South West Citizen Assembly Notes of Meeting 12th February 2015

South West House Blackbrook Park Avenue Taunton

In Attendance	Apologies
Christine Teller Chair	Cliff Puddy
Pat Eagle	Tom Foot
Kevin Dixon	Joy Capel
Gilly Gotch	Claire Bullock
Simon Mathias	Sunita Berry
Mac Merrett	Anne Miskelly
John Miskelly	Claire Bullock
Joanna Parker	
Malcolm Watson	Copy to: Debbie Pritchard
Vaughan Lewis, Senate Chair, NHS England	Carol Clarke
Martin James, Clinical Director, Cardiovascular Network (PM only)	Peter Rowe
Michelle Roe, Network Manager, Cardiovascular Network(PM Only)	Diana Hall Hall
	Pat Harris
	Lucie Woodruff

Christine welcomed everyone including Mac as a new member to the group and Vaughan Lewis Paediatrician RDE and Chair of Clinical Senate.

A networking lunch has been requested by the Quality Improvement Team (NHS England)

1. **Notes of last Meeting for Accuracy and Matters Arising.**

- The Notes were agreed as an accurate record of the meeting

Matters Arising

- **Re Item 2** It was requested and agreed by the meeting that 'CA Priorities, Challenges and Solutions for SW' be a standing CA Agenda Item.

Action: CB/CT

- Care.data needs to be on next Agenda, Media still reporting 'public concerns'.

Action: CB/CT

- Members' Skills Audit - some members still need to complete and send to Claire Bullock so that appropriate CA development training can be progressed.

Action: CT/CB/SB

- **Re Item 5** Senate Council Update, the CA needs to decide who the extra person will be to attend the SC with the CA Chair and agreed it needs to be a rotating position to ensure person with best specialist knowledge attends.

  Action: All

- **Re Item 6 Integrated Personal Commissioning**

- At the meeting on 30th January, members who attended identified several issues:

- Personal commitment
- Culture change
- Time element required to set up
- Too many separate budgets
- Providing the clients plan against funds available and without any clear view how the IPC can be managed financially and set against a depleting social care budget
- Assumptions made that Health/Social Care and Voluntary Sector work in unison

  Action: Watch and Wait

2. Senate Update and Citizen Assembly Input to Senate Assembly March 12th 2015

- VL reported that during the lead up to the General Election there will be limited activity and plans but likely ongoing projects will be:

- Urgent Care Review,
- Proposal for the reduction and rationalisation of specialist centres
- Reduction in trauma centres
- 7 day working/workforce effect on care standards
- Potential for Strategic Critical Care Network. Work completed on future proposals for stroke services
- Similar programmes are occurring across the country and so far are demonstrating that there is a 30% improvement in outcomes and an increase in survival rates. All the programmes are clinically driven.

- CA can usefully input to the SA and SC by supporting the Care.data launch, which has had a rather poor reception from some patients and GPs although the benefits of participation, to research, cannot be over –emphasised. The Genome project, for example, is already supplying enormous quantities of information to give health care providers information to treat, prevent and cure disease.

- A discussion took place re current services and concerns e.g. the need to support a more efficient health service using sophisticated techniques and available data to provide individually tailored treatments. Patients need to receive clearly defined information on what is available and where, particularly in rural areas, longer journeys are involved which may affect their outcomes.

- The CA would like to discuss further how to get the best feedback from the public re services, Survey Monkey provides a quick response.

  Action: Feedback to Claire Bullock to share experience and any thoughts

CA Input to the Senate Assembly on 12/3/15

- The group discussed and agreed CA input on March needs to include

- Review of the 1st year using visual imagery
- How CA responds to requests for information from SC
- Demonstrate interaction with local community
- Identify challenges
- Added value CA provides

  Action: CT/SM/KD to progress

Feedback from Senate Council (VL)

May 2014 and October 2014

- Citizen Assembly involved in 2 SC deliberations: 1) Discharges from Acute Hospitals and 2) Configuration of Acute Hospital services in the SW
- Value and Use of Community Hospitals discussed → Simon Stevens has no blue print, suggests develop organically. Devon has many but some areas have none.
- Commissioning Tools and their limited use, organisational boundaries an issue, suggest co-commissioning, pooled budgets managed by a single organisation
- Meeting and collaboration of Royal College of Surgeons to discuss future and validation of A/E and Emergency Surgery
- Identified changes in Cancer Services with improved survival and outcomes
- An ongoing Laparotomy audit now in its 2nd year has already shown that 30, 000 people in England and Wales undergo this procedure each year with 15% of patients dying within a month
- Rationalisation of Specialist Services **.**
- Patient Experience needs to be considered

Jan 2015

- Business meeting: agreed to reduce SC membership from 40 to 25. Agreed needs broader range of representatives across all areas of the SW.

- The Clinical Senate role to change, as it will take on the tasks of the former National Clinical Advisory Team, which reviews and validates a range of health services.

- Peer review to be retained and an independent view will be established for any proposal of a service change.

- Kings Fund Review and findings on reconfiguration of services discussed, key points

- Not well evaluated

- Limited evidence
- Drivers financial and workforce
- Didn't meet stated aspirations.

- The evidence did not suggest that reconfiguration, including moving to a more community-based model of care, will deliver significant savings.
- Improvements in quality can be achieved through reconfiguration, but these are greater for specialist services, and service improvement strategies may deliver more significant improvements.
- Availability of experienced medical and nursing staff is shown to be important, but there is limited evidence on how many staff are needed, of what type and over what time period.
- There is no 'optimal design' for local services; their configuration will depend on the local context and the specialty-specific balance between access, workforce, quality, finance, and use of technology.
- The balance between access, workforce, quality, finance and technology will play out differently for patients with different levels of clinical risk and complexity.
- Those planning services need to look across the full care spectrum to ensure the most efficient distribution of services, to remove duplication, and to ensure that patients receive the right care, in the right place, at the right time.
- Proposals should be underpinned by workforce details and financial plans with supporting service improvement strategies

TO NOTE: Summary of Kings Fund Re-configuration Report: http://www.kingsfund.org.uk/publications/reconfiguration-clinical-services.

Public Health 5 year Forward Document

- Provides a necessary forward view for the NHS. Outlines a patient centric approach to health services delivery

- Wanless report (10 years ago) identified issues with smoking, diet, alcohol→no action
- Need closer working relationship between NHS and Public Health England
- Need to audit performance against Health and Wellbeing Charter (surveys, Cquins)
- Public Health principles need integrating into commissioning
- Develop preventative agenda (involve employers and employees)

Strategic Clinical Network Leads Meeting

- Four main for drives for change discussed→financial, workforce, access and quality with a possible 5th - technology

- Agreed to be part of Emergency Review - supportive of the Senate and integration of health and social care

Systems Leadership

- Local Area Teams have merged now a sub region of NHS South which has compromised the future role of Systems Leadership

- Local Area Teams and the SWSCN are not sufficiently resourced to take responsibility for Systems Leadership

Vaughn was thanked for his very useful information and feedback

Action: To note

4. CA Review

- Paper circulated prior to meeting; Need to consider this paper, including consideration of delivering an annual report and its circulation.

Action: Feedback to CT, CB, VL and SB by 28th February 2015

3. Patient Stories

- Joanna Parker led the discussion on the value of patient stories and feedback concerning personal experience of health and social care. Discussed were: the logistics of accessing feedback and its use and value to the CA in being able to illustrate and present to the SC.

- The CA has previously used Survey Monkey; it's quick, straightforward and easy to use but has limitations and can lack depth. Other areas in England have developed systems: Patient Voice South has organised a webex, Dorset has Citizen Journalist, HW Hampshire has used film and the Patient Association provides community reporting.

- Patient stories can be a powerful tool but each story is unique; real patient experience may touch on emotional points but how do you weigh up one story against another? A key concern is how do you reach those seldom heard?

- The members agreed that this was an important and vital area and would probably benefit from the more complete interagency patient story but would require resources and time to complete.

Action: CA to consider using patient stories (and the process) for the next SC deliberation and more generally.

5. Cardiac and Stroke Service Mapping (Martin James /Michelle Roe)

- MJ, Clinical Director, Cardiovascular Network has been asked to address the Emergency Care Review for Stroke and Cardiac Services by mapping current services and providing a range of future options.

- This review has been prompted by Sir Bruce Keogh's Service Review which proposed co-alignment and rationalisation of services, as well as providing a resilient and sustainable seven day service.

- At present there is a high mortality rate from stroke, poor scanning times in some hospitals and access to a stroke unit is variable. Where there are less than 2 nurses for 10 patients a higher mortality rate occurs.

- A computer model has been devised for stroke care in the SW which can identify specialists available and where the fastest treatment occurs. The map shows where all Stroke and Cardiac patients are currently treated and how the map would look; e.g. looking at the road system and travel time by having two specialist centre (Bristol/Plymouth) in the future. It is important to note that re-configuration is not a panacea for improved services.

- Cardiac patients needing Primary Percutaneous Coronary Intervention (PPCI) should take no more than 90 minutes from door to balloon

- Once a decision has been reached about these services it will be the responsibility of the paramedic to take the patient to the most appropriate specialist centre, which may be further away than the local hospital. Prior to any changes the public need to be consulted and the reasons for any changes explained fully. The public consultation will be undertaken by the CCG.

- The CA then raised a number of points that will need to be considered:

- Travel time
- Carers travel
- The effect of the pressure on a specialist centre
- Possible move of other services to a non specialist centre
- Repatriation after 72 hours to local hospital for ongoing treatment/recovery
- Substantial cost to the Ambulance Trust (longer and more journeys)
- People close to borders could be taken to another county

- Christine Teller thanked Martin James and Michelle Roe for their informative presentation and will provide the groups e - mail details if they require any further support in the future.

Action: MJ and MR to be sent CA mailing list CT

- **The next meeting is on 28th May 2015 Venue to be advised**