How clinical senates can support commissioners in transforming services

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Chair, South East Clinical Senate
Clinical senates: background

- Created 2013 (HSC Act)
  - NHS Future Forum:
    - there should be clinical advice and leadership at all levels of the system
    - clinical senates should be created to provide a forum for cross-specialty clinical expertise, collaboration and advice
  - Housed by NHS England
  - Validated following the Smith review of ALBs (2015)
- Provide advice that is:
  - Clinical
  - Impartial
  - Strategic
  - Multi-professional
Clinical senates: remit

• To take a broad, strategic view of healthcare
  • overview of major service change (>1 CCG)
  • address cross-cutting issues not otherwise being addressed
• Assist commissioners and health systems to:
  • ensure outcomes and quality are at the heart of the commissioning system
  • promote the needs of patients above the needs of organisations or professions
  • advise on clinical pathways and service change when there is lack of consensus in the local health system
• Work can be:
  • ‘Pro-active’: senate-initiated topics
  • ‘Reactive’: responding to requests from commissioners and health systems
• Advisory, not statutory
Clinical senates: structures

Clinical Senate Council

CCGs
AHSN
PPE
Medical
Nursing
Social Care
Mental Health
PHE
Pharmacy
AHPs
HEE
Dental
NHSE Med Dir

Assembly
Expert clinical panels
Working groups
Benefits of using clinical senates

• Independence (from commissioners, providers, NHS England)
• Multi-professional (including PPE)
• Evidence based approach to achieving clinical consensus
• Alternative to royal college or other professional body reviews (and NCAT replacement)
• Alternative to expensive consultancies: free (currently)!
• Potential facilitative/convener role
  • Honest broker
  • Can host system-wide events
• Can provide challenge, re-assurance, air cover
Potential limitations of clinical senates

- Finite capacity for multiple synchronous programmes of work

- Time scales from request to production of report
  - 3-6 months for full panel review and report
  - Shorter time scale for tabletop reviews.

- Avoiding conflicts of interest without outside input

- Resources
  - Chair (2-4 sessions), manager (0.5-1.0 WTE), admin support.
  - Clinician participation voluntary
Role in service change

- Algorithm and reference to NHS England document
- 5 tests
  1. Strong public and patient engagement.
  2. Consistency with current and prospective need for patient choice.
  3. Support for proposals from commissioners
  4. **Clear, clinical evidence base**
  5. **Conditions met for any planned closures of hospital beds**
Phases in the reconfiguration process

Planning and delivering service change for patients. NHS England Nov 2015.

Clinical senate support for reconfigurations and service re-designs

Phase 1: Strategic sense check

Phase 2: Formal clinical assurance
Examples of clinical senate work supporting commissioners

- **Case for change reviews** (e.g. STPs, specific services)

- **Clinical service re-design** (taking whole system perspective):
  - Acute Services
  - Stroke
  - Vascular, Emergency, Specialist Surgery
  - Dermatology, Ophthalmology, Rheumatology
  - Maternity, Paediatrics

- **Hospital reconfigurations**
  - Review of specific proposals
  - Underlying principles (e.g. clinical co-dependencies)

- **Integrated care**
  - E.g. ‘Re-Thinking Out of Hospital Clinical Pathways’

- **Theme based cross cutting topics**
  - Helping Smokers Quit (London)
  - Physical Activity and Exercise Medicine (East Midlands)
  - Advance Care Planning (South East)
Clinical co-dependencies of acute hospital services

| Column Titles: Clinical specialties and functions supporting the 11 major acute services in the rows |
| Must be co-located | Must at least inreach | Could be provided by network | Non-dependent |

| Row Titles: The 11 major acute services whose dependencies on the specialties and functions in the columns is being described. |
| A&E/Intensive Medicine | Acute Infectious Diseases | Cardiology | Emergency Medicine | Endocrinology | General Surgery | Haematology | ITU | Medical Radiotherapy | Nuclear Medicine | Orthopaedics | Paediatrics | Pathology | Plastics Surgery | Psychiatry | Radiology | Reproductive Medicine | Respiratory Medicine | Rheumatology | Trauma and Orthopaedic Services | Urology |
| Must be co-located | Must at least inreach | Could be provided by network | Non-dependent |

1. Must be co-located
2. Must at least inreach
3. Could be provided by network
4. Non-dependent
Practicalities

• Discuss possible reviews at an early stage with clinical senate management teams

• Agree the question and scope

• Agree timescales, reporting arrangements

• PID-based approach recommended
Clinical senates and web addresses

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