South West Clinical Senate

Conference Brief from the South West Clinical Senate Assembly meeting

Held on Thursday 12th March 2015
In The Rougemont Hotel, Exeter

Conference Brief

Vaughan Lewis welcomed and introduced the South West Senate Assembly. The Assembly then received the following presentations:
(slides available at www.swsenate.nhs.uk)

1. **The Patient and Public perspective** – Christine teller Citizens' Commissioner
2. **The View from Torbay** – Kevin Dixon, Citizens Assembly member
3. **Challenges for the Citizens' Assembly** – Simon Mathias, Citizens' Assembly member
4. **Changing models of care** - Nigel Edwards, Chief Executive Nuffield Trust
5. **What's gone wrong with urgent care and what should we do?** - Jonathan Benger, National Clinical Director for Urgent Care, NHS England
6. **A commissioning perspective** - Matthew Dolman, GP and Chairman Somerset Clinical Commissioning Group
7. **Swedish approach to health and social care integration** - Anette Nilsson, Improvement Strategist, Qulturum in the County Council of Jönköping, Sweden
8. **Five year forward view** - Nigel Edwards, Chief Executive Nuffield Trust
9. **The art of the possible for future frontline services** - Emma Williams, Head of Operations for the Urgent Care Service, South West Ambulance Service

The following questions were raised and discussed during the panel discussion:

- **What design principles work in the Nuffield Trust area?**
  Firstly, an area must be defined which can be very hard. Issues lie with misdiagnosing the system. Problems arise because the organisation is held to account for how it is run and clinical success does not equate to financial success. Commissioning needs to agree to share the gains from new initiatives.

- **If a patient does not comply with advice, who is responsible for a poor outcome?**
  An example is 'what is the purpose of orthopaedics'? The clinicians' responsibility for pain free mobility or just to complete an operating list? It must be a shared responsibility.

- **Why is the Swedish change model led by local authority rather than healthcare?**
  In Sweden, local authority runs healthcare and they could see the need to move to providing what the elderly wanted not what the services thought they required.

- **Given the size of the financial challenge, how realistic is it to provide new models of care?**
  - Cultural change is required at the start so it is a question of getting through this phase. It needs to be taken back to the community and to think differently about health and social care.
  - Currently getting rid of waste in the system pathway by pathway which is slow and not easy.
  - We cannot assume out of hospital care is cheaper so the question is how to improve efficiency and in particular how to generate this into cash? It is doubtful the system has the capacity to make spare cash but it can become more efficient.
  - There needs to be control over the change rather than the current emphasis on resisting change.

- **To what extent has Sweden risen to the challenge of recognising emotional needs rather than just the objective of 'going through the system'?**
  - It is important to ask all the time – 'what matters to you?' Staff who communicate with the elderly can see the changes to the way of working and what is important to the elderly is emotional support rather than medical interventions etc.
  - Seniors coaching seniors – this network can be used to support the system.

- **There is a sense of disconnect between what happens in voluntary organisations and how healthcare can respond to that?**
  This could be politically sensitive. Here is a need to use the knowledge held by voluntary organisations to find out what is generating demand for urgent care.

- **With regards to patient and public involvement in the Senate, are we at the bottom end of meaningful public involvement for service redesign?**
  There is still a huge learning curve for meaningful public involvement. There is discord between a patients view of healthcare immediately post treatment and further along the pathway and rehabilitation back to normal life.

- **20% of patients cared for within the NHS have treatable conditions, the rest are about health inequalities. Is there a role for health and social care professionals to enable challenging conversations with patients and the public?**
  - There has been mention of engaging politicians and whether they have a leadership role?
  - Health and social care professionals need to engage the public as part of a network. What is it we want from society?
  - 4% of expenditure is for prevention and the rest is for treatment. The NHS has a role to play with changing this as it provides the interface with patients and the public and can lead examples for healthy lifestyles.

- **There is discord about public opinion. The health community has a structure that public opinion/wishes do not fit in to.**
  - False barriers need to be broken down.
  - NHS has a poor sense of geography – interventions need to be organised around a place and geography.
  - There is a tool on the commissioning website which shows the flow of patients in England.

During the afternoon session, the assembly members joined one of the following breakout sessions:

1. **Doctors in crisis – what are we going to do about it?** - Dr Chris Manning, Upstream Healthcare, Action for NHS Wellbeing
2. **Behavioural economics** - Russ Moody, Public health England
3. **New models of care** – making it happen – Matthew Dolman, GP and Chairman Somerset Clinical Commissioning Group
4. **Managing healthcare in a rural landscape** - Professor Sheena Asthana, Professor of Health Policy, University of Plymouth

Brief notes of the discussions from each breakout session follow the conference brief and the presentation slides are on the Senate website.

Appendices

1. Attendance
2. Doctors in crisis – what are we going to do about it?
3. Behavioural economics
4. New models of care – making it happen
5. Managing healthcare in a rural landscape

1 Attendance

Present:

Vaughan Lewis, Senate Chair		
Sunita Berry	Nigel Edwards	Teresa Middleton
Marion Andrews-Evans	Sara Evans	Russ Moody
Martin Ansell	Paul Eyers	Andrew Moore
Sheena Asthana	Tessa Farrow	Anette Nilsson
Tim Ayers	Daniel Flanagan	Sean O'Kelly
Mary Backhouse	Alison Flanagan	Anita Pearson
Cheryl Baldwick	Caroline Gamlin	Jackie Pridham
Graham Bamforth	Lorna Geach	Sarah Redka
Kathryn Bateman	Gilly Gotch	Guy Rooney
Mary Baulch	Jonathan Graham	Mark Scheepers
Jonathan Benger	Paul Hardy	Mark Selman
Marcus Bradley	Sian Harris	Lizz Shah
Phil Bullock	Ulrike Harrower	Vicki Slade
Ian Chorlton	Susan Hawkins	Michelle Smith
Jacqui Clinch	Peter Heywood	Emma Stapely
Martin Cooper	William House	Debbie Stark
Tim Craft	William Hubbard	Joe Teape
Diane Crawford	John Hyslop	Christine Teller
Katie Cross	Georgia Jones	Helen Thomas
Ian Currie	Bruce Laurence	Frances Tippett
Peter Davis	Peter Lewis	Rebecca Vermeer
Geraint Day	Peter Mack	Ros Wade
Andrew Dayani	Chris Manning	Amy Warren
Kevin Dixon	Simon Mathias	Tariq White
Matthew Dolman	Ethna McCarthy	Emma Williams
Pat Eagle	Daniel Meron	Louise Witts

Apologies:

Adrian James	Ian Orpen	Paul Winterbottom
Andy Neville	Isobel Rorison	Peter Brambleby
Andy Seymour	Jane Scott	Peter Rowe
Andy Smith	Jane Tizzard	Rachel Harrison
Angie Abbott	Jeremy Martin	Rachel Levenson
Ann Millar	Jo Black	Richard Eyre

Anthea Patterson	John Graham	Sally Pearson
Anthony Farnsworth	John Readman	Sally Simmonds
Carol Gray	Jonathan Davies	Sanjay Vyas
Claire Bethune	Joy Youart	Sarah Jackson
Colin Philip	Karen Roach	Shelagh McCormick
Dan Williams	Katrina Glaister	Stephen Lowis
Debesh Mukherjee	Kerri Jones	Stuart Graham
Deepak Gupta	Maggie Arnold	Sue Dolby
Derek Greatorex	Malcolm Watson	Sue Mulvenna
Dina McAlpine	Mandy Cripps	Susan Mizen
Fay Beck	Margaret Bamford	Tim Noakes
Giles Haythornthwaite	Mathew Cramp	Tim Scull
Gina King	Nick Hollings	Trevor Beswick
Glyn Harding	Nick Michell	

2 Doctors in crisis – what are we going to do about it?

"What can we do to address/impact on wellbeing of doctors and healthcare staff?"

1. **Personal:**

- Managing: consider life as balance between work<>not work and importance of work-life/home balance
- Managing self-expectation
- Honesty with self and colleagues
- Maintaining ambition across life (and not just work)
- Learning to say NO
- Maintaining relationships
- Taking pride in achievements
- Space for reflection (time and place)

2. **Practice (or relevant organisation):**

- Management of work-life balance and effects of sickness absence/difficulties with recruitment/part-time or job-share arrangements
- Because of strong pressure from student stage onwards to cope/manage, introduce proactive health review of junior doctors during training and career, to combine with support/supervision/coaching/annual appraisal/revalidation
- Lack of early recognition of issues and interventions and partly 'failure' of individual students/doctors to feel OK about raising issues or concerns earlier rather than later
- Lack of self-care training (and its importance if recommended for the public and needing to be modelled to them) throughout training and thereafter
- EWTD
- -"Listening Ear" service provided by one medical membership organisation but lack of uptake (? Due to some factors related to doctors finding it difficult to seek help). Opportunity to look further into this issue and address it (both upstream during earlier training and downstream)
- Current services for doctors "London-centric"; near-complete absence of systemic availability of appropriate Occupational Health across country. Opportunities to press for systemic availability

3. **Patch (or Locality and some are in fact Province and Patria):**

- Recruitment-Revalidation-Retirement processes -> considerable anxiety
- Training to address own health variable across localities/regions
- Work-life balance issues and anxiety as a result of having to move jobs/"up sticks" especially in rural areas as people progress through career/have families
- Recruitment difficulties re GPs and paediatricians
- ARCPs?

4. Province (or Region):

- Not having an effective voice regarding causes of illness/stress and solutions to address same - "sense of impotence"/"loss of autonomy"
- Responsibility to act vs ability to change things/locus of control
- Practice increasingly "dictated"
- Support services "patchy" - though some areas have arranged their own, eg sessional doctors around Bath
- West Deanery good at providing support for doctors in training - counselling, coaching, mentoring, careers advice, educational supervision, but stops at post- training transition
- Emerging "underclass" of Trust, SAS, sessional doctors, locums and consultants who have very little support/development and more likely to have complaints made about them
- Lack of supportive groups/sense of attachment - in hospital secondary to EWTD, in community to fragmented services

5. Patria

- -"People should look after themselves/self-care better and more so GPs are not nearly so pressured" (patient-voiced comment)
- Educating patients in seeking alternative provision/healthy activities and having realistic expectations
- Fear of GMC; suicides, distress and mental illness whilst waiting for process
- Need for support for doctors through complaints, SUI investigations and coroners inquests
- Stigma re mental health of doctors
- Risk and risks of addiction
- Need for a national Practitioner Health Programme and proper professional support system
- Balint beyond CCT

3 Behavioural economics

Questions from presentation:
- What is the optimum % to get the best response (75% vs ¾ ?)

- Notes from feedback on question:
  - NHS England has an Excellent Organisation Champion Network. This could be a conduit to support the healthy workforce agenda.
  - Trusts have their own problems, and there aren't any networks within the trusts or across trusts – there is a lot of silo working.
  - Stress and mental health issues are becoming more apparent.
  - Emailing out of hours, when on leave or even sickness is occurring. It was suggested that sometimes this can be due to personality type or the expectation of those you report to, or at least the impression given by those around you, that cause people to behave in this manner.
  - It was suggested that having an auto block on emails when on leave so people have to resend emails once a person has returned from leave.
  - There is low staff morale and a lot of negativity within the NHS despite management trying to frame it in a positive light.
  - Question: how can we make it more positive?

  Suggestions:
  - Celebrate our successes
  - It was suggested that there is a training gap with the senior leadership down to supervisors – anyone who is in a leadership/management position
  - Have staff barometers
  - Create a movement across the whole NHS to be positive

4 New models of care – making it happen

- Concentrating on population health and outcomes. Providers have to think together in a collaborative way clinically.
- Citizens Assembly – there needs to be a consensus about what care is. It will have different meanings to different patients, and this will define whatever shape it takes.
- Working at scale – what are the enablers that will move this forward
- Primary care has to be different but how we do bring it along. Developing leadership is key but reality is that it is a real challenge
- How can the Senate be involved – is there a role for the Senate – how would they influence new models of care – it is in outcomes and what are they delivering.

- Five Year Forward View is just a blueprint. It is not definitive and will evolve.
- Prevention – how are we going to affect that? Traditional boundaries - the whole bigger indicative picture.
- Changing primary care at scale. The registered patient list is a very powerful population health structure in place. 270 bids for (MCP (Multispecialty Community Provider)) models of care across the country and 29 were chosen.
- A very good example is Lakeside – Northamptonshire. Patient population of 100,000 with 5 practices and a community hospital. It is a very dynamic design. http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/community-sites/
- PAC (Primary and Acute Care Systems) potentially to move towards ACO (Accountable Care Organization – Commissioning and Health and Local Authority. Pool budget, big footprint, and integration. This identifies leads for prevention. If outcomes are right, the provider group will have an incentive to prevent upstream.
- Primary care homes – an area that absolutely needs to be addressed. It has to be one of the priorities. There are real concerns about the quality of care in some care homes.
- There is a Health and Social security database throughout the South West through the Commissioning Support Unit so we can model retrospectively the cost for health and social care. It needs refining.
- Networking - at a professional level, we can identify models that will work but due to organizational boundaries, there is no real engagement to deliver the systems to put the network in place. There are fledgling ODNs (Operation & Delivery Network) in the South West which are starting to understand their purpose a little bit more but the governance around it is problematic. Anything they do is mapped through current landscape of organizations. Governance around IT is a major issue and restrictions pose difficulties.
- Vanguard/Forerunner models - reflect changing systems.
- Outcomes are critical. These are based around the process of wellbeing.
- COBIC approach - *Commissioning for Outcome-Based Incentivized Contracts.* A capitated budget for a number of people allows us to move the money differently

and incentivise prevention. Try a lead provider model or most capable provider as seen in Cambridge model.

- Key bit: stratification - phase over five years and build in population. From Symphony data, those cohorts of people can be identified that we can affect quicker changes for. Over time there can be a joint approach to costs over benefits.
- Moving forward, different contracting, key is the outcomes, based on Symphony we have to find a different way of incentivising a different type of care. Generate outcomes with patients' carers and restructure organizations
- Primary care plus hospitals come together to become the lead provider for that population.
- Commissioning reform (capitated).
- Provider reform in terms of restructuring.
- Redesigning pathways together.
- With a network of hospitals across the South West and with type units and with a capitated budget for the population, delivering outcomes that are completely different shifting money towards prevention.
- Progressive prevention.
- Investment in technology.
- Information Governance reform.
- Investment into a portal to share information across systems.
- Welfare development.
- Approach politicians about sharing data/financing a shared portal. Mobilise citizens - Patients should be able to share their care plans to support the professionals. Citizens Assembly and Senate can play a part in giving patients a voice about their personal medical records and approach Government.

5 Managing healthcare in a rural landscape

- Large amounts of funding available in urban areas compared to rural areas
- Hard to recruit people in to social care roles in rural areas
- Utilise community hospitals more efficiently
- Travel costs for nurses/carers not being paid
- Could public health consultants be put in to GP practices to assist with financial advice so that GPs could focus on clinical issues?