NATIONAL STEERING GROUP FOR SPECIALIST CHILDREN'S SERVICES IN SCOTLAND: PRIORITISATION MEETING
THURSDAY 28 FEBRUARY 2008, CONFERENCE ROOM A, ST ANDREW'S HOUSE, EDINBURGH

Present: Malcolm Wright, Chief Executive, NHS Education for Scotland
Sharon Adamson, West of Scotland Regional Planning Group
Jennifer Armstrong, Senior Medical Officer, Scottish Government Health Directorate (by telephone link)
David Cline, National Planning Manager, Scottish Government Health Directorate
Lorraine Currie, Chair, Child Health Commissioners' Group
Deirdre Evans, Director, National Services Division
Rory Farrelly, Nursing Officer, Women and Children, Scottish Government Health Directorate
Graham Foster, Child Health Commissioner, NHS Forth Valley
Annie Ingram, North of Scotland Regional Planning Group
Morgan Jamieson, National Clinical Lead for Children and Young People's Health Services in Scotland
Heather Knox, Regional Planning Director, West of Scotland
Jan McClean, Regional Healthcare Planner, South East and Tayside (SEAT)
Jamie Redfern, General Manager, NHS Greater Glasgow and Clyde
Jackie Sansbury, Director of Strategic Planning, NHS Lothian
Anne Wilson, Action for Sick Children (Scotland)

In Attendance: Mary Sloan, Scottish Government Health Directorate
Louise Smith, Senior Medical Officer, Scottish Government Health Directorate
Robert Stevenson, Head of Children and Young People's Specialist Services Team, Scottish Government Health Directorate

Apologies: Karen McNicoll, SEAT

INTRODUCTION

1. Malcolm Wright opened the meeting by thanking everyone for their contributions to the development of the National Delivery Plan for Children and Young People's Specialist Services in Scotland. He reminded the Group that the budget had been confirmed by the Scottish Parliament and that an additional £2m in Year 1, £10m in Year 2 and £20m in Year 3 would be available for specialist children's health services. This funding would be as recurring as was possible – no restrictions would be imposed on using it for non-recurring purposes. Malcolm suggested this was a significant investment, and processes and principles had to be devised for allocating this money. That was the purpose of this meeting.

2. Malcolm went on to say that paragraph 47 of the National Delivery Plan acknowledged that its recommendations would have to be assessed and prioritised through formal NHS planning processes. A lot of work still had to be done as the Working Group reports were at various stages. Malcolm also pointed out that para 48 of the Plan set out key criteria that should be used during the assessing and prioritising process and that para 49

stated that the National Steering Group should refine the criteria and processes for prioritisation, using existing local, regional and national mechanisms.

TERMS OF REFERENCE – WHAT WE HOPE TO ACHIEVE

3. Malcolm hoped that as a result of the meeting a paper could be produced outlining how to get from A-B in terms of the prioritisation process.

4. During discussion the following points were raised:

- Myra Duncan had been taking the lead on behalf of the Directors of Planning: a session had taken place looking at the levels at which services were planned, the outputs from which had been circulated to those who had attended. These would be discussed again at a meeting in April before being circulated to other Groups
- Derek Feeley had led a prioritisation workshop with Directors of Planning which had looked at criteria – the National Steering Group should take account of the outcomes from that
- Another workshop would take place towards the end of April to pull together the planning work and to discuss workforce, financial issues, specialist services: planning structures would also be considered
- The work of the National Steering Group would have to stand up to independent scrutiny
- There was broad agreement on the outcomes of the reviews but the recommendations would have to go through formal planning procedures: some of the reports would stand up to independent scrutiny, others might need more work
- The recommendations in the Plan were not disputed but more robust evidence was needed to back them up
- The meeting today should identify the "must dos", the larger Steering Group should review the reports
- Services should be categorised into which needed national, regional or local planning
- The National Delivery Plan should set out a strategic framework, allowing for flexibility between the NHS Boards and regions
- Some of the recommendations in the Delivery Plan recommended a national approach – NHS Scotland had to be signed up for national services
- The Delivery Plan included priority actions
- It was easier to identify the high risk areas and to make a shortlist, eg investment in a consultant for haematology, but the Group had to understand the reports better to prioritise the other recommendations
- The Steering Group could take decisions on high risk areas but the planning systems already in place should prioritise the other recommendations
- The Plan aimed to put equitable services in place across Scotland but which would be delivered regionally
- There were local and regional planning processes in place but there wasn't a national planning process
- Some existing services should be formalised, eg neonatal transport
- A 3 year achievable and measurable implementation plan had to be developed
- Public health colleagues should be involved
- Regional ownership of the national services was needed: public involvement was also important. All Scotland-level decisions would be taken to the Board (including special

Board) Chief Executives but robust evidence would be needed. The Steering Group should work with the Chief Executives' Group on prioritisation

- Modernisation was crucial but lead in time for training would be needed
- The status of the recommendations was questioned as the consultation exercise was about to begin. It was suggested there was no need to await the outcome of the consultation exercise to take action on the "must dos"

5. Malcolm summed up by stating the significant level of new resources had to be prioritised and a process had to be developed for planning these extra resources. The meeting today would identify the "must dos": at the 14 April meeting, the main Steering Group would scrutinise the reports to make the evidence more robust and to identify the services which should be planned nationally, regionally or locally – but would it be possible to scrutinise all the reports in one day? Some work on evidence and prioritisation should be done to prepare for that meeting. The meeting on 31 March would sign off the process, decide which reports needed scrutiny and decide what questions should be put to the report authors. On 14 April, the Steering Group would then look at the reports. The outcome of the 14 April meeting should then be fed into the Chief Executives' Group who would take the decisions.

Actions:

Produce a cover sheet for each report outlining the recommendations broken down into different categories – those already extant policy, agreed as priorities by NSG and those requiring further work

Circulate reports again prior to 14 April meeting:

Invite report authors to the 14 April meeting.

CRITERIA

6. During discussion on criteria these points were raised:

- Services which were not doing well, based on available data, should be highlighted
- Clinical outcomes where European levels were not being met should be highlighted
- Early diagnosis was important (by paediatricians in primary care?)
- Categories for criteria could be:
    - Value for money
    - Improved quality, outcomes, benefits to patients
    - Sustainability
    - Strategic priorities for NHS

- Service priorities might be different in different parts of Scotland, eg where gaps existed in one part of Scotland but not in others
- Some services should be planned on an all-Scotland basis but would be run by regional teams
- Equity of services, taking account of resources available, would be important
- Access to services as close to home as possible had to be borne in mind: the balance should shift from tertiary services to District General Hospitals
- The criteria should include when it would be right for a child to see a general consultant and when he/she should see a paediatric consultant
- The policy context, eg *Better Health, Better Care* must be remembered
- Modernisation and capacity had to be considered
- The recommendations should be separated into clear categories, eg "must dos" etc

- Who would take the decisions about how much money would go into each service was questioned. Health Boards have the statutory authority
- The Steering Group must be careful not to "re-invent the wheel". Boards had the experience in planning but should existing criteria/mechanisms be used as the model or should the lead Board model be used instead?
- Boards could use their own prioritisation methods but national criteria was required
- A qualitative assessment of the recommendations was needed
- Not all the recommendations would require scrutiny, eg the recommendation to host an Age Appropriate Care conference wouldn't need to be scrutinised
- The paper to be developed for the 31 March meeting should set out how to handle scrutiny, prioritisation and criteria
- A list of urgent "to dos" should be produced after 14 April meeting for the Scottish Government to release funds. The Chief Executives should be consulted to agree the allocation of the resources, and to then manage them

Action:
Produce a paper outlining prioritisation principles for further discussion at meeting on 31 March.

SERVICES REQUIRING URGENT ACTION

7. The meeting agreed the services which required urgent action were:
- Rheumatology – perhaps the most urgent, requiring a consultant post
- Paediatric surgery – perhaps the second most urgent
- Children's cancer – high risk, MCN now established
- Gastroenterology – "falling over" in some areas
- Metabolic services – high risk
- Cystic fibrosis – high risk, MCN to be established
- Age appropriate care
- Managed Clinical Networks – these can make things happen but investment needed for Network offices. Some MCNs will be regional, some will be national. £85,000 needed to run a new Network in its first year. Those who have already set up a Network should be released to set up new Networks.

8. Other work needs to be done, eg defining what "regional consultant" means - a consultant working in an outreach model from the centre but with infrastructure in other areas with dedicated sessions? It was challenging though for Boards to provide infrastructure capacity. Telemedicine must be more linked up and held to account.

9. Should the new resources be micro-managed at national level or should each Board decide how to allocate the earmarked funding? Services can be improved if someone is held to account. Training would be essential. The approach already taken for cardiac services was put forward as a potential model The meeting on 31 March should look at Network support, infrastructure and general surgery .

Action:
Proposals to be produced for next meeting to address the capacity and immediate service issues identified in the discussions- RPG's and NSD.
Deirdre Evans to produce a paper on MCN infrastructure investment.
NHS Education for Scotland to analyse the National Delivery Plan and to bring forward proposals for education and training programme to support development of new roles..

RESOURCE ALLOCATION

10. During discussion it was pointed out:

- Resources must be allocated nationally for national services and allocated regionally for regional services
- Any national oversight would require national resources
- There was a strength in allocating resources to the regional planning groups who would then split the money between regional and local services
- People will expect the Arbuthnott formula to be used: tertiary services only work if local services are in place: investment would be needed in DGHs as well as in the specialist centres
- The resources should be directed where there were gaps, eg for cystic fibrosis the gap was in primary not tertiary care
- The money should be allocated where it was most needed and where it would be best used
- Additionality needed and the process would have to be performance managed.
- Processes were already in place, eg MCNs were required to produce 6-monthly and annual reports
- Consideration must be given to what information was needed before making the decisions.
- Outcomes must be measurable. There must be evidence on how the investments have improved services
- A multi-disciplinary approach must be taken, eg where a new consultant was required, other back-up posts would also be needed
- Existing regional mechanisms should be used based on what had worked in the past for example cardiac and cancer arrangements.

11. Malcolm summed up by saying the existing planning structures should be used to allocate the resources. He went on to thank everyone for their contributions to the meeting and reminded them that a lot of work needed to be done before the 31 March meeting.

Action:

Representatives to submit examples of existing processes that are in place to Robert Stevenson.