

**NATIONAL STEERING GROUP FOR SPECIALIST CHILDREN'S SERVICES IN SCOTLAND  
NOTE OF PLANNING AND COMMISSIONING WORKSHOP  
FRIDAY 21 SEPTEMBER, CONFERENCE ROOM B, ST ANDREW'S HOUSE, REGENT ROAD, EDINBURGH**

Present: Malcolm Wright, Chief Executive, NHS Education for Scotland, Chair  
Andrea Cail, Project Manager, Specialist Children's Services, Scottish Government  
Helen Byrne, Director of Acute Services Strategy Implementation and Planning, NHS Greater Glasgow and Clyde  
Fiona Dagge-Bell, NHS Quality Improvement Scotland  
Brian Dornan, Head of Strategy and Planning, Health Directorate, Scottish Government  
Zoe Dunhill, Patients' Services Director and Community Paediatrician, Royal Hospital for Sick Children, Edinburgh  
John Froggatt, Deputy Director, Child and Maternal Health Division, Scottish Government  
Joanne Gillies, Workforce Division, Scottish Government  
Heather Knox, West Regional Planning Manager, West of Scotland Regional Planning Group  
Morgan Jamieson, National Clinical Lead for Children and Young People's Health in Scotland  
Chris Myers, NHS National Services Division  
Mary Sloan, Policy Officer, Child and Maternal Health Division, Scottish Government  
Louise Smith, Senior Medical Officer, Scottish Government  
Robert Stevenson, Head, Specialist Children's Services, Scottish Government

Apologies: Myra Duncan, Regional Planning Manager, South East and Tayside  
Jackie Sansbury, Director of Strategic Planning, NHS Lothian

1. INTRODUCTION AND WELCOME

1. Malcolm Wright thanked everyone for attending the meeting, despite the confusion around the dates. This was a follow-up to the workshop which had taken place on 10 August.

2. NOTE OF 10 AUGUST WORKSHOP

2. Malcolm acknowledged the concerns which had been expressed by Myra Duncan and Jackie Sansbury who were unable to attend. He explained that the outcome of this planning and commissioning workshop would feed in to the work Derek Feeley was leading with regional, local and national planning colleagues. Derek had asked for recommendations from this group on the planning and commissioning of specialist children's services: other groups were feeding in to Derek's work as well.

3. Brian Dornan reported that the Directors of Planning were meeting on 10 October. Other Groups were looking at the planning of national services, eg neurosurgery; the link between service planning and workforce; and specialist services generally. Jennifer Armstrong, National Services Division, was working on a paper on low cost, low volume services. These groups would present papers at the 10 October meeting and this Group was invited to present a paper also.

4. Malcolm summed up the item by acknowledging the concerns expressed by planning colleagues on taking this work forward and confirmed that the work of this Group must dovetail with the work of other Groups.

### 3. KEY ISSUES: OUTCOMES FROM REVIEWS

5. Robert Stevenson reported that many substantive reports had been produced in the last 3 years which had highlighted that further action was needed. Core issues on specialist children's services had been flagged up in the Kerr Report *Building a Health Service Fit for the Future* and in *Delivering for Health*. There was evidence of lack of investment and service hotspots. There had been some successes, eg cardiac surgery and renal services. Robert suggested that effective planning and commissioning was essential.

6. Robert went on to report progress since these documents had been published: the Child Health Support Group had been revamped into the Children and Young People's Health Support Group; the National Steering Group for Specialist Children's Services had been formed; regional planning had been set up; *Delivering a Healthy Future An Action Framework* had pulled many policies together into one document with identified leads and timetables; a review of paediatric intensive care (PICU) had been fast-tracked and was now a national service; and the new Government had reaffirmed its commitment to the building of the 2 new children's hospitals.

7. There was general agreement that some services were not sustainable. The previous system for providing services had been reactive and not proactive, with a lack of prioritisation. Hotspots had developed, eg PICU, metabolic services – which were now being delivered as national services – cancer, complex respiratory, gastroenterology, paediatric general surgery and neurology. Variable investment at Board and regional level had taken place, particularly around workforce: service delivery varied from very good to almost non-existent and variable clinical outcomes occurred, eg survival rates for muscular dystrophy in Scotland did not compare well to some other countries. The outcomes in some services were as good as the rest of Europe, others were not. There was a lack of capacity in Scotland to deliver change.

8. The process in England had been reviewed and different planning and commissioning methods had been highlighted in the Carter review. Thought had to be given to what were the unique features of children's specialist services. Issues raised in that process and the work of the National Steering Group for Specialist Children's Services in Scotland included: what criteria should determine where services sit – up to 500 for a national service; 1,000-3,000 for a regional service? – how to prioritise, how to create capacity to deliver change, what were the appropriate levels for planning and commissioning of services in Scotland?

9. During discussion these points were made:

- The agenda for change impaired the ability to redesign services to create capacity – staff were being graded differently in different Board areas: critical care grading was a mess: people might go to Boards with higher grading rather than where they were most needed
- Difficulties arose if enhanced roles were treated differently across Scotland
- Training an enhanced practitioner takes 5 years
- In England the Primary Care Trust (PCT) was the employing authority
- Planning and commissioning has been aligned with SHAs and are now coterminous
- Ownership/leadership was an issue – one Board has to take responsibility
- Leadership accountability must be clear – where did it sit, the Scottish Government, National Services Division (NSD), with NHS Boards?

#### KEY ISSUES: DISCUSSION PAPER

10. Malcolm explained the discussion paper outlined the background and that it suggested options, not solutions. Derek Feeley was leading the core work – the principles of planning and commissioning had to be defined. National Services Division focused on what it could commission and did that very well but it was constrained. Children’s services need national and regional planning and commissioning. Regional planning was very important but it must be strong and robust. The gap between what NSD and the regions plan/commission must be filled. At a national level, should the role of NSD be changed; was there new capacity in the health directorates or should one “host” Board take on the leadership role on behalf of all Boards, with appropriate governance and delegated financial authority, for a range of specialist children’s services? Should a collaborative planning structure be created bringing together the 3 Regional Planning Groups? What model should be put in place?

11. Brian Dornan reported that Directors of Planning were looking at similar issues – which specialist services should be delivered nationally, regionally, locally; the remit and criteria of NSD; and was there appropriate capacity at regional level. It was not envisioned that the Health Directorate would take this on but it was too premature to predict the outcome of discussions – things might be clearer after the meeting on 10 October at which the sub-groups were getting together.

12. During discussion it was pointed out:

- Chief Executives had control over the funds for their area: children’s services were not given sufficient priority: savings had to be made in the current year
- Regional planning consortia must have an edict to invest resources but the regions operate very differently – some regions gave more priority to children’s services than others
- In England, resources were top-sliced, eg a robust tariff was in place for cystic fibrosis which depended on how ill the person was
- Revenue streams appeared higher down south but careful thought had to be given to benchmarking, eg PICU had a lower level per bed in Scotland than in England

- We currently have a system where NHS Boards take the lead role and have delivered the required support for children's services
- Clearer criterion should be established to determine what is planned nationally, regionally and locally
- Substantive discussion would take place on 10 October. Collective commissioning would be considered
- Secondary care and support services must be taken into account as well: a lot of secondary services were planned regionally: regional and hospital services should be a regional entity - cohesive hospital services were essential
- A range of services were provided locally but were planned above regional level but below national level
- Dedicated resources were required: regional planning was very stretched
- Governance and accountability issues should be determined before resources were considered
- Getting the right level of accountability might have the knock on effect of producing the right amount of capacity
- At present accountability lay with Chief Executives: this didn't need to change but what should be planned regionally should be clarified
- A performance management system aligned with planning and commissioning was required
- Targets could be put in place for children's services to make Boards more accountable
- The current planning and commissioning arrangements were fragmented: there was no consensus on where leadership should sit.

13. Malcolm summed up by suggesting there was no support for the option to create significant capacity for national services at a Scottish Government level. The options were: an enhanced role for NSD, regions collaborating better, or one "host" Board with statutory authority to work on behalf of all Boards.

#### 4. CASE STUDIES: PICU

14. Chris Myers reported that NSD assisted in managing the PICU service. PICU was under pressure, for example during increased emergency referrals during the winter, elective procedures had to be cancelled. Pressures had arisen due to the new consultant contract, waiting time regulations and Agenda for Change. PICU had been designated a national service for 5 years from April 2007, £3.8m additional funding had been secured which allowed for increased bed numbers and increased staffing. The 2 PICU units were involved in joint recruitment – they were having to recruit from down south – they had joint meetings on protocols and planning and ran a joint website.

15. The current issues facing the service included the recruitment of experienced staff. A review of the transport and retrieval service was due to start in October and would report at the end of January 2008. Analysis of a high dependency care audit was underway – all the hospitals had sent in returns which included information on patient numbers, episode times and durations, whether the admissions had been elective or emergency and how the patient had been transported.

16. During discussion the following points were raised:
- It had taken 2 years to set up the nationally planned PICU service
  - PICU had been operating under the host health board model – what were the shortcomings, what was the added value of NSD?
  - NSD would be better resourced than the host Board, NSD had planning and commissioning expertise, and better performance management
  - Sufficient resources was the key to providing the capacity to deliver good services
  - The PICU service would be difficult to replicate for other services
  - The “host” Board model placed accountability in one place but that Board needed support from the other Boards within the region, required a good leader and must be linked into statutory responsibility
  - Planning was fragmented at present because no-one “owned” it
  - Would there be a conflict of interest if the “host” Board model was adopted, maybe the “host” should be a special Board rather than a territorial Board
  - NSD sat within the NSS – need good leadership and good support mechanisms
  - Need a distinction between those services needing to be planned nationally and those requiring regional planning: NSD should plan very specialist services and could coordinate the planning of others
  - Regional planning must include secondary services and must have good leadership and adequate resources
  - Should NSS be the statutory authority for national services with top slicing from Boards?
  - The “host” Board model was in place for regional planning but national leadership at Government level was needed to avoid different levels of services being available in different areas
  - The Scottish Government was reluctant to take on planning and commissioning – a statutory body at national level was required, perhaps a “host” territorial Board or a “host” national Board, eg NSS
  - It should be set out which services should be planned at which level
  - The difference between a “host” Board and NSS should be negligible, there would be similar governance issues.

#### CASE STUDIES: GASTROENTEROLOGY

17. Andrea Cail reported that a group reviewing gastroenterology had identified the challenges 3 years previously, eg inflammatory bowel disease needed shared care resources which included nutritional support: better management of the more specialist conditions, eg liver; and teenagers being treated by adult services. Problems in reviewing the service had been difficult because the data was patchy.

18. The Group had recommended that a regional service should be set up with each region having a minimum of 3 whole-time equivalent consultants. The service should network with District General Hospitals (DGHs). A 24 hour service could be provided on a regional basis.

19. The model that had been developed in the North of Scotland region had been shared with SEAT (South East and Tayside) and with the West of Scotland. A lone

post had been established in the east: a consultant outreach service had been established from Inverness.

20. Continuing issues included:
  - consultant numbers were still short in the east and the north
  - Levels of care had still to be agreed
  - The regions should plan the service but a national component should be identified to pull the 3 regions together to ensure equity of service
  - There was a shortage of nurse specialist and dietician posts in DGHs and in the children's hospitals
  - There was an 11 week wait for a first appointment
  - Stronger links should be developed with the adult services.
  
21. During discussion, it was suggested:
  - National input was needed for regional teams
  - Gastroenterology had been a good specialty to test issues – it could be planned/commissioned nationally but it was better to be a regional service. It was a good working model
  - Regional MCNs with a national component could be the answer
  - The recommended 3 WTE consultants could have a special interest in gastroenterology but could also have a special interest elsewhere
  - Could NSD host regional discussions – be a facilitator and provide expertise? NSD could work on a national basis with MCNs
  - Workforce issues remained – no mechanism to develop AHP and nursing roles was in place
  - Recommendations on performance management and leadership were needed to ensure services improved: accountability sat with operational management but difficulties arose with competing priorities
  - The same standard of care was needed across regions: DGHs should provide the same level of care as the specialist children's hospitals (at present 2 DGH paediatricians ran clinics in the central children's hospital)
  - The Scottish Government produced the policies and should therefore take responsibility for performance management, linking in to John Connaghan's delivery system
  - The NHS QIS inspection programme shaped people's ideas but QIS couldn't visit all services all the time – standards should be set.

#### KEY ISSUES: RESPIRATORY

22. Robert Stevenson reminded the meeting that a number of reports had been produced and there had been improvements since the cystic fibrosis report had issued in 2002 but problems had occurred in agreeing the revenue implications to implement the recommendations. Cystic fibrosis was planned and commissioned on a national basis for adults but not for children and young people: it should be planned nationally but delivered regionally and locally. Complex asthma should be planned regionally and delivered locally, approximately 3,000 children were involved. Home ventilation was a growing challenge: at present there were around 45 cases but this was expected to increase to about 120 by 2011. There were significant clinical governance issues in sustaining the delivery of this service under the current model. A complex care case

can cost from £250,000 - £500,000 per year. A number of services were identified as being vulnerable in the short to medium term.

23. There was concern that although the cystic fibrosis report had been published in 2002, it had still not been implemented. The challenges included: the sustainability of local services; staffing; education and training; and resources with an estimated requirement of £2.5m to implement the recommendations.

24. Possible solutions to the challenges included: establishing a national cystic fibrosis MCN but with a regionally delivered service; improved access to AHPs; increased investment; and provide nationally commissioned services with local requirements being taken into account.

25. During discussion it was suggested:

- Specific recommendations could be included in the National Delivery Plan for Specialist Children's Services
- Interim solutions should be found for "hotspots", eg many services were provided by a significant number of academic posts and universities were not so keen to support NHS work now
- Commissioning arrangements could be disentangled for specific conditions.

26. It was concluded that further detailed work had to be undertaken to address the outstanding significant issues, including the cost implications of the significant increase in demand.

## 5. ACTION POINTS/RECOMMENDATIONS FOR THE NATIONAL DELIVERY PLAN FOR SPECIALIST CHILDREN'S SERVICES IN SCOTLAND

27. Brian Dornan reported that similar issues were being raised by the different groups looking at other services suggesting that the current system of planning and commissioning had to change. It was suggested a mandatory audit could identify gaps in service provision, the data could be published and this would facilitate performance management. It was also suggested the clinicians would support that. It was suggested too that the HMI-led joint inspections could look at leadership, implementation of the Action Framework and service issues. At present there was a disconnect between planning and implementation. Those involved in implementation, eg local planners, should be involved in the planning stages.

28. It would be important to be seen to have reviewed services in a systematic way and not be seen to have reviewed some specialties and not others. There should be a clear divide between what services should be planned nationally and what should be planned regionally, separating specific conditions. A consistent model could be produced but there would still be resource prioritisation.

29. The Scottish Government recognised there was a disconnect between policy and implementation and it was keen to see implementation. It was interested in performance management but resources would be tight.

**Action: the discussions to be pulled together in a paper, which would be shared with those who had been unable to attend: the paper to be submitted for the**

**10 October meeting of Directors of Planning. A representative from this group should attend that meeting.**

30. Malcolm thanked everyone for taking part in such a full and helpful discussion.