Wessex Clinical Senate

Minutes

WESSEX CLINICAL SENATE COUNCIL MEETING

Minutes of the Wessex Clinical Senate Council Meeting held on Tuesday 3rd March 2015 09.00 – 15.00 at The Ageas Bowl, Botley Road, West End, Southampton SO30 3XH

Senate Council members in attendance:

William Roche	(WR)	Clinical Senate Chair
Stuart Ward	(SW)	Medical Director, NHS England, Wessex
Denise Cope	(DC)	Clinical Director, WessexSCN, Mental Health, Dementia, Neurological Conditions
Richard Jones	(RJ)	Clinical Director, Wessex SCN, Cardiovascular
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, Wessex SCN, Maternity and Young People
Nigel Watson	(NW)	Local Medical Committee and GP (10.30 am onwards)
Mary O'Brien	(MO)	Deputy for Jim O'Brien – Public Health England
Andrew Mortimore	(AM)	Director of Public Health – Health and Wellbeing Boards Representative
Adrian Higgins	(AH)	Clinical Director Unscheduled Care and Community Services West Hampshire CCG
Ruth Williams	(RW)	Nurse Director, NHS England, Wessex

Attendees/Observers:

Debbie Kennedy	(DK)	Senate Manager, NHS England, Wessex
Sara Cobby	(SC)	Senate Support Officer, NHS England, Wessex
Janice Gabriel	(JG)	Wessex SCN Manager
Sally Stanley	(SS)	Quality Improvement Lead, Wessex SCN
Gilbert Gundu	(GG)	Quality Improvement Lead, Wessex SCN

Guests:

Dominic Hardy	(DH)	Director of Commissioning Operations, NHS England, Wessex
Lesley Stevens	(LS)	Director of Mental Health and Learning Disabilities, Southern Health Foundation Trust
Mark Smith	(MS)	Transformation Director, South CSU
Alison Griffiths	(AG)	Project Manager (Mental Health) Wessex Academic Health Science Network
Keith Lincoln	(KL)	Director of Quality, Wessex Academic Health Science Network

Liz Mearns	(LM)	Medical Director, NHS England
Kath Florey-Saunders	(KF)	Head of Mental Health and Learning Disabilities Dorset CCG
Katy Bartolomeo	(KB)	Senior Commissioner (Mental Health and Substance Misuse) Integrated Commissioning Unit
Nick Parkin	(NP)	Commissioning Manager for Mental Health and Learning Disabilities, North East Hants and Farnham CCG
Hugh Griffiths	(HG)	Inspector, Hampshire Constabulary
Paul French	(PF)	Locality Chair Dorset CCG and GP

Apologies:

Matt Hayes	(MH)	Clinical Director, Wessex SCN, Cancer
Lionel Cartwright	(LC)	GP and Dorset CCG
Lucy Sutton	(LS)	Associate Director, Wessex SCN
Chris Kipps	(CK)	Clinical Director, Wessex SCN, Mental Health, Dementia and Neurological Conditions

Item	Subject	Action
1.0	**Welcome** The Chairman welcomed those present to the meeting and introduced Dominic Hardy and Liz Mearns.	
2.0	**Mental Health** WR explained how an invitation to a Police and Mental Health Summit hosted by the Home Office had triggered some horizon scanning work to identify whether the issues experienced in London were the same issues in Wessex. He presented data that showed that 17% of years of life lost were related to mental health or behavioural problems, so the impact of mental health problems were a cost to society as well as to the individual's health and wellbeing. At the previous meeting the difficulties in recruiting to and sustaining the mental health workforce were identified as well as the pressures on mental health services caused by the impact of local authority budget cuts and the implementation of good practice in working relationships with the police. There was CQC evidence for some local authority areas in Wessex (but similar evidence was not collected for all areas) that the service offered to patients in crisis was not satisfactory and needed improvement. **Patient story** The Senate heard a true story of the recent experience of a patient called Chris with mental health services. In his view, his attempt to access the service that he needed in crisis recently posed more of a challenge than in previous crises seven and ten years ago. In the end he wasn't successful in securing the care that he had previously received when he had similar needs. Key issues were: changing thresholds (what was a severe mental illness seven and ten years ago is no longer, adequacy of telephone triage, assessments that placed him below threshold for place of safety, lack of continuity of care across primary, secondary and community care, over-reliance on carers. **Planning Guidance** DH outlined the new standards in mental health service • 50 per cent of patients experiencing their first episode of psychosis would access NICE concordant care within two weeks of referral.	

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	• 75 per cent of patients with depression or anxiety disorders needing access to psychological therapies would be treated within six weeks of referral, and 95 per cent in 18 weeks. By 2020 all hospitals were to have effective liaison mental health services in place across acute settings. DH explained that new standards in mental health services would give focus on the gaps in service as they did when they were introduced for cancer, although he recognised that the cancer targets had taken many years to achieve the improvements of today. The Senate Council agreed that there needs to be a change in the culture and approach to mental health services and that the creation of standards and targets would help to stimulate change. However there was a concern that by focusing on a two week wait for psychosis, there was a risk that people with other needs would have to wait longer and this would not be acceptable. The Strategic Clinical Network (SCN) needed to find a way to assure themselves that this would not happen. Prevention and early intervention were crucial and a cultural change towards mental health would help this. Untreated mental health problems created a wider cost for society. Children's and Transition to Adult services also needed to be improved. Children could fall out of the service after CAMHS. There was a need to enhance psychiatry skills in primary care and there needed to be more focus on treating people with severe mental illness in primary and community care settings. The Council also felt that the adequacy of funding for mental health services was an issue which needs to be addressed. It was however, acknowledged that there was some good practice in Wessex. DH said that £80m for mental health would fund the measures for 2015/16. It would be split with £40m to support implementation of the early intervention in psychosis standard, £10m to support the IAPT standard and £30m targeted to support the development of liaison mental health services. CCG representatives present were concerned that this funding was not ring-fenced and could be diverted to other services (such as the acute tariff).	
3.0	**Mental Health Strategic Clinical Network 2014/2015** DC presented the work currently being undertaken in the SCN. Current projects included looking at the diseases/conditions from which people with several mental illness die earlier than the general population and projects to try to help patients with severe mental illness to have better access to services to help to stop smoking. Work was also being done with Health Education Wessex to look at the complicated pathway for Huntingdon's disease to make it more straightforward for patients and families and ultimately reduce expenditure. The SCN and AHSN were both using the SCN Wessex Health Passport project to support the parity of esteem agenda and to help people to manage their own pathways. Mental health workforce re-design was also being looked at together with the development of the existing workforce to be able to carry out the changes required, in collaboration with Health Education Wessex. The parity of esteem programme should help to encourage recruitment and retain staff. SP reiterated the problems with recruitment. There was a current crisis in the supply of doctors wanting to take up the profession and a similar problem in the nursing	

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	profession. The Senate Council felt that the way mental health services were currently provided did not facilitate this change, particularly as there was often a division between mental health services and other services (such as substance misuse). What was needed was a 'holistic carer' between primary care and mental health services who did not assess without offering some service.	
3.1	**CSU: –Heat map** LS and MS explained the aims and objectives of Parity of Esteem work programme in relation to mental health and the challenges with regard to parity. Work is being done with the SCN. The aim is to make good practice available to all and to close the mortality gap of 15-20 years that currently exists in mental health. The Senate Council welcomed this work programme and looked forward to seeing some tangible changes and milestones for delivery as soon as possible.	
3.2	**Academic Health Science Network - Psychosis pathway** AG advised that the AHSN have been developing a psychosis pathway to take the learning from the development of stroke and cancer pathways in response to national standards and targets. Acute psychosis tended to be a young person's disease and therefore early detection and intervention could have a huge impact on a person's future life. Currently only 1 in 10 people get access to CBT and only 8% of people with schizophrenia were currently in employment. Carers of people with this illness had little support. The pathway was being piloted in Southern Health Foundation Trust with patients aged 16-35. This is a 2 year programme with the first year concentrating on implementing the pathway and the second measuring outcomes. Data shows that 16,000 people are living with psychosis in Wessex and that these patients required intensive support. Employment was also an issue with over 2000 people in Wessex who want to work, but were unable to do so. WR said that employment was a huge challenge. There needs to be a culture change to try and keep people in employment. There are big financial implications when people are waiting 7-8 weeks to be seen by a professional, taking time off work and possibly needing a carer to also take time off to look after them. There was concern that the piloted pathway was for a limited age range when the new waiting time standard/target was up to age 65.	
3.3	**Street Triage** HG gave a short overview of what was happening with those people picked up by the police who had mental health issues. In 2013 around 100 persons per month were taken in by the police and of these 50% were put in cells. In Southampton there were 20 in one month. It was acknowledged that this was not acceptable and a lot of work was done, with Southern Health in particular. The number had now reduced to 4 per month in police cells. Southampton had two in the last six months as police now looked to find alternatives. From April 2015, the police and Southern Health were planning to use Medisec, a mental health transport service for Section136 patients. Medisec would take the patient to the place of safety/suite and stay with them until they are settled. Hampshire was one of three counties in the country (Devon and Norfolk being the	

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	other two) without a commissioned place of safety for children. That will change from 1st April 2015 with Southern Health provision. SCAS had trained their staff in Mental Capacity Act and to contact the police and take the patient to A&E. UHS had also done good work in putting together pathways in A&E for Section 136 patients and HG is pushing for these to be taken on across all hospitals in Hampshire. HG said that his top priority would be for psychiatric liaison services 24/7 in all A&Es in Wessex. The Isle of Wight was one of the first in the country to introduce street triage. The target time for response was 20 minutes. There was an attempt to replicate this in Southampton a year ago with a mental health worker in the control room and one in a car. LM asked if there were patients who regularly re-appear in police cells (high intensity users). HG said there were and the police keep details of these users and how to manage them. In North Hampshire there was a different ambulance service and patients are taken to Frimley Green and Surrey Borders. There was an issue as Hampshire police did not have the same working relationships in South East Coast. WR said that the support that the police have given to Mental Health Services should be recognised. He thanked Hampshire Police for their ongoing efforts to improve the service that people with mental health needs who came into contact with the law received.	
4.0	**Role of Quality Surveillance Group (QSG)** RW gave a presentation on what the Quality Surveillance Groups did particularly around mental health. There was a focus locally on CAMHS in November 2014. The group looked at what some of the outstanding mental health issues were and where they would appear on the plan going forward. Urgent mental health issues would also be addressed by the QSG as they arise.	
5.0	WR expressed his thanks to all guests and speakers who then left the meeting.	
6.0	**Senate Council Deliberation in camera** WR asked Senate members to declare any new Conflicts of Interest. WR declared a part-time role as interim medical director in Guernsey and NW declared an involvement in the Vanguard bid for Hampshire. There were no other conflicts of interest expressed. WR welcomed LM and RW to their first meeting as Senate Council members. **Minutes of the Meeting held on 4th December:** The Minutes from the meeting on 4th December were agreed**.** **Matters arising** **Maternity Recommendations** SC had raised an issue regarding the Maternity Recommendations which were then re-written to reflect that geographic consideration should be taken into account in the admission of first time mothers. She added that her request to change the recommendations were to reflect patient choice. WR thanked her and noted her comment but observed that this should be informed choice, including awareness of transfer times. AM was also thanked for his comments. The recommendations had been generally welcomed by commissioners particularly around the pre-conceptual, mental health and early pregnancy aspects.	

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	Vascular services The Senate recommendations around vascular services for Hampshire were still being implemented although progress had been slow. Dorset could ask the Council for recommendations on vascular services as well which could also involve Salisbury. The Senate Council would take the same pathway approach to the Dorset request for advice as it did for Southern Hampshire. **Clinical Services Review** It was likely that there will be a referral from Dorset around service change following the Clinical Services Review currently being undertaken. There might need to be an extraordinary meeting of the Senate Council in early July. WR and DK have explained to Dorset the level of scrutiny and timescales which would be involved.	
7.0	**Mental Health** The Senate Council members deliberated. WR would write up the recommendations and distribute for comment.	
8.0	**Reimagining Primary Care** DK reported that this was now a joint programme with the AHSN and there was resource set aside for it. There were also two interested parties so far, but the team would like to run it as a formal tender to gather more interest. The need for this programme has become more important because some parts of Wessex were expected to be successful in their Vanguard bids. We need to have an objective academic analysis of the starting position was before any service change in terms of activity and quality around Primary Care and related services (Phase 1). WR asked for any comments on the scope and nature of the work. NW said that there was a need to be careful with language and asked who leads on out of hospital care in the system? SW also asked how was primary care and prevention defined and how do you measure that. FR said that it would be useful to look at integrating Social Services, Community Care and Primary Care. AH felt that the key issue in the request was around advice on a sustainable model for Primary Care and therefore, whilst the other issues were all pertinent, it should be remembered that that was the request from the CCGs and that is what solutions should be offered for. DK had drafted some terms of reference for a steering group to oversee the project. Membership of the group was discussed. DH would chair and the membership would be representatives from LMC, PHE, HEE, sub regional nurse director and medical director (if available), CCG, LA and Providers. Volunteers were requested. The group would be largely virtual to oversee the programme. There was likely to be an inaugural meeting once an external organisation had been appointed to discuss the brief and then most of the business would be conducted by exchange of emails informing the Senate of any issues. SP said that it was important to have a link between this steering group and that of the primary care workforce task group.	
9.0	**Future Topics** • Dorset Clinical Services Review of which a component may be Vascular surgery which will also involve Salisbury	
10.0	**Next Meeting** Wednesday 10th June 2015 – held for Hampshire Hospitals Review Wednesday 8th July 2015 at the RNLI Poole – confirmed for Dorset Clinical Services Review	