Wessex Clinical Senate

Minutes

WESSEX CLINICAL SENATE COUNCIL MEETING

Minutes of the Wessex Clinical Senate Council Meeting held on 4 December 2014 at the River Test Meeting Room, Ordnance Survey Offices, Adanac Drive, Southampton SO16 OAS

Senate Council members in attendance:

William Roche	(WR)	Clinical Senate Chair
Lionel Cartwright	(LC)	GP and Dorset CCG.
Gary Connett	(GC)	Paediatrician, Wessex Academic Health Science Network
Suzanne Cunningham	(SC)	Consultant Midwife, University Hospitals Southampton
Hayden Kirk	(HK)	Consultant Physiotherapist, Solent NHS Trust.
Ranjit Mahanta	(RM)	Consultant Liaison Psychiatrist for Older Adults, Frimley Park Hospital
Simon Plint	(SP)	Dean, Health Education Wessex (am only)
Frank Rust	(FR)	Patient and Public Representative
Alyson O'Donnell	(AO)	Clinical Director, Maternity and Young People SCN, NHS England, Wessex
Sally Nelson	(SN)	Deputy for Jim O'Brien – Public Health England
Bob Coates	(BC)	Deputy for Andrew Mortimore, Southampton City Council

Attendees/Observers:

Debbie Kennedy	(DK)	Senate Manager, NHS England, Wessex
Sara Cobby	(SC)	Senate Admin Officer, NHS England, Wessex
Janice Gabriel	(JG)	Wessex SCN Manager.

Guests:

Felicity Cox	(FC)	Area Director, NHS England, Wessex
Julia Bagshaw	(JB)	Head of Primary Care, NHS England, Wessex
Gareth Bryant	(GB)	GP Local Medical Committee

Apologies:

Matthew Hayes	(MH)	Clinical Director, Cancer SCN, NHS England Wessex
Richard Jones	(RJ)	Clinical Director, Cardiovascular, NHS England, Wessex
Denise Cope	(DC)	Clinical Director, Mental Health, Dementia and Neurological Conditions
Andrew Mortimore	(AM)	Director of Public Health, Southampton City Council
Nigel Watson	(NW)	GP and Wessex LMC
Adrian Higgins	(AH)	West Hampshire CCG
Bennett Low	(BL)	Deputy for Ruth Williams, Nursing Directorate
Lucy Sutton	(LS)	SCN & Senate Associate Director, NHS England, Wessex
Stuart Ward	(SW)	Medical Director

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1.0	**Welcome:** The Chairman welcomed those present to the meeting. He asked those present to refresh their declarations of conflict of interest. WR declared that he had been involved in a review of vascular surgery in West Sussex. There were no other Conflict of Interest declarations.	
2.0.	**Minutes of the meeting on 11th September 2014:** The minutes of the meeting on 11th September 2014 were discussed. It was suggested that more detail should be added to the minutes with respect to the concerns about the clinical model proposed for patients who would be treated not at the Critical Treatment Hospital (CTH) in future but at the remaining Basingstoke and Winchester Hospitals. WR did not think this was necessary as the Senate Council's full report would be published as part of any future consultation on the service change. Consultation on the Hampshire Hospitals proposal would be met by commissioners. A site had since been identified and made public in North Waltham. The impact of the proposed relocation of services on the Eastleigh population remained a concern. WR stated that the Senate Council report on the development of the CTH by Hampshire Hospitals proposal had been sent to North Hampshire and West Hampshire CCGs, who had forwarded it to Hampshire Hospitals for comment. Comments were received but no additional information which materially affected the findings. He had also sent invitations to the Medical Director to discuss the contents of the report with him, but to date no approach had been made. FC said that the CCGs had found the Senate Council report helpful and were working on a commissioner-led business case. It was agreed the minutes of the meeting from 11 September 2014 should be published on the Senate Council website.	
2.0	**Vascular Services in South East Hampshire:** FC introduced the interim report from the project team. She stated that multi-disciplinary team (MDT) meetings had been held attended by vascular surgeons from Portsmouth and Southampton and a business case was being developed. Areas of concern were co-dependencies in Portsmouth Hospitals and the need for capital development in University Hospitals, Southampton. There needed to be better collaboration between the two sites, although improvements have been made. Emerging issues such as Portsmouth taking on the Chichester was hampering progress recently. Portsmouth HOSC was of the opinion that moving the abdominal aortic aneurysm service constituted a major change whereas Hampshire HOSC was not. Chichester HOSC was supportive of vascular services for their patients being provided from Portsmouth rather than Brighton. NHS England was going through organisational change. Susan Davies was the interim Director of Commissioning and the replacement for Simon Jupp who was	

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	now Chief Operating Officer at PHT. Regional and area teams needed to work more closely. Boundaries and patient flows should be looked at in a wider context. FC said a multi-senate approach to this would be welcomed. Outcomes had improved in both Portsmouth and Southampton. It was noted that this was the first formal vascular clinical service collaboration between the two hospitals. It was agreed this was a valuable step forward. WR introduced the discussion on the interim report from the project team. He summarised the recommendations of the Senate Council in September 2013, which were made following presentations and discussions between representatives from Portsmouth Hospitals (PHT), University Hospital of Southampton (UHS) and the Vascular Society. The senate view was that discussion between surgeons on where the surgery took place was leading to a lack of focus on the preventative care to avoid the surgery in the first place. The Council were concerned particularly about diabetic care and the number of deaths following amputation. Whilst the high number of deaths may be because these patients were in receipt of end of life care and the amputation was late in life rather than inappropriate, there was no data presented which showed this to be the case or otherwise and the outcomes for amputees were poorer in Portsmouth than Southampton. Some amputations could potentially be avoided with better public education, vascular and diabetic care. If amputations are undertaken for symptom relief of a distressing condition then psychological support should be available both pre/post amputation. The Senate Council had no information as to whether this was the case. Vascular society data on outcomes by surgeon had been circulated with the agenda. One surgeon was conducting the vast majority of abdominal aortic operations in PHT with good outcomes and although another surgeon had recently been appointed also with good outcomes, this was not sufficient to sustain a vascular surgery service for the future. The sustainable services nationally had at least 6-7 surgeons. With increased stenting, screening and interventional radiology, the demand for open vascular surgery has reduced and was still reducing. The Senate saw a role for specialists in vascular medicine not surgery: surgeons will gradually be replaced by vascular interventionists with radiological and surgical skills. The Senate Council was therefore still proposing that the two services be amalgamated into one clinical service across the two sites with one clinical director in charge and one rota. It was noted that the data in the interim report was not complete and some other data on amputations and waiting times between aneurysm screen and aneurysm surgery would give a more detailed picture on vascular services in South East Hampshire. FC would ask for this in the business case. The Senate Council felt that there was considerable potential in nurse-led and therapy-led vascular medicine which was not being exploited by the service. It was noted that patients with Peripheral Arterial Disease (PAD) and Claudication should have non-invasive assessment and a nurse-led programme including smoking cessation, medication and exercise, prior to consideration of surgical intervention.	

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	The Senate Council advised FC to look to the MDT which was already in existence to develop these pathways and a single service across the two hospital sites with one clinical director under one management structure. It was recognised that in the past, PHT and UHS had been encouraged to compete with each other but this was not a model which was sustainable for the future. FC said that there was a growing recognition that the health organisations and local authorities in Portsmouth and Southampton would benefit from closer collaboration, but the problem was that the health regulators only look at the sustainability of a single organisation. She asked WR if he could contact the medical directors of CQC, Monitor and the NHS Trust Development Authority. It was agreed that the business case be brought to the 3rd March 2015 meeting of the Senate Council and that the regulators be invited to attend.	
3.0	**Horizon Scanning: Helping the Police to support people with vulnerabilities** The Chairman introduced the topic and explained that an invitation had come to Senate Chairs and other stakeholders from the Home Office to attend a meeting to discuss the problem of access to appropriate care for people with vulnerabilities who come into contact with the police. There had been a number of deaths of vulnerable people in custody nationally. The meeting was attended by the families of some of the people who had died in London. Hampshire and Dorset constabularies also attended. There have been national resilience funds and pilot projects – namely in Dorset. In London, if a vulnerable person ended up in a police cell, commissioners would know by way of Serious Untoward Incident (SUI) Never Event reporting so it was monitored closely. In Wessex, there is no requirement to record a vulnerable person in a police cell as a SUI. DK presented the evidence she had found to date. There have been recent service changes to how people with mental illness are dealt with if there is a call to police or ambulance services as a result of the Home Office initiative. Horizon scanning was one of the Senate Council's roles. WR reported that NHS England (Wessex) did not know what the impact of these recent service changes has been on mental health services; whether admission rates have gone up or there has been more pressure on beds, as this was not monitored. There are a number of mental health street triage projects where a police officer responding to the call was accompanied by a mental health professional across Wessex, funded on a fixed-term or short-term basis. Their hours of operation varied. DK shared details on the impact of the Hampshire and Isle of Wight Projects. There had been an 80% reduction in mentally ill patients being detained in police cells over last 2 years in Hampshire. It was noted that a national NHS Ambulance Service protocol for the management of patients experiencing mental health problems had been introduced from 1st April 2014. The new protocol outlined how NHS ambulance trusts would aim to respond to Section 136 incidents within 30 minutes to conduct an initial clinical assessment and to arrange transport to a place of safety or emergency department. Again, the impact of this new protocol on mental health	

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	services/accident and emergency services was not known. As a result of these projects there had been an increase in the number of vulnerable people transported via ambulance as opposed to by police car. There was a question as to whether South Central Ambulance Service could cope. FR added that in borders with Surrey, it was a different ambulance provider (South East Coast). There were psychiatric liaison services in Accident and Emergency Departments who can help to detect mental health problems and signpost appropriately. These have existed for some time, but there was recent evidence that due to funding and other problems they have been withdrawn/under pressure. JG said that she was a magistrate and was still seeing vulnerable people in court who had been held overnight in police cells. She added that in certain parts of Wessex it was not possible to get a psychiatric assessment. WR had anecdotal evidence of mental health patients being discharged into primary care contrary to NICE guidance and could only surmise that this was to relieve pressure on secondary care. RM cautioned those present not to focus on bed capacity as it was best for the patient to be treated in the community and not admitted. He added that psychiatrists work as one member of a multi-disciplinary team and it was this team based approach that was most beneficial to patients. Street triage, Psychiatric Liaison Services and Ambulance Service protocols all existed to get the patient to the right place but that need not necessarily be a bed. DK added that the recent report from the King's Fund "The reconfiguration of clinical services – what is the evidence" stated that there was good evidence that community based models of care, home treatment and crisis resolution teams improve outcomes whereas bed based models do not. However, no information was held by NHS England (Wessex) on the impact of the above service changes on mental health community services either. It was reported that there was a serious problem in recruiting mental health nurses and doctors with the result that mental health services were operating with a high level of staff vacancies. This was believed to have been compounded by cuts in social services budgets where there was also a reduction in the number of social workers in mental health. Finally, the current organisation of mental health and substance misuse services had meant that patients were directed towards one or another, but not both. This was far from ideal. NHS England (Wessex) regularly monitored referral to admission times but no other data on mental health trusts. Another indicator of pressure on mental health beds could be an increase in the number of placements out of area or in the number of patient safety incidents. The regular assurance meetings and the Quality and Surveillance Group (QSG) were the vehicle by which all commissioners were alerted to any concerns about mental health services. Concerns have been raised at the group about CAMHs and the	

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	use of section 136, but no concerns have been raised specifically linked to any pressure on beds or any shortage of community mental health services due to recent changes triggered by the Home Office. JG added that there was a "parity of esteem" event on 9th March 2015, to review work underway and to discuss a way forward. She extended an invitation to the Senate Council to this event. Work was currently underway on a "heat map" to identify where there were gaps in service. She confirmed that this would be ready by 3rd March 2015. It was agreed that JG would ask the parity of esteem group to share the "heat map" information at the Senate Council meeting on 3rd March 2015. It was agreed that DK would work with the QSG to scope the size and extent of this problem and seek advice from the Mental Health Strategic Clinical Network Steering Group to produce a proposal for the meeting of the Senate Council on 3rd March 2015. BC also referred to a summit on Acute Psychosis in Southampton. He agreed to send relevant information from this meeting to DK.	
4.0	**Primary Care** WR explained that a request for advice had been received from CCGs for Senate Council advice on a safe and sustainable future for primary care. This was in response to emerging and immediate issues locally with GP recruitment. In order to do this, the Senate Council needed to understand the extent of the problem and to consider some potential solutions. In view of this requirement, a draft document "Re-imagining Primary Care" has been produced. The aim is to tender this piece of scoping work to an external organisation as there is limited capacity to do this internally within NHS England (Wessex). Rather than simply deliver primary care in a different way or on a larger scale, the project has been extended to include community services and social care. This is in recognition that an imaginative change was needed and this was an ambitious project. LC started the discussion by explaining how primary care services were contracted and commissioned. JB explained that the tender document could not be too broad as emerging issues could be missed. GB felt it was a good step forward, but action was needed quickly, as many GPs retiring or taking early retirement. It was agreed that those present send DK comments on the tender document and identify any companies/organisations that they thought could do the work. GPs are now looking for more flexible working with many working part-time. Partnerships appear to be less attractive than salaried posts – particularly for larger organisations where doctors are able to pursue their special interest as well as undertaking general practice. Consideration needs to be given to how the general practitioner job description could be made more attractive, as it does not	

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	appear to currently appeal to medical graduates. Geographical factors are also important in that rural practices or practices on the Isle of Wight have more difficulty recruiting. There was a huge administrative burden on GPs and the job has changed dramatically. The workload from secondary care into primary care was increasing and there was also the increase in the elderly population to take into account. Pharmacy services are also important as they advise people who would have normally gone to a GP. Public health messages could help manage patients' expectations. WR said we therefore need to look at what services currently look like, what are the population needs and the general practice workforce in Wessex rather than nationally as referenced in the document. He asked if the LMC could help with that mapping work. He suggested that the LMC and Senate could run an evening event in the future with GPs to outline the current state of the service and what the challenges are. The Senate role is to review options for service change and reconfiguration. It could comment on the current state of services, but its role was not to provide the solution. LC mentioned that the next stakeholder engagement event for the Dorset Clinical Services Review would be held on 17th December – he extended an invitation to Senate Council members. It was agreed that DK would send out the details. The clinical services review covered all services including primary care so LC suggested that it could inform the tender/scoping work.	
5.0	**Maternity** WR thanked SC and AO for their hard work in finalising the maternity recommendations. It was not an easy task to crystallise the Senate's discussion. It was noted that the communications team had suggested some changes which those present accepted. The 'Healthy Mother/Healthy Baby' project was discussed. At present it was focusing on diabetes but was likely to be extended to epilepsy and mental health in future. Post–natal checks are important for diabetic mothers and yearly monitoring should be recommended. Lifestyle advice was also important. The request for seven day emotional support following a stillbirth came from mothers themselves. FR endorsed how important this was even years after the event. There was some discussion about screening for Hep B, Hep C and HIV. There was concern about where responsibilities for screening blood born viruses lie. SC did not think maternity services were confused about this. DK to pick up with public health within NHS England (Wessex) The question was asked why Vitamin D was particularly mentioned in the recommendation on antenatal care. What about Folic acid, iron etc? WR said that he understood there to be a problem with vitamin D deficiency and the Senate Council were asked to emphasise it. The Senate Council approved of recommendations, which would now be sent to	

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	Commissioners as a courtesy to enable them to respond fully to any queries which might result from publishing. A communications plan was also being prepared.	
6.0	**Forward View and Future Topics** The Senate Council and Strategic Clinical Networks have been approached to attend clinical reference groups to review cardiovascular and cancer services following the acquisition of Heatherwood and Wexham Hospital by Frimley Park Hospital. SC to send details of the events to Senate Council and SCN members. It was speculated that there may be an issue with patient flows: cancer patients from Frimley flow into Guildford at present and this is a long way for patients from Slough area to travel. DK added that Frimley are to be congratulated for engaging with commissioners and the strategic clinical networks/senate before any options for reconfiguration had been put forward. WR reported that a review of the improvement architecture by NHS England was impacting on SCNs and Senates. Little was known about future structures but one of the recommendations could be that Senates should work regionally more as patient flows were often across boundaries so the Frimley work is an example of how we were already doing this. Topics for March meeting – • Vascular Business Case • Mental Health • Primary Care • Paediatric Vision document • Frimley Park acquisition of Heatherwood & Wexham • Dorset Clinical Services Review	
	Close The Chairman closed the meeting and thanked the Senate Council for their input.	
	Next Meeting: Tuesday 3rd March 2015. Venue tbc.	