, Endeavour House, Ipswich

Members Present:

Dr Michael Bamford	Babergh District Council
Peter Byatt	Waveney District Council
Michael Chenery of Horsbrugh	Norfolk County Council
Tony Goldson	Suffolk County Council
David Harrison	Norfolk County Council
Robert Kybird	Breckland District Council
Alan Murray	Suffolk County Council
Tony Simmons	Forest Heath District Council

Witnesses Present:

Service users, carers, public representative

Patrick Thompson	Chairman, Norfolk LINk
Marion Fairman-Smith	Chairman, Suffolk LINk

Unison representatives

Emma Corlett	Unison Steward, NSFT
Jeffrey Keighley	Regional Organiser

Mental Health Charity: Julian Support Ltd

Ben Curran	Business Development Manager

Adult and Children's Social Care Services

Peter Devlin	Adult Mental Health Social Care Lead, Suffolk CC
Carol Carruthers	Assistant Director – Strategic Commissioning, Children's Services, Suffolk CC
Sharon Jarrett	Commissioning Manager, Children's Services, Suffolk CC

NHS Commissioners

Dr John Hague	GP Mental Health Lead, Ipswich and East CCG
Karen Wood	West Suffolk CCG

Clinicians

Dr Gillian Collighan	Consultant Old Age Psychiatrist, NSFT

Norfolk and Suffolk NHS Foundation Trust (NSFT)

Dr Hadrian Ball	Medical Director
Kathy Chapman	Director of Operations (Norfolk)
Aidan Thomas	Chief Executive
Debbie White	Director of Operations (Suffolk)

Norfolk Clinical Leads

Dr Julian Beezhold	Consultant Psychiatrist – specialist in acute/crisis mental health services; Chair of Trust's Medical Advisory Committee (MAC)
Dr Laurence Potter	Consultant Psychiatrist – specialist in access and assessment and primary care mental health
Dr Claire Lussignea	Consultant Psychologist – Adult
Dr Neil Ashford	Consultant Psychiatrist – specialist in dementia and complexity in later life

Suffolk Clinical Leads

Dr Siri Robling	Consultant Psychiatrist
Dr Viv Peeler	Consultant Psychiatrist
Heather Balleny	Consultant Clinical Psychiatrist
Anna Vizor	Consultant Clinical Psychiatrist

Carers Council (Norfolk & Waveney)

Mary Rose Roe	Vice Chair

Service Users Council (Norfolk & Waveney)

Stephen Fletcher	Chair

1. Chairman's Announcements

1.1 The Chairman welcomed Members, witnesses, and members of the public to the second and final meeting of the Joint Committee. He stated that the Joint Committee aimed to conclude its hearing at today's meeting and conclude its work by 21 March when the moratorium for the County Council elections commenced.

2. Apologies and Substitutes

2.1 Apologies were received from John Bracey (Broadland District Council) and Dr Nigel Legg (South Norfolk District Council).

3. Minutes

3.1 The minutes of the meeting held on 11 February 2013 were agreed by the Joint Committee and signed as an accurate record of the meeting.

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

4.1 No interests were declared.

5. Items of Urgent Business

5.1 There were no items of urgent business.

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

6.1 Members received the annexed report (5) which included further information and evidence from witnesses and from Norfolk and Suffolk NHS Foundation Trust (NSFT). Witness submissions were received from the view of service users, carers, and the public, staff, housing support partners, adult and children's social care, and commissioners. The report also included information on future needs assessment data and further information which was requested from the NSFT at the previous meeting. Within the supplementary agenda there was additional information including Unison's response, and updated table of the proposed impact on the workforce, financial details and the high level risk assessment for the strategy. The Chairman explained that he would work through each section of the report in turn.

6.2 Members had also received an updated document for this report which replaced Appendix I Document 5. This updated document is attached at Appendix A of these minutes.

6.3 The Chairman drew the Joint Committee's attention to Appendix A of the report which contained a letter from Sheila Preston. During the discussion of this letter the following points were made:

- The Chairman summarised the issues highlighted in Ms Preston's letter and asked Members to comment and question the NSFT on these issues.

- Members asked whether training had been scheduled to develop the Trust's staff to ensure they have the skills and competencies to deliver the service strategies. The Chief Executive of NSFT responded by saying that the training provided was not generic training and would take place for each team before the changes to their team was implemented. He added that there was no reduction in the training budget over the next four years and the budget had been set for 2013/14.

- Members asked whether there would be representation for mental health issues on the Health and Wellbeing Boards and the Chief Executive of NSFT stated that this was a question for the Members to ask their local authorities. The Chairman from Norfolk LINk added that only the commissioners, not the providers of healthcare, had a place on the Norfolk Health and Wellbeing Board. It was noted that Healthwatch would be formally established on 1 April 2013.

- The Vice Chair of the Carers Council (Norfolk & Waveney) explained that the NSFT had encouraged carers to attend focus groups and give their input. She said she was disappointed with the response from carers and would work to address this. She noted that carers were concerned about the extent of proposed staff reductions.

- The Vice Chair of the Carers Council (Norfolk & Waveney) noted that 'Improving Access to Psychological Therapies' (IAPT) was a national initiative and was not available to the extent that carers would like. In relation to Cognitive Behaviour Therapy (CBT), it was noted that only 10% of schizophrenia patients received this treatment.

- The Vice Chair of the Carers Council (Norfolk & Waveney) said that beds were sometimes commissioned outside the NHS through providers such as Julian Support and Stonham Housing. She added that often staff who had worked for the NHS previously were often employed by these organisations and she would be happy for these services to be used more frequently if required.

- The Vice Chair of the Carers Council (Norfolk & Waveney) stated that she felt that from her own view as a carer her son benefited by frequent contact with a support worker and a review by a psychiatrist every six months to check his medication. The new strategy would enable this pattern of service.

- The Medical Director stated that in general terms, the quality of services across the Trust was not uniform. In some areas services were of a very high quality. Monitor, the regulator, rated the service with a 'green' indicator showing that there were no serious problems at present in the service and there were no outstanding Care Quality Commission (CQC) improvement notices. While there was no room for complacency this showed that service quality in general terms was acceptable.

- The Chair of the Service Users Council (Norfolk & Waveney) stated that he felt that the Trust's work with the third sector, including Julian Support and Stonham, was benefiting service users and the Trust should build on this relationship.

6.4 The Chairman drew the Joint Committee's attention to Appendix B of the report containing a letter from a service user/carer, which had been anonymised for the purposes of publication. The author had provided a name and address and asked that the contents of the letter be shown to the Committee. The name and address were withheld because the author's expressed permission to put them in the public domain had not been received. During the discussion of this letter the following points were made:

- The Chief Executive of NSFT explained that he knew the author of the letter and had arranged to meet with this individual to discuss the contents of the letter.

- Members expressed the concern that there was not enough early intervention carried out by highly skilled clinicians. The Medical Director explained that severe mental illnesses had onset mainly between the ages of 14 and 25 and early intervention was aimed at this age group to apply treatment and to bring about a better clinical outcome. There was a role that consultant psychiatrists had to play in accurately diagnosing these illnesses however the issue resulted from the cost of these skills. Consultant psychiatrists were the most expensive resource for the Trust and therefore their time had to be targeted. The Medical Director said he somewhat agreed with the point in the letter made in relation to this issue.

- Members suggested that the education and health budget should work together. However the Medical Director explained that the transferring of resources was a political decision and not one the Trust could make.

- Members asked whether the in-patient beds for children assisted in early diagnosis. The Medical Director explained that he was unsure whether that service supported early diagnosis and he said colleagues could usually make a diagnosis on an assessment in an out-patient or community setting. While diagnosis was not so difficult, it was managing the individual and their circumstances which posed the most challenging problems.

6.5 The Chairman invited the Chairman of Suffolk LINk to make any comments and reminded the Joint Committee that Norfolk LINk provided evidence at the previous meeting. The Chairman of Suffolk LINk made the following points:

- The Chairman of Suffolk LINk noted that the comments to the LINk had increased dramatically since the new strategy for the Trust was announced. She added that quite a few of the responses were in support of the single access gateway but were not sure that service could be sustained at acceptable levels given the proposed budget reductions.

- Members of Suffolk LINk had pointed out that NSFT was still a relatively new organisation and although they recognise that some services had improved and these improvements brought Suffolk services more in line with the services already provided in Norfolk, there were still some services causing concern where comments to the LINk have increased recently.

- There were concerns regarding the speed of change. There was already a great deal of change happening in the NHS and it was felt that the NSFT changes should not be rushed. Substantial efficiency savings must be phased over a 4 year period and not front end loaded as proposed.

- The LINk did not feel that people fully understood the changes and overall it was the speed of the changes that concerned them. They also were concerned about whether the outcome of the changes would be as NSFT expected.

- In Suffolk, the Serco proposals for community heath services and the Trust's proposals were out for consultation simultaneously and there were concerns about the impact of both of these proposals together. Suffolk LINk members questioned whether the NSFT and Serco changes had been considered as a whole and whether one service change could mean there was an increased demand on another. They also asked how services would cope with an increased demand.

- There was still little known about how the Trust would work with all the GP CCGs and although plans were being discussed and agreed there was still great uncertainty.

- The LINk surveyed the dementia and Attention Deficit Hyperactivity Disorder (ADHD) services last year and these areas had not improved. The repeat survey showed that integration was still a problem, services were not working together and it was not easy for carers to get information about services.

- The LINk questioned the success of increasing the number of carers' assessments when there were no additional services for carers. More carers' assessments meant there was less money for respite services and other support services. It was noted that there had been an increase recently in the number of comments about the Crisis Support Service and the LINk was still investigating the reasons for this.

- The LINk had been alerted to the problems some people were having accessing the Refugee Support Services. This had raised the issue about increased demand as the Black Minority Ethnic (BME) population in the county was increasing (as shown in the 2011 census). This number was likely to increase further by an unknown number from Europe in 2014 which may place further pressure on Trust resources. There was concern whether this issue had fully been taken into account

- Recently comments and vocal concerns had risen about the Integrated Wellbeing Services. LINk members felt that insufficient money was being allocated under the Wellbeing contract to provide appropriate services for people who had an enduring mental illness, who were previously supported by MIND. The lack of services for this patient group could not be sustained and they felt that relying on secondary service as a fall back position was not the answer and it did not provide for the needs of these service users.

6.6 The following points were noted during the discussion following the presentation by the Chairman of Suffolk LINk:

- Members asked whether NSFT had been involved in discussions in Suffolk in relation to the community healthcare contract. The Director of Operations for Suffolk responded that there had been discussions and the Trust was working with SERCO but that there was not complete harmony between the proposals and work was ongoing.

- The Chief Executive of NSFT added that at the moment the Trust was working towards a phased plan and everything was not planned to change on 1 April 2013. The Director of Operations for Norfolk said the first phase of the new Access and Assessment Service started in Norfolk on 18 February 2013. While it was very early days to determine the success of this first phase the performance so far had shown that there were fewer people requiring face-to-face contact as a result of the detailed telephone triage service. Previously more people would have received face-to-face assessment and then not actually have been taken on by the service. The 24hr crisis team were experiencing less pressure and were able to focus on those in a genuine crisis situation. Over the first three weeks of operation the service has received one complaint from a GP practice which was the result of a misunderstanding. This level of complaints was lower than with the previous service and feedback from GPs was generally positive. The Chief Executive of NSFT noted that without the Access and Assessment Service 60% of the referrals to the Crisis Resolution Home Treatment (CRHT) Team had been non-appropriate referrals. While the Access and Assessment Service anticipated to receive approximately 100 referrals each day it was receiving slightly more than that and it was confirmed that the number of patients had not been anticipated to reduce in numbers. It was expected that there would be the same level of referrals with the new system.

- The GP Mental Health Lead, Ipswich and East CCG explained that self-referral was an important way of obtaining mental health services and usually resulted in a better quality of referral. Service users who self-refer are generally more ill than those who do not.

- The Chief Executive of NSFT responded that he felt it was important to consult with service users when it was most relevant to them and their services because that is what they really cared about.

- The Chairman of Norfolk LINk stated that beds were not the ultimate answer and consideration should be given to the patients needs and not focus on getting the patient into a bed. Members stated that the Dementia Intensive Support Team (DIST) service had been running 2-3 years in Norfolk to support patients and their carers. The service focussed on helping those through a crisis or at risk of being referred or admitted to a care home or hospital. The DIST provided care one or two times per day to support the patient and carer during a 4-6 week period of difficulty and helped to reduced carers admissions. It was highlighted that this service could further reduce the burden on beds.

6.7 The Chairman invited the representatives from Unison to make any additional comments and present their evidence to the Joint Committee, at Appendix C. During the discussion the following points were made:

- The Unison Steward clarified to points 9, 21, and 27 of the submission at Appendix C. She stated that these points referred to the written and verbal submission to Health Overview and Scrutiny Committee by Dr Chris Jones of the Local Negotiating Committee. Concerns raised by the British Medical Association (BMA) referred to related to local press coverage of the BMA concerns.

- The Unison Steward noted that their main concern was that they were not confident of how the Trust's duty of care would be met. She also noted that the revised figures received by the Trust indicated that there would be an 18% reduction in funding for clinical staff instead of a 24% reduction and she asked whether this was accurate. Finally she asked whether the assertive outreach service would remain a standalone service or would be integrated within another team, and whether the reductions in whole time equivalent staff included those who were on fixed term appointments.

- The Regional Organiser stated that the Nicholson Challenge meant that the Trust had to make 20% funding reductions but the Government said recently that the NHS funding is ring fenced. He asked where the robust commissioning was within the financial saving plans. He was aware that all six trusts were facing these cuts and were struggling following major restructures. He asked who would be accountable if these trusts failed. He felt that the NHS was being integrated into the private sector and standards were being lowered and there was less accountability. He questioned whether any provider could offer a service with 20% less funding. He also asked about transitional funding and whether this would be a loan or extra funding.

- The Regional Organiser stated that while dementia, poverty, and mental illness were on the rise, funding and staff were being taken away. There was a huge loss of knowledge and experience taking place as staff were leaving. Members pointed out that around 60% of the 262 posts that would be lost were already vacant. It was noted that in relation to point 6 of the submission it stated that temporary staffing costs stood at £17m but should be £12m (8% of posts). The Chief Executive of the NSFT noted that this was an area of significant challenge and vacancies needed to be carefully managed. His overall approach was to minimise redundancies while balancing this against safety and quality issues. He said that the Trust had provided the quality measures to the commissioners (as shown on pages 140-145 of the agenda papers). If the measures began to highlight concerns with quality and safety NSFT would instigate action plans to address the problems and the commissioners would monitor them.

- The Consultant Psychologist for Adults said that contact with service users was important for some users but did not in itself lead to better outcomes, and not all patients required the same approach. The quality of what the Trust staff did when they were with the patient was most important. NSFT had assertive outreach for some service users who found it difficult to engage with the services. The Consultant Psychiatrist from Suffolk stated that this outreach would be maintained and would be broadened to reach young people and catch illnesses earlier.

- The Chief Executive of NSFT explained that the Mid-Staffordshire Trust went down a path of salami-slicing services and did not carry out full redesign or a consultation. The NSFT had made a decision not to go down this route but instead to try to redesign the service to cope with funding reductions and they were carrying out a large consultation process.

- Members asked about changes to hours and patterns of working and NSFT's assessment of its ability to recruit to certain hard-to-fill posts. The Chief Executive responded that issues varied around different parts of the counties. Some recruitment was more difficult in rural areas but ability to recruit depended on the service and the location. He added that there was a 10% turnover annually in any case.

- Members questioned the Trust about levels of staff morale. The Unison Steward responded that staff morale varied across the organisation depending on the depth of cuts teams faced and the history of staff reductions that they had experienced. The Central area team seemed to have been hit hard and therefore morale there was low.

- Members asked where staff would be in the transition from in-patient beds to providing services in the community. The Director of Operations for Norfolk explained that there would be a transitional process and staff would slowly move over to the new model of service as the workload transferred and in effect, there were two services running side-by-side. There would be both in-patient and community staff remaining especially in the early days of the changes.

- The Medical Director confirmed that the Trust had a dedicated early intervention team.

- In response to a Member question the Medical Director explained that students were an important asset to the Trust and it was often students who raised concerns regarding safety. He said there was more that the Trust could do to utilise students and trainees, both nurses and doctors. Workforce planning was needed and training capacity had to be a core function of the Trust's work. Throughout the difficult national budgeting issues the NHS would remain a large employer and there would be successful careers to take up within the NHS.

- The Unison Steward confirmed that West Norfolk did have a dedicated early intervention team however morale was low and there were persistent difficulties with recruitment. Caseloads were capped at 15 and traditionally these teams in Norfolk had been well-resourced.

- The Chairman of Norfolk LINk asked about staff relations. The Regional Organiser replied that the trade union negotiated on behalf of all staff and obviously non-members did well out of that arrangement. He added that the Trust needed to enable and support trade union representatives to fulfil their role. The Medical Director added that staff were approaching the issues in a professional way.

6.8 The Chairman invited the Business Development Manager from Julian Support Ltd to present his evidence to the Joint Committee. During the discussion the following points were made:

- The Business Development Manager stated that Julian Support Ltd accepted the broad principles regarding the need to make cost savings, efficiencies and, in some instances, improvements to the quality of service delivery. Their concerns did not relate to what the changes were but rather how they were implemented.

- The Business Development Manager noted the excellent working relationship that Julian Support Ltd had with the Trust which allowed them to challenge the Trust when necessary. He recognised the national financial situation and the pressures this put on the Trust but he had some concerns about the risks facing the Trust.

- The Business Development Manager stated that Julian Support Ltd had been fully involved in the consultation process and the developments. However as pressure mounted on the Trust it became more introspective and he felt that the third sector became marginalised from the process of redesign.

- He added that there was a risk of third sector commissioning being railroaded by the complexity of procurement processes. There were also risks in respect of the assumptions about demand. The pressure on Trust staff and the impact on morale was taking place at the same time as the rollout of personalisation. He added that morale was also a challenge faced in the third sector. There was the risk that personalisation would be oversubscribed which would bring added pressures. There was the risk of gaps in the timetable in relation to service provision. Training and development was also an issue to consider and staff needed to be located where their skills were best used. Assertive outreach needed a particularly style of working.

- The Business Development Manager confirmed that the Trust and Julian Support Ltd shared data on risks in respect of individuals and this had traditionally been effective. They also shared information with district councils' housing teams. However he had some concerns regarding the Trust's proposed single point of access and it was important that this did not cause a barrier to the flow of information. Members questioned the third sector capacity to provide additional support in the community and it was confirmed that resources were limited, particularly in Norfolk. The Business Development Manager said that NSFT made assumptions about third sector capacity without cross referencing with the commissioning intentions to make cost savings within the third sector.

- The Chair of the Service Users Council (Norfolk & Waveney) mentioned that there would not only be increased pressure on the Trust, public services, and the third sector, but service users themselves, many of whom were in receipt of benefits, and were having their benefits cut. This would double the pressure felt by the service users. The Chief Executive responded by saying that the Trust was working with others to put pressure on the Department for Work and Pensions to protect those with mental health problems from the cuts.

(The Chairman adjourned the meeting for a break. The meeting reconvened at 3:20pm.)

6.9 The Chairman summarised the letter received recently from Thetford GPs. The letter is attached at Appendix B of these minutes. During the discussion about the letter the following points were made:

- The Chief Executive of NSFT said that the Trust felt that Thetford should come under the Norfolk services but recognised that this was not a decision for the Trust alone and not necessarily one that the Trust should lead on. The Trust was not proposing to bring Thetford under the Norfolk and Waveney services in 2013-14 but would be working with South Norfolk CCG, the GPs, social services and other stakeholders to decide the best way forward. The Director of Operations in Norfolk noted that different stakeholders supported different solutions. She also pointed out that while it was possible to have Norfolk community services and Suffolk beds this would not be easy for continuity of care.

- Members presented the Trust with a scenario where a service user who had killed in the past then called the Trust to say they were concerned they may kill again. A situation like this happened in London. The Chief Executive of NSFT responded by saying that this was an extremely rare scenario and individuals in this circumstance would have an immediate assessment. The Access and Assessment service would have access to the patient's history but in any case this person would already be known and be in contact with the Trust's services.

- Members highlighted again the need for information sharing between partner agencies such as the police, ambulance services, the NHS, and local authorities. It was noted that more needed to be done with education services and the Chief Executive of NSFT agreed. He noted that social services were already co-located with Trust services in Suffolk. In Norfolk, there was a Section 75 agreement between social services and the Trust and efforts were being made to negotiate an agreement with reduced bureaucracy to meet the funding gap. He added that Norfolk Constabulary recently set up a joint meeting between themselves, the CCG representatives, and the ambulance service about how backroom functions could work more closely.

- Members asked the length of time it would take to see a psychiatrist. The Consultant Psychiatrist from Suffolk stated that in Suffolk urgent assessments would take place within four hours of referral if necessary. The Consultant Psychiatrist who specialised in access and assessment stated that urgent but non-emergency cases were assessed within three days. There was a significant medical component to the access and assessment team. The Medical Director confirmed arrangements for patients who presented at A&E or to the police. The Trust did have a Section 136 suite in Norfolk if it was required for them to take a patient into custody.

- The Chairman of Norfolk LINk added that following the Francis report it was likely that the NHS bodies would be looking more closely at how the multi-agency approach was working in Trust areas.

6.10 The Chairman invited the representatives from Suffolk adult and children's social care to give their views to the Joint Committee, which would be considered in addition to the written submissions from Norfolk adult and children's social care at Appendix D and E. During the discussion the following points were made:

- The Adult Mental Health Social Care Lead for Suffolk County Council explained that in their service the mental health social workers operated within the NSFT and he managed the integrated staff and that budget. There was no distinction between the health and social care colleagues and both had been equally able to give their views in the consultation process.

- The Adult Mental Health Social Care Lead for Suffolk County Council said that the main question was what the proposals meant for services users. Suffolk's adult services transformation programme 'Supporting Lives, Connecting Communities' was compatible with the proposals which focussed on prevention, early intervention, the family perspective, and further integration of primary and secondary care so service users would appreciate more continuity. He emphasised that this allowed for the more effective use of resources in a coordinated way to get the most efficient service.

- The Assistant Director for Strategic Commissioning in Children's Services and the Commissioning Manager in Children's Services for Suffolk County Council stated that they had been fully consulted on the proposals. They said that they had received responses to the concerns they raised, which were set out in the agenda papers at 6.4 and 6.5 (pages 126-127).

- The Assistant Director for Strategic Commissioning and Commissioning Manager from Suffolk County Council said that there were two slightly different service delivery models in the two counties and Waveney was within the Norfolk model. They wished to see a consistent approach across Suffolk and both counties. The Chief Executive of NSFT responded by saying that the services in Norfolk would vary quite significantly.

- The Assistant Director for Strategic Commissioning and Commissioning Manager from Suffolk County Council also noted their concern over the speed of access to mental health services. The Child and Adolescent Mental Health Services (CAMHS) regarded the single point of access and assessment as a positive development but they questioned what would happen if a referral was deemed inappropriate. They asked where this inappropriate referral would go and how this was monitored. The Consultant Clinical Psychiatrist for Suffolk said that the integrated assessment service and preventative approach, along with its close work with parents and communities, helped to avoid people from falling through the net.

- The Assistant Director for Strategic Commissioning and Commissioning Manager from Suffolk County Council stated that there was a risk of diluting specialist skills. Being such a small service it was more at risk of being affected by staff absence and sickness than it had been in the past. This aspect meant that there seemed to be little opportunity for professional development and adequate supervision in such a small service of five teams. They questioned the proposed skill mix of the teams. The Consultant Clinical Psychiatrist for Suffolk explained that the NSFT would ensure that staff would have time within their specialism and this would be maintained.

- The Assistant Director for Strategic Commissioning and Commissioning Manager from Suffolk County Council noted the impact of the proposals on the wellbeing service for 16-18 year olds. There was a risk that pressure may be shifted from Tier 3 to Tier 2 services. The Director of Operations for Suffolk said that the NSFT had a very integrated service with NHS Suffolk and Tier 2 and 3 formed part of this integrated service. Outcomes for these services would be the same based on Key Performance Indicators (KPIs) which would monitor this. The Consultant Clinical Psychiatrist from Suffolk added that these integrated delivery teams included a team for CAMHS and child workforce for those under 14 years of age, a team for teens and young people aged 14 to 25, and a neuro developmental workforce. There was also the wellbeing service which would be working more with the community. It was likely that the child specific workforce would work with the youth workforce and a small group of child workers would be supported by youth wellbeing and adult service workers.

- Members asked whether the Trust had considered how support of ADHD children with paediatric services were affected by the proposals. They asked if there were advantages of scale and increased expertise in the areas of self-harm and eating disorders. The Director of Operations for Suffolk responded saying that autism services were subcontracted to Serco who were working to make this service better than it had been historically. Services for eating disorders were now more equitable across the county. The bid for 14-25 year olds in-patient was with the CCG. The Medical Director said that the paediatric community services in Norfolk were provided by community paediatricians in a community trust and they were clear about which aspects of the ADHD service were their responsibility and which were that of the NSFT. In Norfolk CAMHS made specific provision for children with eating disorders. The Chief Executive added that there were inpatient services for eating disorders and there were also patients receiving care for this elsewhere through other providers. The level of need for eating disorder services tended to be stable.

- Members asked what the Trust's plans were to face the great challenge posed by the increased incidences of dementia in the future. The Medical Director responded he had no doubt that the forecasts for the number of cases of dementia would be significant. He said future service would need to be commissioned and additional resources would need to be provided to accommodate this demand on services.

6.11 The Chairman invited the Consultant Old Age Psychiatrist from NSFT to make any comments and present her verbal evidence to the Joint Committee. During the discussion the following points were made:

- The Consultant Old Age Psychiatrist explained to the Joint Committee that the senior clinical staff faced a 60% reduction and were greatly losing expertise in important areas. The Chief Executive said that senior clinical posts had been reviewed and the reduction originally proposed had been reduced and fewer staff would be leaving the service than had originally been planned. The Director of Operations in Suffolk added that there had been an increase in the number of doctors but this had been offset by a decrease in the numbers of support workers and psychological therapists. The Medical Director stated that he was personally reviewing the number of staff on medical grades in Norfolk and Waveney and was consulting personally with all 50 or so consultants. He would be in a position by the 27 or 28 March to make a formal recommendation to the Trust. He said a likely outcome being the significant upward revision in numbers of medical staff. For 2013/14 the reduction in number would be brought about through vacancy management as there were a number of post holders nearing retirement. He said it was likely that there would be no compulsory redundancies in 2013/14 for medical staff. He noted that non-medical colleagues were concerned that doctors were being treated differently to other staff and the NSFT was yielding to undue pressure but this was not the case. Reductions in the number of doctors had a disproportionate impact because their expertise was required for 24 hour cover and for wider medical training and research purposes.

- The Consultant Old Age Psychiatrist expressed her concern regarding about being asked to train Band 6 nurses to diagnose dementia in patients using a guide instead of the extensive medical knowledge required and available to senior clinicians. She stated that she felt it would be a better option to train GPs in making a diagnosis as they had a solid medical background. The Director of Operations for Suffolk said that she would not rule out Band 6 nurses for this role and she felt that the statements made did not give credit to the extremely talented nursing colleagues working with the Trust and this sentiment was echoed by the Chair of the Service Users Council. The Consultant Old Age Psychiatrist said that while she appreciated the quality of nurses working for the Trust, some of the drugs used for dementia could have serious affects on frail and elder patients and prescribing them required medical training to understand their impact on a patient.

- The Consultant Old Age Psychiatrist felt that there was not enough consideration at the start of the pathway when the patient presented at the memory clinic. She said that on average 50% of patients presenting in their 50s would have dementia and 50% would have a rare neurological disease. Right at the start patients needed to be seen by someone qualified to make a diagnosis and to prescribed the right medication. She added that there was about a 25% increase in patients at memory clinics in the past 3-4 years.

- The Medical Director said that there needed to be a distinction between the model and staffing. There would always be some risk when managing a change from one model to another and the best way to moderate the risks was by having senior medical staff around to handle any issues which arose.

- The Medical Director said that the Royal College of Psychiatrists provided a letter informing the Trust that they were concerned over the safety of services during the change period. The Acting Nurse Director and he in turn wrote to Norfolk and Waveney commissioners saying that they could not safely deliver the changes without additional funding. The Norfolk and Waveney CCGs were yet to formally respond however he was optimistic that additional transitional funding would be provided.

6.12 The Chairman invited the Suffolk NHS Commissioners to make any comments and present their verbal evidence to the Joint Committee. During the discussion the following points were made:

- The GP Mental Health Lead for Ipswich and East CCG and the representative from the West Suffolk CCG said they felt that joint commissioning was something they wished to encourage and they broadly supported the Trust's strategy. The national funding reductions were non-negotiable. The CCGs had challenged the Trust's reduction in senior medical staffing numbers and methodology and this had been fruitful.

- The GP Mental Health Lead for Ipswich and East CCG noted that the CCGs would need to discuss the bid for additional transitional funding to support NSFT during the period of change with the NHS National Commissioning Board. The overall transitional funding budget was made up of 2% of all CCG budgets, but the exact formulation of the fund was being addressed at present.

- In response to a Member question, the GP Mental Health Lead for Ipswich and East CCG said he was looking forward to working with Healthwatch once it was formally established.

- Members stated that £3m was spent on mental health locum doctors and this had been reported in the media and asked how the Trust was reducing this burden. The Medical Director agreed that locum doctors were expensive and did cost more than a substantive member of staff but there were circumstances when they were required. He stated that local managers and clinicians made the decision over whether to take on a locum doctor. He agreed that costs could suddenly escalate which had happened around September 2012. At this time locums, temporary staff, and out-of-hours placements all caused sudden cost pressures and were all areas of discretionary spending. It had been decided that these temporary measures were the best solution rather than recruiting at that time which had prevented further redundancies. The Trust was now seeing some improvement in the spending levels in these areas.

- Members asked about insurance for staff vacancies and about having a bank of doctors instead of using locums doctors. The Medical Director stated that while this was theoretically a good idea, he felt that this would take time and significant effort to organise and there may not be many doctors who signed up. He also said it was likely that the Trust would be required to pay a retainer for these staff even when they would have provided little or no service to the Trust.

- The Director of Operations for Norfolk noted that the reduction in managers in NSFT had resulted in savings greater than 20% as set out on page A20 of the supplementary agenda papers, and this had allowed more investment in clinical staff numbers. The Chief Executive noted that this was one of the sources of funding for the additional clinical posts retained. He noted that the management costs in NSFT were low and the Trust was within the 25% of lowest cost trusts in this respect.

6.13 The Chairman invited the NSFT to make any summary comments to the Joint Committee. During the discussion the following points were made:

- The Chief Executive of NSFT said he was optimistic that the Trust would receive additional transitional funding. He said that teaching funding was being used and discussions were underway, especially in Norfolk, on Commission for Quality and Innovation (CQuIN) funding to be used to retain staff in dementia areas.

- The Chief Executive of NSFT said that the Trust would consult with staff and key stakeholders before implementing major changes, such as reducing in-patient beds. However, the Trust also needed to get on with providing services and implementing necessary changes. He felt that the consultation thus far had been open and that Trust had responded to feedback.

- The Chairman of Norfolk LINk stated that both Norfolk and Suffolk LINk were in agreement with the direction of the changes and he hoped that provision of services would be sustained for patients. He also hoped that the NSFT would continue to work with the local HealthWatch as they had with LINk.

7. Conclusion of the Joint Committee

7.1 Members were asked to consider their potential conclusions and recommendations regarding NSFT's draft Service Strategy 2012/13 – 2015/16, based on the evidence heard at the two meetings of the Joint Committee, in relation to:

- The extent to which the proposed changes were in the interests of the health service in Norfolk and Suffolk;
- The impact of the proposals on patient and carer experience and outcomes and on their health and well-being;
- The quality of the clinical evidence underlying the proposals; and
- The extent to which the proposals were financially sustainable

7.2 It was also suggested that Members may also wish to comment on the extent to which patients and the public have been consulted on the proposals and the extent to which their views have been taken into account. The Joint Committee may wish to make recommendations to Norfolk Health Overview and Scrutiny Committee and Suffolk Health Scrutiny Committee regarding the scrutiny or monitoring of the changes that NSFT proposes to make over the next four years.

7.3 During the discussion the following points were noted:

- It was felt that NSFT should involve Healthwatch in their consultation and in development of the service strategy

- Members noted the potential for the mental health services changes to increase pressures and costs in other areas such as social care and the voluntary sector. It was felt this was something that needed to be monitored.

- Members highlighted that the Joint Committee had not looked at the full extent of the risks of the strategy proposals and suggested NSFT could consider using a peer review.

- It was suggested that NSFT should consult with health scrutiny before making substantial changes 'on the ground' and that Norfolk Overview and Scrutiny Committee and Suffolk Health Scrutiny Committee should revisit the subject in 6 to 9 months time in any case, reviewing the progress of the strategy.

- It was suggested that NSFT should closely monitor its workforce costs during the transitional period and consider how to avoid excessive locum costs.

- It was suggested that CCGs should provide an adequate level of transitional funding to support the Trust in slowing down the speed of implementation to ensure a safe transition

- It was suggested that NSFT should work with the GP practices, CCGs and other stakeholders on the issue of whether the Norfolk or Suffolk service model should apply to Thetford.

- Members hoped that councils would ensure mental health was taken into account in the appointments to Health and Wellbeing Boards and in the work of the Boards.

- Members felt that a report for the Joint Committee should acknowledge new and positive developments in the NSFT draft strategy.

- It was clarified that continuation of this Joint Committee was not possible because of the new health scrutiny regulations that come into effect on 1 April 2013 and the County Council elections in May. Further actions would take place through each County Council's Health Scrutiny Committee or, if they felt it necessary, a new Norfolk and Suffolk Joint Scrutiny Committee could be formed after the County Council elections.

RESOLVED

7.4 That the report of the Joint Committee would include recommendations drawn from the record of discussion from the two meetings of the Joint Committee. It would be agreed by the Chairman, Vice Chairman, and members of the Joint Committee and forwarded to NSFT and other relevant agencies, including those who had given evidence to the Joint Committee, by 12 April 2013.

The meeting closed at 5:15pm.

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.

Appendix A

Proposed Impact on workforce - Norfolk and Waveney - 010313

Band	Type	Staff in Post @ 31st January 2013	Vacancies @ 31st January 2013	Establishment @ 31st January 2013	To Be @ Mar-16	Total gross reduction / (increase) in WTE (Establishment)	Total gross reduction / (increase) in WTE (Staff In Post)
		[a]	[b]	[c] = [a] + [b]	[d]	[e] = [c] - [d]	[f] = [a] - [d]
1+2	AFC	37.58	4.88	42.46	56.31	-13.85	-18.73
3	AFC	249.69	17.30	266.99	238.49	28.50	11.20
4	AFC	176.63	3.31	179.94	131.74	48.20	44.89
5	AFC	179.61	55.05	234.66	195.80	38.86	-16.19
6	AFC	339.54	29.60	369.14	281.40	87.74	58.14
7	AFC	126.61	4.69	131.30	99.00	32.30	27.61
8a	AFC	51.01	9.29	60.30	36.40	23.90	14.61
8b	AFC	37.17	-0.41	36.76	31.20	5.56	5.97
8c	AFC	3.95	0.39	4.34	11.80	-7.46	-7.85
8d	AFC	6.67	0.00	6.67	6.63	0.04	0.04
9	AFC	0.37	0.00	0.37	1.37	-1.00	-1.00
SAS/Staff Grade	Medic - under review	22.72	6.30	29.02	Under review	Under review	Under review
Consultant	Medic - under review	52.45	6.60	54.85	47.45	7.10	0.50
Total		**1284.01**	**137.00**	**1421.01**	**1137.59**	**249.90**	**119.20**

Version (Feb-13)

Norfolk and Suffolk NHS
NHS Foundation Trust

Medical vacancies 31 March 2013

Medical 'to be' 31 March 2014

Proposed Impact on workforce - Suffolk - 010313

Band	Type	Staff in Post @ 31st January 2013	Vacancies @ 31st January 2013	Establishment @ 31st January 2013	To Be @ Mar-16	Total gross reduction / (increase) in WTE (Establishment)	Total gross reduction / (increase) in WTE (Staff In Post)
		[a]	[b]	[c] = [a] + [b]	[d]	[e] = [c] - [d]	[f] = [a] - [d]
1+2	AFC	125.89	12.65	138.54	32.94	105.60	92.95
3	AFC	114.27	20.06	134.33	205.95	-71.62	-91.68
4	AFC	79.93	12.51	92.44	76.20	16.24	3.73
5	AFC	143.85	20.25	164.10	156.60	7.50	-12.75
6	AFC	189.52	24.31	213.83	157.00	56.83	32.52
7	AFC	66.23	11.88	78.11	46.70	31.41	19.53
8a	AFC	20.92	9.28	30.20	35.90	-5.70	-14.98
8b	AFC	15.50	6.71	22.21	14.20	8.01	1.30
8c	AFC	11.55	1.01	12.56	9.10	3.46	2.45
8d	AFC	2.80	-0.06	2.74	2.00	0.74	0.80
9	AFC	0.00	0.00	0.00	0.00	0.00	0.00
SAS/Staff Grade	Medic	12.80	0.30	15.00	14.50	0.50	0.20
Consultant	Medic	38.06	6.50	40.20	31.50	8.70	2.20
Total		**821.32**	**125.40**	**944.26**	**782.59**	**161.67**	**36.27**

Medical vacancies

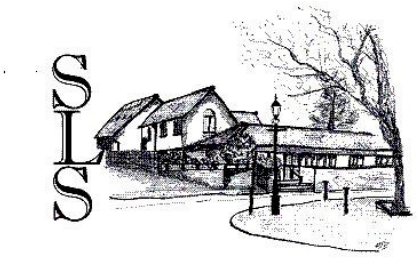
Version (Feb-13)

31-Mar-13

Norfolk and Suffolk NHS
NHS Foundation Trust

Appendix B

Dr M Hadley-Brown
Dr Martin Belsham
Dr Jon Bryson
Dr Meriel Overy
Dr John Scott
Associates:
Dr Tracey Tessaro
Dr Milesh Gohil
Managing Partner:
Mr Robert Howes-Ward



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Friday 8th March

Dear Alan Murray

Re: Mental Health Provision in Thetford

We the undersigned practitioners represent the views of the General Practices in Thetford. Between the three of us we have over 70y experience of caring for individuals with mental health difficulties and in addition Martin Belsham set up and has been providing, a tier three substance misuse service for the town over the last 15 years.

We wish to express our reservations about the way NWMHT is seeking to impose a new service for secondary mental health care in Thetford, including a new referral pathway into Norfolk, without any consultation with or explanation to General Practitioners or patients in the town.

Historically Thetford is a very different market town from others within Norfolk. The population derives largely from a London overspill programme in the 1960s, which saw families from London being moved to the country to provide a workforce for the expansion of light industry in the town. This demographic has been further altered by the settlement within the last 10y of large numbers of Portuguese and Eastern European residents, greater than other local areas as evidenced by the cost of interpreter services used by the Thetford practices, which have been three times larger than any other Norfolk practices. These social factors give Thetford a workload that is different from other parts of rural Norfolk. We GPs who have been working in the town for long enough have observed the transient stays of psychiatrists posted to Thetford, leaving the town on approximately a 5y cycle to work in less demanding areas.

Deprivation in Thetford, we have two council wards in the bottom 10% in the UK, brings with it social factors that impinge on mental health. Approximately 15y ago Dr Belsham and the then in post Consultant Psychiatrist Dr Marlies Janssen attended a Thetford Town Council meeting to impress upon the elected members the unacceptably high levels of sexual abuse within generations of the population, that was a causal factor in such a large amount of mental health and substance misuse problems. The level of this problem was greater than Dr Janssen had seen in her previous posts in psychiatry, including inner city posts elsewhere. We wished to highlight the need for social factors such as housing and education to be changed, particularly within the estates of Thetford, so that this behaviour became unacceptable and victims could be helped to access services.

This historical perspective perhaps helps to illustrate the pressures on General Practice within Thetford, as not only are we pressed from a mental health perspective but also from the overall weight of expectation within the community that accompanies such a demographic mix. This workload and its perception within the Norfolk General Practitioner population has meant that both practices have had unfilled GP vacancies for a long time. Indeed a GP recently resigned from Grove Surgery and publically cited within the Thetford Magazine, pressures of workload and how he, as a young practitioner, felt unprepared by his training for the demands placed upon him as a doctor in the town.

The NWMHT are proposing to put in place a new provision of secondary mental health services for Thetford patients. We have traditionally had services provided by Suffolk MHT which fits much better with our overall referral patterns, where the vast majority go to West Suffolk Hospital, Bury St Edmunds, which is only 10 miles from Thetford and has public transport access. We have over many years fostered very close working relationships with the SMHT. There is a community mental health team situated in the Thetford Healthy Living Centre and link workers in the practices. The Consultants and community team are very well known to us and our patients, thus enhancing close working and liaison between services, especially with the substance misuse service where so many patients have dual diagnosis problems.

Thetford mental health workers are very well aware of the large number of clients that fall into a moderate mental health need, served poorly by talking therapies but who will also not meet the criteria for severe mental illness such as psychosis. Examples are the large number of patients with personality disorders that drift in and out of crisis and do not appear to be catered for within the suggested secondary care model. The preponderance of these patients reflects the social circumstances we have previously described and we fear a resultant increase in General Practitioners being asked to manage these patients within primary care but without adequate training, time, resources or support.

As GPs we are working closely with patient groups in our locality and also at CCG level, to alter patient pathways in a considered way and to commission new services as a result. This is the favoured approach by the government BUT there has been no such commissioning with these proposed changes. The implementation of these changes is being pushed through by the provider organisation without adequate consultation with patient and Professional groups and we predict that these changes will have a serious adverse effect on patient care and could potentially lead to pressure on General Practice that we are poorly placed to absorb.

We feel very strongly that if these changes are to occur, the same standards of proof of quality should be placed upon NWMHT as applies to all other organisations commissioning and changing pathways of care. Thus far there have been no discussions with patients or GPs in Thetford to assuage our fears or explain how our patients will benefit from the proposed changes. Until such an exercise meaningfully happens we request the changes are put on hold to allow a detailed look at new pathways and services.

Yours sincerely

Dr Martin Belsham
GP, School Lane Surgery
GP, Community Alcohol and Drugs Service

Dr Martin Hadley-Brown
GP, Senior Partner, School Lane Surgery

Dr Chris Riddell
GP, Senior Partner, Grove Lane Surgery