Notes of South West Clinical Senate Council

Held on Thursday 10th November 2016
In Taunton Rugby Football Club

Meeting Notes

		Action
1	**Welcome and introductions**	
	Round table introductions – attendance and apologies listed below. Agreed to use a discursive format during the morning presentations at this and future Senate Council meetings.	
	Principles for Community Transformation in the South West	
	As the Sustainability and Transformation Plans (STP) are published, it is likely that the Senate will be required to assure community transformation proposals. The aim of the day is to develop some generic principles for community transformation as a resource for Clinical Commissioning Groups (CCG).	
2	**Primary Care Setting**	
	Dr Phil Yates presented; • Background to the historic split between health services, community health and the emergence of primary care models. • Primary Care challenges are leadership, values and legitimacy. • For STPs – who will they communicate with in the community to represent the voice of the community and take forward delivery? • Hospital clinicians who move into the community will need support – who will provide this? • In order that the workforce does not become de-skilled, staff will need to be either generalist or specialist. • To date, growth in the transformation fund has been used to bail out acute Trusts – when will primary care see some of this investment? • The arrival of STPs is an opportunity to increase prevention strategies in the New Models of Care. • Community plans are reliant on local authority. Funding cuts will affect packages of care and what can be supported in the community.	
3	**Workforce Strategy and Planning**	
	Clare Hines, Associate Director Workforce Strategy & Planning and Deputy Local Director - South West, Health Education England presented. • The workforce model cannot be designed until you have the clinical model and vice versa. Therefore it needs to be decided if the clinical model has sufficient detail to decide the skill base required. • Different environments will require different skills and this needs to	

	be built into plans. Query whether the STPs are asking the right questions to be able to develop detailed plans? • The STPs must be supported to get the right skills and tools in place to support the work. • Query about whether, if each footprint moved to a community model, due to the increased workforce capacity required, there would be enough workers in the country to support it? • Apprenticeships in the organisation would be an investment in the workforce for that organisation. Widening of placements for pre-registered staff for better experiences. However, service capacity must have space for placements in order to maintain supply of nurses and GPs – future workforce. • Local communities must be convinced via engagement. • Time must be spent on modelling to understand the workforce requirements and skills needed. • Workforce planning frameworks: Calderdale framework, Six Steps and Population Centric Model. There are facilitators available to guide the use of a framework. • Workforce transition assumes the use of 60% of the current workforce. So re-skilling and up-skilling are key. However, willingness to change needs to be assessed and staff need to be supported, valued and confident in using new skills. • It was reported that professional registration needs to be brought into line with emerging expectations that staff will work outside their usual scope of practice. Action: Chines to feed this back to HEE. • Local workforce boards will influence STPs.	**CHines**
4	**The evidence, or lack of, for community transformation**	
	Sarah Purdy, Associate Dean of Social and Clinical Medicine, University of Bristol presented; • Integrated IT systems, more communication across the system and coordination and continuity of care are all best practice. • Hospital at Home study (available online from Shepherd Cochrane 2016): the result is increased time between admissions and increased patient satisfaction. It is expected to be cheaper but there is limited evidence to support this. Consideration of the burden on carers supporting patients at home. • Social admissions discussed – not medically justified. Care in the community is required. • GP led assessment units reduce admissions to acute Trusts but as this is not yet sufficiently ingrained there is little evidence. • Alternatives to acute hospital care: http://www.bristol.ac.uk/media-library/sites/primaryhealthcare/documents/managing-uncertainity-PDG-evidence-report.pdf • Triage via GP at front door of acute settings/ST5 or above at A&E leads to greater likelihood of discharge. Use nursing colleagues to find out what patients want and work with patient and family to discharge.	
5	**Integration Case Study**	

	Karen Frankland, Director of Primary Care, Nottingham City Care presented; The Chief executive is the workforce lead for the STP footprint. City care features: • Transfer to assess – out of community hospital to home. Using local acute and City Care staff. Results in saving on packages. • Grow your own – future staffing. • Minimum wage at a level to attract staff. • Commissioned to provide all out of hospital care so engagement with the home care sector. Joint training raises the quality of care in care homes in the city. • Sector connector – third sector funding available to them which is not available to NHS. • Access to volunteers/carers – so can hard wire patients back into the community. • Manage borders to ensure patients do not end up in the wrong setting but easy to move across services. • Access to and navigation of health and social care via one number to a triage hub to avoid admissions. This number is also linked to 111. • Dedicated 'falls' ambulance. • Holistic Worker: training to B4 level so they can make referrals. • Service looks at the needs of the population and builds services around demand. • Workforce is an issue and agency staff is one of their greatest costs. Use of apprenticeships and investing in quality training. • Surplus funds reinvested into the social enterprise to maintain a quality service. There are no shareholders. • Social care is integrated: use the same system and referrals are received side by side. • This model could be used as an alternative to GP federations so long as it fits strategically and adds to what is currently being offered. • Provision in a different setting (i.e. rural) requires it to be designed around needs not just legacy. Resource must fit demand and workforce designed to fit the area. • Staff have NHS staff benefits but not as agenda for change.	
6	**Public and Patient Perspective**	
	Kevin Dixon, Chair, Citizens' Assembly presented; The Citizens' Assembly members were asked to forward responses to the following questions: 1. What would you expect patients' main areas of concern to be if changes to community services were proposed in their local areas? 2. What are the key things that need to be detailed in community service change proposals to fully inform patients of the changes and how they will impact services?	

	3. What are the most important issues within health and social care for which patients and the public will want to see details of in the proposals? (see attached for full responses) • General doubt about the fragility of primary care infrastructure to support a community model. There needs to be consideration of the safety nets for the plans. • Clarification required about funds. Plans need to be clear what money is to be saved and what is to be re-invested and where. Issues around how to shift funds across the system. • Public consultation must include honest conversations about current services which are on the cusp of becoming unsafe and how to change these for the better.	
7	**CCG Surgeries**	
	Cornwall, Gloucestershire and Wiltshire CCGs each presented and discussed their community transformation plans with Senate Council members. Outputs for these initial sense checked are documented separately.	
8	**Recommendations**	
	Main points to be included in broad principles: • Strength of the evidence base for community models – use the evidence that is available eg. Jon Glasby study and others from literature review (circulated previously). • Evaluation mechanism for what is to be implemented. Monitoring what is being done and what is effective. A system wide evaluation approach rather than isolated. • Workforce – use of modelling frameworks as standard tool for clinical reviews. Action: Senate to research frameworks and to include in principles which could be adopted. HEE to encourage CCGs to use this. Workforce considerations: timeframe for transforming workforce; changes to service and how this affects workforce; training takes longer than is planned for; systems need to become slicker in the way they organise their own workforce; common sense and flexible approach to silo'd professions (RGN picking up other skills and the challenge of reduced specialisms. • Is the service planned to the right size – economies of scale. • Amend the Senate Clinical Review checklist to specify questions into clearer sections: engagement, model, options etc. • CCGs who have taken part in clinical review to offer testimonial of the value of this process to other CCGs.	**Senate and HEE**

** All presentations available here: http://www.swsenate.org.uk/senate-council/meeting-archive/

Present

Phil Yates, Core Senate Council member and Chair
Rosie Benneyworth, Managing Director, South West AHSN, Core Senate Council member
Sunita Berry, Associate Director, South West Clinical Senate, Senate Management Team
Iain Chorlton, Chair Kernow CCG, Guest
Diane Crawford, Lead Scientist and Director of Medical Physics and Bioengineering, UH Bristol, Core Senate Council member
Katie Cross, Consultant General Surgeon, North Devon Healthcare NHS Trust, Core Senate Council Member
Ellie Devine, Senate Manager, South West Clinical Senate, Senate Management Team
Kevin Dixon, Citizens' Assembly Chair, Core Senate Council Member
Maddy Ferrari, Head of Operations, Wiltshire Health and Care, Guest
Karen Frankland, Director of Primary Care, Nottingham City Care, Speaker
Derek Greatorex, Clinical Chair, South Devon and Torbay CCG, Guest
Susan Hawkins, Clinical Lead Physiotherapist, Royal Cornwall Hospital Trust, Core Senate Council Member
Clare Hines, Associate Director Workforce Strategy & Planning and Deputy Local Director - South West, Health Education England, Speaker and Core Senate Council Member
William Hubbard, Consultant Physician and Cardiologist, RUH Bath, Core Senate Council Member
Kathryn Hudson, Director of Integrated Commissioning, Kernow CCG, Guest
Ceri Hughes, Consultant Head and Neck Surgeon, UH Bristol, Core Senate Council Member
Georgia Jones, Head of Penninsular Foundation School, Health Education England, Core Senate Council Member
Julie Kell, Associate Director of Transformation, North Somerset CCG, Guest
Sally Pearson, Director of Clinical Strategy, Gloucestershire Hospitals NHS FT, Core Senate Council Member
Claire Prentice, Operations and Assurance Manager, NHS England South, South West, Guest
Sarah Purdy, Associate Dean of Social and Clinical Medicine, University of Bristol, Speaker
Sarah Redka, Senate Support Officer, South West Clinical Senate, Senate Management Team
Rachel Rothero, Transformation Director, Cornwall Partnership NHS Foundation Trust, Guest
Peter Rowe, Consultant Nephrologist, Plymouth Hospitals Trust, Core Senate Council Member
Debbie Stark, Public Health Healthcare Consultant, Public Health England, Core Senate Council member
Ian Turner, Observer
Mark Walkingshaw, Deputy Accountable Officer/Director of Commissioning, Gloucestershire CCG, Guest
Malcolm Watson, Citizens' Assembly Member, Guest
Ted Wilson, Community and Joint Commissioning Director, Wiltshire CCG, Guest
Jenny Winslade, Chief Nursing Officer, South West Ambulance Service, Core Senate Council Member
Paul Winterbottom, Consultant Psychiatrist, 2gether NHS Foundation Trust, Core Senate Council Member

Apologies

Marion Andrews-Evans, Core Senate Council member	Bruce Laurence, Core Senate Council member
Mary Backhouse, Core Senate Council member	Peter Mack, Invited
Sara Evans, Core Senate Council member	Linda Prosser, Core Senate Council Member
Paul Eyers, Vascular Surgeon, Taunton & Somerset NHS FT	Ann Remmers, Bruce Laurence, Core Senate Council
Caroline Gamlin, Senate Management Team	David Slack, Invited
David Halpin, Core Senate Council member	Emma Stapley, Bruce Laurence, Core Senate Council
Joanna Kasznia-Brown, Core Senate Council member	Mark Stone, Bruce Laurence, Core Senate Council