NHS
Northern England
Clinical Senate

Meeting:	**Northern England Clinical Senate Council Meeting**	
Date:	**Tuesday 14 July 2020**	
Time:	**5:00pm – 6:00pm**	
	Virtual Teams meeting	
Present:	**Name:**	**Initials**
	Dr John Bourke, Consultant Cardiologist & Senior Lecturer Department of Cardiology, Newcastle Upon Tyne Hospitals NHS FT	JB
	Dr Sam Bethapudi, GP in Durham City, Post-graduate trainer, member of Public Health England North East and the RCGP North East Faculty	SB
	Prof Mike Bramble, Consultant Physician, P/T Consultant, Gastroenterologist, South Tees Hospital NHS FT	MB
	Prof Andrew Cant, NE Senate Chair, Consultant in Paediatric Immunology, Newcastle Upon Tyne Hospitals NHS FT	AC
	Ben Clark, Deputy Director – Clinical Delivery, NHSEI - NEY	BC
	Prof David Colin-Thome, Independent Consultant GP (retired)	DCT
	Lesley Durham, Director and Lead Nurse at the North of England Critical Care Network	LD
	Dr Katie Elliott, Northern Cancer Alliance	KE
	Debbie Freake, Director of Integration, Northumbria Healthcare	DF
	Dr Paul Goldsmith, Consultant Neurologist, Newcastle Upon Tyne Hospitals NHS FT	PG
	Prof Chris Gray, Medical Director, System Improvement and Professional Standards, NHS North East and Yorkshire	CG
	Elaine Henderson, Director of Nursing Delivery at Northumbria Healthcare NHS FT	EH
	Mr Gareth Hosie, Consultant in Paediatric Surgery, NUTH	GH
	Dr Lesley Kay, Consultant Rheumatologist, Newcastle Upon Tyne Hospitals NHS FT	LK
	Angela Kennedy, Consultant Psychologist, Tees Esk & Wear Valley NHS FT & member of NE Mental Health Network	AK
	Mr Raj Khanna, GP and Emergency Department Consultant, South Tyneside and Sunderland NHS Foundation Trust	RK
	Dr Jean McLeod, Consultant Physician in Medicine & Diabetes, North Tees and Hartlepool NHS FT	JMc
	Dr Robin Mitchell, Clinical Director, Northern England Clinical Networks	RM
	Jacqui Old, Director of Children's & Adult Services, North Tyneside Council	JO
	Jo Poole, Senate Manager, North East North Cumbria, Yorkshire & Humber	JP
	Maria Roache, AHSN	MR

	Dr Jeremy Rushmer, Consultant in Anaesthesia & ITU & Executive Medical Director Dr Jonathan Slade, CNE DCO Team Medical Director, NHS England Mr Barry Slater, Consultant colorectal surgeon, Northumbria Healthcare NHS FT Dr Andy Simpson, Consultant in Emergency Medicine, North Tees and Hartlepool NHS Prof Gerry Stansby**,** Consultant Vascular Surgeon, Newcastle Upon Tyne Hospitals NHS FT & Chair of NE Vascular Advisory Group	JR JS BS AS JS
Senate support:	Karen Pellegrino	KP
Apologies	**Name:**	
	Maurya Cushlow, Executive Chief Nurse at the Newcastle Upon Tyne Hospitals NHS FT Peter Kelly, Centre Director North East, PHE Fiona McEvoy, Head of Nursing Quality, North Tees and Hartlepool NHS FT Dr Jon Scott, Consultant Physician/Geriatrician, South Tyneside Hospital NHS FT	MC PK FMc JSc

MINUTES

1.		INTRODUCTION	Lead	Attachments
	1.1	**Welcome and Apologies**		
		AC welcomed everyone to the virtual meeting. Apologies received, noted as above.	**AC**	
	1.2	**Minutes of previous meeting**		
		Minutes of the previous meeting held on 9 June 2020 were recorded as accurate.	**AC**	
	1.3	**Matters arising/actions from previous minutes**		
		None noted.	**AC**	
2.		**AGENDA ITEMS**		
	2.1	**Update on Senate normal business** No further updates for Northern England Clinical Senate (NECS) from the previous meeting. The Yorkshire and Humber review for the Humber Coast and Vale Health and Care Partnership has now been published and can be viewed here.	**JP**	

		NECS members involved were; • Dr Andy Simpson, ED Consultant, North Tees & Hartlepool NHS FT • Dr Stephen Sturgiss, Consultant Obstetrician, Newcastle Upon Tyne Hospitals NHS FT • Dr Raj Khanna, ED & Paediatric ED Consultant, South Tyneside & Sunderland Hospitals NHS FT • Prof. Mike Bramble, Senior Fellow in Gastroenterology, South Tees Hospitals NHS FT • Fiona McEvoy, Head of Nursing Quality, North Tees & Hartlepool NHS FT The commissioners were grateful for the help provided by the Senate and stated that it was very useful. Dr Stevens Sturgiss is also currently supporting a review in Yorkshire and Humber on the stand alone midwifery led unit in Pontefract, this is a desktop review and should be completed by week ending 17th July. BC added from a regulation perspective work seems to be moving into looking at the restoration of services, there's a recognition that this could be very difficult given the need to maintain a flexible response to any second peak of covid 19. There are also some practical restrictions in terms of capacity reduction caused by social distancing, reduced bed capacity and infection control measures.		
	2.2	**Senate discussion on:** **Rehabilitation and recovery** 1) Has anything happened from your profession's / specialty's organisations / sectors perspective that has an implication for the re-set / restoration of services that has changed or become more apparent since last month's call or what are the things you need most from a different sector in order for your to restart / sustain services (e.g. if in the acute sector what do you need from primary care and social care, if in social care what do you need from the NHS etc) 2) What are the big workforce changes that you think we need to see (numbers, roles, training, ways of working) as a consequence of the COVID response and future way of working? 3) Where are the key pinch-points within current services that need new solutions for that you have yet to see addressed (e.g. endoscopy) or need to be more fully worked through across sectors (e.g. rehabilitation)? 4) How do you think we need to change our service model to make sure that the most vulnerable populations are	**JS/AC**	

		supported (from both a deprivation, demographic or geographic perspective)? The Senate Council members discussed these points and a summary can be found below; **MSK,** an example of what has gone well - a representative group including the British Orthopaedic Association, Pain Society, Rheumatology and GIRFT along with the patient experience team and Public Health England have launched a rehabilitation strategy, which includes lots of information and videos. There's an emphasis on reopening the first contact Practitioner Service and rehab for people who have had long term covid or been in ITU. A 'change challenge' started by musculoskeletal will hopefully be rolled out into other specialties. Restoration of services is starting in London led by David Solman using GIRFT as a guide. Things that have needed to change might be more efficient. Examples given were merging and managing waiting lists across a whole ICS rather than individual trusts, telephoning patients and some shared decision making. There are 750,000 people waiting for orthopaedic services in London. There is a need for a community provision for non inflammatory painful conditions so these patients would not come through rheumatology services but noted that with virtual clinics it is difficult to make a rheumatology decision without examining a patient. The Chartered Institute of Economics and Health and Human factors are helping people back to work and restoring services. **Specialised Commissioning -** have a project looking at a group of patients who had a spinal cord injury that were discharged quickly and what happened to them in the rapid emptying of hospitals. This links with the third sector as spinal charities are interested in patient's experience. Also looking at rehab including stroke and the way this group were rapidly discharged and the outcome of patients that were discharged in the first two weeks. The aim is to understand why all patients discharged from hospital did not come back, review the data on this (including mortality data) and consider the implications for future winter planning. This will give a national picture and can be broken down to regions so that there is an understanding regionally of who was readmitted. This information does not include children and pregnancy. **Diabetes clinics -** have been managed virtually and have worked well and would look to extend these links with patients. Uploading data has been a huge step forward, technology has completely changed the interaction		

		Whilst it is not quicker to conduct clinics digitally, it can be productive and is likely to be a lasting change for diabetes care. The region was struggling to cope with waiting times before covid arrived and restoration planning is very difficult. Colleagues will have to identify opportunities to do something radically different and difficult choices and decisions will have to be made. The ICS's have an approach about how to share and understand risk between secondary and primary care. Workforce capacity is going to be the issue. **General Practice** -. Telephone consultations have worked well but confidentiality can be an issue and some people must be seen face to face. There is a need to get this safely back to normal. A 10 minute appointment can take up to 30 minutes with current measures. The capacity in general practice is significantly less and it was already under pressure because of workforce issues. Some GP's are under pressure having to manage patients who previously would have seen in secondary care. Lots of work about stratified follow-up and remote monitoring and reducing follow-up in secondary care for cancer patients. Regarding endoscopy this is the biggest bottleneck at the moment in cancer services and the biggest contributor to people waiting a long time. It requires a specialist workforce and concerns are around it being an aerosol generated procedure. Issues around managing patients expectations who are on the waiting lists and what to do if something changes, therefore good communication is key. Training in general practice has changed slightly. It is evident that clinicians given the freedom to act within a certain remit can make changes. One to one training has been a challenge but have used Teams and Zoom. There is also a digital divide, ie the frail and the elderly and vulnerable patients, this requires more detail. Finances of various health organizations, including all Royal colleges, are of serious concerns. **Paediatrics** - Remote consultations have worked well but there is a worry about confidentiality, especially if sensitive information is being shared. There is a need to ensure that the consultation remains private. Other issues have been when parents email sensitive/intimate images and the integrity of deleting this information and therefore a need for encryptions for these online consultations. Safeguarding is a problem where the vulnerable may be missed and also issues with paediatric child protection. Capacity in surgery is starting to get back, but only to age range of 3-5's, it is a concern how surgical services will recover.		

		Cardiovascular, virtual meetings have taken place twice weekly across the North East and North Cumbria Cardiology Group and linking in with the National Cardiovascular networks on a weekly basis. The numbers of patients presenting has dropped as it has with emergency patients in the early lockdown period and remained like this for some weeks. Recently there has been an upturn in critical aortic stenosis and a problem with regard to elective waiting, capacity is down about 50%. Issues around people being asked to shield and the risk coming to hospital. A window of opportunity over the summer months may lead to procedures being done. October time onwards outpatients will be virtual. Essentially for the foreseeable future it looks like capacity will be outstripped by demand, to the point where choices will have to be made. **Vascula**r - from a surgical perspective the North East is doing well, the surgical approach is largely trying to categorise cases into those that can and can't wait and those that are elective. Using the network in the North East between the vascular units and other surgical units to support each other should it be required. Issues with a backlog of elective cases and a reduction of beds to allow for social distancing. Aneurysm screening is generally to be considered safe and should now restart but varying with results nationally and across the region as some venues remain closed. Worry is that patients don't do well if have covid, nationally data on infections is emerging showing major morbidity and mortality. They originated from either spread from staff to patients or between patients. Currently using the Nuffield Hospital to get restarted on some procedures in Newcastle. Surgery is catching up well and using virtual clinics has been successful. There will be fewer inpatient beds. No easy solutions. **Neurology -** technology has been really important and been managed well. Neurology, is in a good position as before covid the removal of direct access to clinics meant that patients would be triaged with advice or decide to telephone or book in face to face. This has helped manage demand effectively. With covid, this has continued but the biggest problem is with the restrictions of numbers in outpatients. This has amplified a longstanding issue in terms of efficiency of patient throughput, therefore there is a need to look at logistics if capacity is going to be able to meet demand. **ALL** observations were made about everyone's challenges and the huge mountain to still to climb. How well and effective the overnight transformation of services happened especially in areas where it had been difficult to get interaction before. What can be learnt about what it was that		

		liberated clinical teams to be able to make the transformations and what can be taken forward? What needs to be able to be picked out and take it forward. ie more examples of good practice. A number of reviews have been set up looking at what has worked well. The AHSN in Yorkshire and Humber are collating and sharing information and Public Health England with Specialised Commissioning has created a repository for people to deposit information, learning from what has been done. Providers and other organizations are recognising positive change and are keen to not slip back. **Emergency Medicine** – current problem with beds and flows reduced also getting deflections from other departments. Need to triage people to attend the Department via a telephone conversation. Don't have waiting rooms that are going to be suitable. There is also the difficulty with staff need to constantly wear masks and how this limits communication especially when dealing with paediatric patients **Social Care -** in relation to safeguarding, , there have been some virtual assessments but most areas have maintained around 80% of face to face contacts. Regarding statutory assessments, there is a push to get back to 100% in the next few weeks. For children and families and adults where there are safeguarding concerns, there should be a level of assurance. Thoughts now are to prepare for winter and the implications of a flu pandemic and how to bring back focus on the needs of people and health and social care needs. Alongside that some hidden harm that hasn't necessarily been spotted like increased levels of debt, debt recovery, and unemployment, how to look at other data but also seeing trends around domestic abuse and mental health. The current situation has highlighted some important lessons to be learned from the breakdown between hospital care and social care, particularly for the frail elderly. Social care and the local authority have always had a strong relationship with partner organisations, but it's definitely got stronger and not just around frail elderly, but also across the whole breadth of services. Some of that comes from a changing of the mindset and not getting stuck in systems and processes. It's been about people doing the right thing. Care homes has had a lot of national and local recognition, but the care sector has been supported in a joint effort between health and social care. The challenge for the future is to set the bar to a high		

		standard and maintain it, this is a golden opportunity and shouldn't be wasted. **AC** brought the discussions to an end by saying as part of the recovery process moving forward the Senate will be asked to look at various schemes and these comments and ideas that have been shared in this meeting will be useful in that context.		
3	**MEETING CLOSE**			
	3.1	**Any Other Business** **AC** thanked everyone for all the comments made during the discussions and wished everyone a safe and happy summer.		
	3.2	**Next meeting**		
		Next meeting 23 September 2020, 5.00pm – 7.00pm, Teams meeting.		