

Meeting held at the Union Jack Club, Waterloo on 20.2.12

External Reference Group (ERG) meeting, chaired by Jerome Church, BLESMA

1. This note provides a brief overview of the meeting. I do not have a list of those who attended and have asked for a copy from Richard Seymour who ran the meeting. This was the second of two meetings held by the Department of Health on its response to the Murrison Report. The first meeting was attended by amputees, families and focus groups. The ERG meeting comprised of other stakeholders, namely NHS professionals, relevant service and civilian charities, welfare organisations and providers.
2. The meeting was opened by JC and then passed over to Justin Cunningham (DoH) who set out where the process stood and what part the ERG had to play. He explained that the intention was to work towards the preparation of a business proposal that would be sent to the Department of Health for tendering. He outlined the progress made to date in the various meetings and consultation exercises that had identified 4 possible options to follow, namely:
 - Improve all;
 - Centralise care management;
 - Consider a combination of local and specialised centre; and
 - Specialised centres only.
3. JC advised that to date, Option 3 is the preferred option based on feedback from the Armed Forces Network, while Option 4 is preferred by users of Headley Court.
4. He also touched upon the civilian concerns that had been received to date. These included:
 - Two/three tier system;
 - Use of new centres rather than improving the existing ones
 - Prosthetist
 - Travel concerns etc
5. There was some discussion on the number of personnel involved and this number is still unknown. Best estimates are that around 400 ex military are already in the system or, as part of the Covenant, could present themselves for limbs. Those currently in action or recently wounded could be around 300 – 400. There is no indication of where these people would live and therefore which area would be best suited for an enhanced centre. It was acknowledged that, at present, such individuals would be prepared to travel to wherever the expertise was to be found (as happens with those attending Headley Court).
6. The remainder of the meeting was taken up by group sessions to debate the merits of Option 3 including:
 - What good things/bad things would arise from this option?
 - What points would arise from a SWOT analysis?

As a consequence, this note only summarises what was discussed by the group that I was part of.

7. I was part of the group that included Prof. Rajiv Hanspal - the Chairman of the Clinical Advisory Group on Specialist Commissioning who is also a consultant based at Stanmore. While our group sought to answer the questions posed, the majority of the debate centred on whether Option 3 was the most desirable of the options to follow. RH argued very strongly that rather than set up 5 "enhanced" centres, it would be better to have the £15M allocated to a "veterans PCT" or similar body that would be responsible for funding any prosthetic/support costs generated by the ex military. Each individual would then be free to attend whichever centre was the most appropriate/convenient and the funding (e.g. for a new C Leg) would be applied for from the "veterans PCT" body, thereby removing any demand from the local PCT.
8. In this way, the centres would be allowed to grow organically to meet demand as it arose. RH cited a similar situation that occurred in the past surrounding specialist centres to cater for children with congenital limb loss. A review at the time recommended 5 centres to be located around the country and this was increased to 10 to allow them to be more accessible. In the event, the review recommendations were not taken up and a few centres able to cater for the needs of children with limb loss developed organically. RH felt that the majority of DSCs have evolved in the same fashion and was worried about the effect an enhanced centre would have on its close neighbours that had been established for the last 30-40 years.
9. These views, together with those of the other groups were discussed at the end of the meeting and it seemed that this idea of a ring fenced pot for veterans with the ability for existing centres to grow to meet demand had some merit and general support. This was despite efforts by the DoH staff to refocus matters on Option 3. During a debate on this idea, the point was made that the two tier system was primarily a funding issue and that prosthetists and centres had the necessary expertise to be able to cater for the issues presented by veterans. It was the funding to allow the provision of the treatment/equipment that was the key issue.
10. From my perspective, the low numbers involved allied to the short 3 year timescale, the unknown factors such as the location of the veterans, how many would present and at what frequency, would suggest that this option is worth taking further. At first sight, it could remove the potential skill drain, address the funding point and remove the need to enhance a handful of centres to the potential disbenefit of others.
11. JC attempted to summarise the general view and outlined a possible scenario based on the debate that started from a ring fenced central fund. He acknowledged that this would require more thought and debate.