South East Coast
Clinical Senate

# Clinical Senate, South East Coast
# 6th Council Meeting
## 2 July 2014, 2.30pm – 4.00pm

| Members | Present | Members | Present |
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| Lawrence Goldberg (Chair) | Y | Tony Kelly, Acute Provider Consultant, Sussex | X |
| Sally Allum, Nursing Director, Kent and Medway Area Team | X | Rachael Liebmann, Acute Provider Consultant, Kent & Medway | Y |
| Mandy Assin, Mental Health Clinician | Y | Joe McGilligan, CCG Collaborative Representative, Surrey | Y |
| Katie Armstrong, CCG Collaborative Representative, Sussex | Y | Carolyn Morris, PPE Representative | Y |
| Maxine Bullen, PPE Representative | Y | Caroline Jessel, Clinical Strategy Lead, Kent and Medway Area Team Lead for Sustainability and Health, South of England | X |
| Christopher Allen (Deputy to Amit Rai) | N | Amanda Parker, Acute Sector Nurse Lead | Y |
| Mohit Sharma, Centre Consultant - Healthcare Public Health Public Health England – Kent, Surrey, and Sussex | Y | Edward Palfrey, Acute Provider Consultant, Surrey | Y |
| Michael Bosch, GP | Y | Amit Rai, Dental Local Professional Network Representative | N |
| David Davis, Allied Health Care Professional Representative | X | Philippa Spicer, Managing Director, Health Education England, Kent, Surrey, Sussex | X |
| Julia Dutchman-Bailey, Nursing Director, Surrey & Sussex | Y | James Thallon, Medical Director/Nursing Director Kent & Medway Area Team | Y |
| Andrew Foulkes, Medical Director, Surrey & Sussex Area Team | Y | Priscilla Chandro, Patient Representative | Y |
| Peter Green, CCG Collaborative Representative, Kent & Medway | X | Guy Boesma (on behalf of Des Holden, Clinical Lead, Academic Health Science Network, Kent, Surrey, Sussex) | Y |
| Linda Honey, Head of Prescribing and Medicines Commissioning, NHS North West Surrey CCG | X | Jo Pritchard, Managing Director, CSH Surrey | Y |
| **In Attendance** | | | |
| Deborah Tomalin (DT), Associate Director, SEC SCNs and Clinical Senate<br>Ali Parsons (AP), Manager, SEC Clinical Senate<br>Ryan Watkins (RW), Clinical Director – SEC Maternity, Children and Young People<br>Jackie Huddleston (JH), SEC Strategic Clinical Network Manager, CVD Network<br>Steven Duckworth (SD), SEC, Strategic Clinical Network Manager, Cancer and MHDN Network<br>Kate Parkin (KP), Associate Director Sussex CCG Collaborative<br>Charlotte Clow (CC), SEC Strategic Clinical Network Manager, MYCP Network<br>Sharon Harris, Interim Project Manager, Clinical Senate (Minutes) | | | |
| **Apologies:**<br>Graham Bickler, Peter Green, Rachel Harrington, Sally Allum, Pat Haye, Christopher Allen, Des Holden, Tony Kelly | | | |

| Item | | Action |
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| 1. | **Welcome and outline of the meeting**<br><br>LG welcomed council members and those in attendance to the meeting. The agenda was introduced, LG summarised the two key elements of the agenda<br>- Presentations from the SCNs area teams, which focused on demographics, services provided and what the Senate needs to know.<br>- Sussex CCG collaborative advice request<br><br>**Council members declarations of interest**<br><br>Chair requested declarations of interest from members. No new declarations of interest were received. | **LG** |
| 2. | **Minutes from the previous meeting**<br><br>The minutes of the previous meeting, 6 June 2014, were reviewed and were accepted as a true and accurate account.<br><br>AP informed members that positive feedback has been received for the hosting of the June council meeting via webinar. The meeting primarily focused on the Advance Care Planning report, the document review and feedback/input from members.<br><br>There were no further matters arising, other than those associated with ACP which have been noted. | **AP** |
| 3. | **Chair's Report**<br><br>**1. National clinical senate work: A brief update from the Senate and SCN NHS England Regional Meeting**<br><br>Recently Senate Chairs, Managers and Associate Directors from across the South Region attended an NHS South of England regional meeting to discuss the function, progress and challenges of clinical senates and strategic clinical networks. We met with Dominic Hardy (recently appointed as Interim Regional Director following the departure of John Berwick) and Nigel Acheson (Regional Medical Director). LG reported that the meeting was an excellent opportunity to collaborate and develop a common understanding and purpose, as well as giving regional NHS England a better understanding of the potential and role of clinical senates. A big expectation that Senates "dovetail" with the operation work with CCGs and justifying our presence.<br>LG confirmed that these meetings will now occur on a regular basis, and will include colleagues from the strategic clinical networks (SCNs) which will help the four regional senates work better together and coordinate our activities with the SCNs where appropriate.<br><br>LG advised that the next national Clinical Senates meeting would be held on 16/07/14. It is anticipated that the final version of the Clinical Review Process that provides guidance on the role of Clinical Senates within the assurance of service change will be approved there.<br><br>This document will be circulated to Council members once finalised -**ACTION.**<br><br>**2. Advance Care Planning report and recommendations update**<br><br>LG reported that the final draft was being prepared, it is anticipated that the document will be published in August. It is expected that publication will be in two formats<br>▪ Core document | **LG**<br><br>**AP** |

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| | ▪ Summary public/patient facing document.<br><br>**3. Progress with recruitment to the CSSEC Assembly**<br><br>Assembly recruitment underway. Gaps remain with nursing and AHP membership.<br>**ACTION** Assistance required in widening the invitation list.<br><br>**4. Activities of other clinical senates**<br><br>4.1 East Midlands: Review of Units of Planning five year strategy documents. East Midlands Clinical Senate made a proactive approach to CCGs to conduct an independent clinical review of their five year strategic plans. Three of the five UoP took up the offer, and the clinical senate set up small working groups from their assembly to review each and provide a detailed commentary. Their clinical senate council then pulled out common themes to reflect back to all the CCGs.<br><br>4.2 South West: Independent Clinical Advice on the Optimal Model for HIV Services in the South West.<br>In January specialised commissioning in the South West approached the Clinical Senate, requesting advice on the optimal model for HIV services. The Council deliberated the synthesised evidence, at the end of which the advice to specialised commissioning was formulated.<br><br>4.3 Yorkshire and Humber: Integrated Urgent Care Services.<br>The Yorkshire and Humber Clinical Senate was provided with a proposed model for the provision of an integrated urgent care service to be delivered to a population in Yorkshire and Humber. The Clinical Senate was asked to review the draft service specification and provide formal clinical advice for the NHS England Assurance process.<br><br>LG referenced the diversity of topics across the country.<br>DT reflected that there did not appear to be a consensus of approach across the country on what issues are taken to an SCN as opposed to what is taken to a clinical senate<br><br>**5. Clinical co-dependencies of hospital-based services.**<br>This item was discussed as part of the meeting's main agenda. | **ALL**<br><br>**LG/AP** |
| **4** | **Briefing session from Area Teams and Strategic Clinical Networks**<br>*The presentation slide set has been circulated with these minutes*<br><br>**<u>AF – Surrey and Sussex Landscape and Key Characteristics</u>**<br>▪ Two mental health trusts<br>▪ Complex health care system<br>▪ Demographic weighted towards the more "well to do"<br>▪ Deprivation in the coastal areas. Urban and rural deprivation mainly isolation<br>▪ A reasonable healthy and wealthy population<br><br>**Existing configuration and system issues**<br>▪ One trust going through foundation status<br>▪ Shared destination<br>▪ Working through out of hospital and primary care services. Journey seen over period of 0-5 years. With a general election due in 2015.<br>▪ Discussions regarding proposed merger between North West Surrey CCG and Guildford and Waverley CCG have taken place. | **AP/JT** |

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| | ▪ Confirmed acquisition – Frimley Park of Heatherwood and Wexham.<br>▪ SASH moving towards foundation trust providing specialised commissioning quality issues.<br>▪ Financial issues at East Sussex<br>▪ Still issues regarding radiotherapy in Sussex<br>▪ Provision of satellite radiotherapy services at SASH<br>▪ Large piece of work<br>▪ Surrey and Sussex walk in centres<br>▪ SCN programmes and work streams<br><br>**JT - Kent & Medway Landscape and Key Characteristics**<br>JT provided:<br>▪ an overview of the demographic and population characteristics of Kent and Medway<br>▪ a summary of current service provision and key patient referral and treatment pathways<br>▪ Summary of existing configuration and service issues<br><br>▪ West Kent model of care with Pembury as the hub for acute service provision Tunbridge Wells<br>▪ Keogh based review not yet undertaken on high end trauma centre in Kent and Medway<br>▪ 1 Keogh challenge trust at Medway Maritime.<br>▪ The Trust has experienced significant senior management changes. Formal link with Trust in Birmingham.<br>▪ Large in-year deficit<br>▪ Substantial challenges but more stability than Surrey and Sussex<br><br>**SCN Reviews**<br><br>Refer to presentation slides www.secsenate.nhs.uk<br><br>*Due to the size of the presentations, for your convenience the above link will enable you to access and save the documents.*<br><br>*To access click the above link, this will provide you with a list of the various presentations from the Strategic Clinical Networks. You will be given an option to view the slides and an option to save.*<br><br>The Strategic Clinical Networks provided an overview of the main issues relating to their services across SEC, particularly areas where quality of care needs addressing:<br><br>▪ Cardio Vascular Disease<br>▪ Maternity, Children and Young People<br>▪ Cancer<br>▪ Mental Health, Dementia and Neurological Diseases<br><br>**JH- CVD**<br><br>▪ Provider population density from South East Coast<br>▪ Population increase of a considerable amount must be taken into consideration. 2012 – 2039 will see the largest growth for the age group 85-89 year olds.<br>▪ Most deprived Brighton Hove/East Sussex<br>▪ CHD in East Sussex, elderly worst hit<br>▪ Hypertension within the elderly and deprived areas worst hit | **JH/RW/ SD** |

- East coastal areas heart failure prevalence Sussex (unrecorded data)
- Quite a lot of data 16+ years for prevalence of obesity. Impact on cardio- vascular disease. Will be reviewing paediatric data once available.
- Upward trajectory is the same across all areas in the South East Coast.
- Obesity needs to be a focus for everyone, given the estimated growth over the next few years.
- Amputation rates in patients with diabetes in a number of CCGs higher than the national average. Foot care briefing for circulation amongst stakeholder group.
- The importance of seeing everything as a disease and how one impact on the other.
- Service maps
- Review services mainly in London.

**RW - Maternity Services**

- Patient journey maternity services
- Landscape was addressed
- Three stand-alone units – one midwife led, one obstetrician led, one obstetrical and midwife led
- No foetal medicine units in KSS. Patients would be seen in London or Southampton
- Critical co-dependencies
- Work going currently taking place developing a maternity dash board nationally, to be used for bench marking
- Nationally attention paid to still birth rates. Poor performance in the UK.
- Lack of consistency year to year
- Improving teen pregnancy nationally
- UK performed poorly pre term birth

**RW - Children and Young People**

Five areas covered

- Landscape
- One A&E for children in Brighton
- No provision for acute community work or avoiding impatient stay.
- Provided advice to East Sussex CCG
- Brighton and Hove
    - Poor immunisation rates
    - High rates of alcohol abuse and self-harm
    - High rate of not in education
- Kent
    - High levels of not in education
    - High levels of teen pregnancy
    - Poor breastfeeding rates
- Medway
    - High levels of not in education or training
    - Youth justice involvement
    - Poor breastfeeding rates
- Surrey
    - Poor rates of immunisation

- Reducing childhood mortality. Higher rate of children dying compared to the same children with the same illness in Scandinavia
- National target to see reductions

- Reducing term infants to neonatal care
- Validation of emergency admissions rates for children unsure of why this is the case at present
- Unplanned hospitalisation of asthma
- Children and young people vision. Looking at integrated care pathways. QVH a rare example of specialised services for CHYP with its challenges. A need to reduce the need for travelling to London for treatment

**SD Cancer Services**

SD presented on behalf of Nic Goodger

- Challenges – 2020 1in 2 of the population will get cancer.
- Transferring into a long term condition
- A fifth to a quarter of patients are diagnosed at an emergency stage
- 1 in 3 die within a year of diagnosis
- NHS Jeremy Hunt aims to name and shame GPs who do not diagnose early or mis-diagnose.

Cancer in South East Coast

- Incidence, slightly lower than national average
- 3 cancer centres
- IOG issued by NICE – each service must comply with IOG
- Specific area SEC
- Getting radiotherapy closer to where patients need it

Data pack by each CCG looking at emergency presentation of cancer

**SD Mental Health, Dementia and Neurology**

SD presented on behalf of Catherine Kinane

- Tier four services for children with mental health, eating disorders.
- 3 large mental health providers – one in Sussex, one in Surrey and one in Kent & Medway

Population

- Interventions including iapts/psychological therapy
- Highest child population is in Medway
- Issues – data is poor. Data to come forth following launch of know intelligence system

Possible solutions

- National crisis care co-dependant document released. The document looks at what a good response will be with mental health issues/diagnosis.
- More likely to die ten years younger than someone who doesn't have a mental illness
- Currently working on a GP leadership programme
- 2/3 of dementia prevalence diagnosis by April 2015 – vast majority CCGs will not make target
- Nihilism around dementia
- Good diagnosis by type and progress
    - Dementias multiply pathological sub types.

Neuro conditions/activity

- Poor transition from paediatric to adult services – poor experiences
- Moving forward – assessed and second with 24 hrs. with a care plan designed

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| **5.** | **Senate Council Meeting 2 July 2014 – Sussex CCG Collaborative Request for Advice**<br>*The presentation slide set has been circulated with these minutes*<br><br>CSSEC has received a formal request for advice from the Sussex Clinical Commissioning Group (CCG) Collaborative, in order to inform Sussex CCGs' strategic planning for future acute hospital services.<br><br>***What are the clinically necessary co-locations (i.e. same site) and co-dependencies (which could be provided on a networked basis) for acute hospital-based services?'***<br><br>The request is for high level, generic clinical advice, not site or region specific. Whilst the request is from East Sussex CCGs, the advice and recommendations are likely to be of interest across all SEC health commissioning organisations, and potentially wider.<br><br>LG summarised the immediate key tasks for Council members:<br>▪ Clarify and confirm the request for advice with the topic sponsor,<br>▪ Discuss and agree methodology, ToR, and working group composition.<br>▪ Agree the support required from the SCNs, and consider required sources of information to inform our report.<br><br>Council members were invited to consider the question posed and consider the outline plan to initiate formal CSSEC work on this important project for Sussex commissioners.<br><br>LG requested comments and suggestions on how to move forward and expressions of queries of relevant queries and concerns.<br><br>Kate Parkin (KP) Associate Director Sussex CCG Collaborative was introduced; Kate was in attendance to clarify the details of the request.<br><br>LG raised the question of the scope of work the request will address and how the Clinical Senate will address the request. LG sought and gained agreement that a Clinical Senate summit would be held in September 2014 as a key component in formulating its final report.<br><br>KA asked how the Clinical Senate works to support CCGs and how do CCGs use the support provided. KA added that CCGs have been clear with the request phase and that the request and outcome of a literature review will be of use to other counties. The further deliberation of the literature review by clinicians at a Summit, a "sense check" will ensure that CCGs are using best knowledge and not just best information.<br><br>It was noted by the Council that time is of the essence, with the CCGs needing advice by the end of September.<br><br>KP added that it would be more useful to have one piece of work looking at Keogh. KP asked if there are any other items CCGs need to be aware of. Such as being aware of inter-dependencies and wider expertise additional sense check.<br><br>JT commented that a Keogh review is urgent. The creditability of clinical senates and SCNs over the next year or so are under the spotlight.<br><br>JM and JT noted that the advice request was relevant to Surrey and Kent & Medway. | **LG/AP** |

AP noted the importance of remembering the boundaries and how work may impact on Thames Valley, Wessex and London. It will be important to seek opportunities for cross senate working and sharing of advice and recommendations

AF reflected that the clinicians ability to be pragmatic in seeking viable and innovative service configuration solutions should not be underestimated
KA noted that it would be great to know what is happening nationally so as not to duplicate.

JH noted that it would be interesting to see what comes out of the national MEC and EC road shows. It will be important to take account of national perspectives need to build into work. LG requested Council agreement on general areas of the request (as detailed in the slide).

JH noted that he would like maternity and neonatology and the mental health agenda added to urgent and emergency services agenda along with paediatric and acute neurology. JM suggested that service links could be via new technologies rather than being physically co located
LG noted that the aim of this review was not to define what an Emergency Centre and a Specialist (Major) Emergency Centre was, but to look at the necessary relationships between urgent and emergency care specialties. Without prior assumptions about the final status of hospitals.

KA stated that it would be helpful for CCGs to know what has worked well in recent years. The final advice would need to refer to Core standards which will enable and define the future the commissioning models
LG noted the importance of looking at what others have done is a good starting point.

LG highlighted that in parallel to this request for advice to the Clinical Senate, each of the SCNs are undertaking a piece of work that:

- Identifies the critical services which either need to be on the same hospital site or could be networked across more than one hospital or site for each of the relevant service areas that each SCN cover

- Identification of core standards for specific services across the whole patient pathway e.g. Stroke

This work will be aligned and assimilated into the literature review. LG stressed the need to fully align and assimilate this work into the literature review.
AF referenced the care policy. BSUH as a vascular provider a critical co-dependant an onward care provider.

JH mentioned the major trauma network and trauma centres, clearly working effectively at reducing morbidity.

LG mentioned future models out of hospital

JP requested clarity of whether the question to the CSSEC focused solely on acute or whether community hospitals were included

KP confirmed that onward care into hospital; community etc. would need to be part of the consideration of co-dependency/co location

JM asked about costs and expressed that it is not possible to have a major trauma centre in every town.

PC noted the importance of systems talking to one another.

KA mentioned the Commissioner's responsibility to commission along the whole pathway.

JM noted that prevention is also important. Focus should be primarily prevention to start with, picked as individual pieces of work.

MB mentioned the Senate Assembly stage of this work needs a sense of what this may look like.

KP Confirmed agreement on behalf of the CCG collaborative of the critical milestones and the proposed timeline

KA mentioned the need for clinical support experts and suggested a a need to reflect independent clinical expertise.
LG confirmed that this would be reflected in the composition of the task and finish project groups and through those individuals invited to the Summit

(MBo and KA left the meeting)

LG confirmed that the project was not location specific. LG expressed that he would be happy to Chair the work and the work programmes but confirmed that he was not the provider of expertise. Mindful of perceived conflicts of interest. There were no objections raised to LG chairing this work.

CM commented that the summit date felt 'too late' for robust PPE involvement. It was agreed to ensure early involvement, and agree appropriate mechanism. This would be reflected in the project plan.

JH noted that wider consultation/engagement will continue with the CCG work.

CM confirmed that consultation and co-production was not the same thing.

AP noted that Phase 1 is a desk top review. Phase 2 will be the Summit. A strong PPE involvement will be required in Phase 2.

SD stated that if the process is about co-production, PPE needs to be involved from the beginning

MS reiterated that Phase 1 is gathering evidence/clinical evidence review and not the deliberation process.

MB raised the question what are the issues for patients and carers? MB further mentioned a carers event taking place between 3 and 5 September, an opportunity to discuss the topic with PPE colleagues in advance of the summit and bring comments and suggestions/input to the summit on the 10 September.

PC stated that if the Council can confirm PPE involvement from the beginning, it would be better for all.

- **ACTION**: MB to liaise with KP to make contact with Sussex PPE leads.

It was agreed not to hold the Council meeting scheduled for Wednesday 3rd September, but instead to convene the Clinical Senate Summit on Wednesday 10th September. LG indicated that it is anticipated that this would be a full day event. Council members were encouraged to hold the date in their diaries. LG confirmed that, further details regarding the Summit would be

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| | provided in due course.<br><br>Council members were reminded that the August Council meeting, (previously arranged for Thursday 7th August) had previously been cancelled to reflect holiday commitments of many members. | |
| **5.** | **Taking Our Programme of Work Forward**<br>LG advised that the project plan would be forwarded to all Council members once finalised.<br>LG undertook to keep Council members informed as the project progressed. | **LG** |
| **6.** | **Dates of next Council Meetings:**<br><br>**Planned August date – cancelled**<br>**Planned 3 September date – cancelled**<br>**Clinical Senate Summit on Clinical Co-dependencies for Acute Hospital Services. 10 September 2014 – venue to be confirmed**<br>**Thursday 2 October 2014 –** Board Room York House, Massetts Road Horley. 14.00-16.30 | **LG** |