NATIONAL STEERING GROUP FOR SPECIALIST CHILDREN'S SERVICES IN SCOTLAND
MINUTES OF MEETING: 7 MARCH 2007
BEARDMORE CONFERENCE HOTEL, CLYDEBANK

Present:
Malcolm Wright, Chair, Chief Executive, NHS Education Scotland
Dr Michael Bisset, Clinical Director, Royal Aberdeen Sick Children's Hospital
Helen Byrne, Director of Acute Services Strategy Implementation and Planning, NHS Greater Glasgow and Clyde
Dr Zoë Dunhill, Patients' Services Director and Community Paediatrician, Royal Hospital for Sick Children, Edinburgh
Deirdre Evans, Director, National Services Division
Jamie Houston, Consultant, Oban and Lorne Hospital
Heather Knox, West Regional Planning Manager, West of Scotland Regional Planning Group
Annie Ingram, North Regional Planning and Workforce Director, North Regional Planning Group
Morgan Jamieson, National Clinical Lead for Children and Young People's Health in Scotland
Anne Leigh-Brown, Information Services Division
Isabel McCallum, Clinical/Project Director – Reprovision of Royal Hospital for Sick Children, Edinburgh
Iain Wallace, Associate Medical Director, NHS Greater Glasgow and Clyde, Women's and Children's Directorate

<u>In Attendance</u>
Dr Ian Bashford, Senior Medical Officer, Scottish Executive Health Department
Andrea Cail, Senior Project Manager, Children and Young People's Specialist Services Team
Rory Farrelly, Nursing Officer, Women and Children, Scottish Executive Health Department
Dr Margaret McGuire, Nursing Officer, Scottish Executive Health Department
Ken Mitchell, Senior Project Manager, Children and Young People's Specialist Services Team
Chris Ridley, Senior Project Manager, *Getting it Right for Every Child*, Scottish Executive Health Department
Mary Sloan, Child and Maternal Health Unit, Scottish Executive Health Department
Robert Stevenson, Head of Children and Young People's Specialist Services Team, Scottish Executive Health Department

<u>Apologies</u>
Colin Cook, Head of Healthcare Planning and Support, Scottish Executive Health Department
Professor Sir Alan Craft, Past-President of the Royal College of Paediatrics and Child Health
Fiona Drimmie, Associate Postgraduate Dean, NHS Education for Scotland
Myra Duncan, Regional Planning Director, South East and Tayside Regional Planning Group
Ellen Finlayson, CLIC Sargent
Rosie Ilett, Child and Maternal Health Division, Scottish Executive Health Department
Professor Stewart Forsyth, Medical Director, NHS Tayside
Jacqui Lunday, Scottish Executive Health Department
Jackie Sansbury, Director of Strategic Planning, NHS Lothian

Rebecca Strachan, Action for Sick Children Scotland
Wendy Wilkinson, Workforce Unit, Scottish Executive Health Department
Professor George Youngson, Consultant Paediatric Surgeon, NHS Grampian

ITEM 1: WELCOME AND APOLOGIES

1. Malcolm Wright welcomed everyone to the 4th meeting of the Steering Group, he particularly welcomed Chris Ridley who has joined the Child and Maternal Health Division of the Scottish Executive Health Department to work on the health aspects of *Getting it Right for Every Child*. Malcolm went on to say the key issue for the day would be discussing the core content of the National Delivery Plan which is due to be issued for consultation in October. He wanted to discuss the shape of the Plan, the key areas it should cover and the process of how to develop it. He informed the meeting that a small group had met 2 days ago and Robert Stevenson would be presenting the proposals which had emerged from that meeting.

ITEMS 2 AND 3: NATIONAL DELIVERY PLAN – CORE CONTENT AND DEVELOPMENT PROCESS

2. Robert Stevenson reminded the meeting that a range of workstreams were underway - some were well advanced, others were just starting. Interim reports were due by the end of March. The Steering Group now had to consider how to manage the next stage of the project. Final reports were due June-August with the aim of producing the National Delivery Plan for presentation to the Minister by October 2007. If substantive changes are proposed this would probably be followed by a period of formal consultation for three months .

3. Robert suggested it would be useful to discuss how to structure the interim reports to inform the final report. It would be helpful to have an early indication on models of care – the suggested 3 or 4 levels seemed to suit most workstreams. The reports should take account of not just the national situation but also regional critical mass and local delivery. Any workforce issues emerging should be shared with Annie Ingram. Financial information also had to be gathered. Decisions should not be taken in isolation, thought must be given to interdependencies with other services. Risk analysis had to be considered too, for example what were the risk issues for delivery/sustainability in the short, medium and longer term?

4. There was a range of services where intervention would be needed within the next 12 months: cancer could potentially be managed: It would be important to identify any areas that would require support over the next 6 to 12 months. The final reports should look towards a 3-5 year horizon and should be evidence based.

5. Stewart Forsyth had helpfully drafted what the core content of the National Delivery Plan might look like. Models of Care would be crucial. The mechanism for establishing national and local MCNs was in place however a gap had been identified at regional level. Also current mechanisms don't deal with all staffing and resource issues. The National Delivery Plan should be clear on resourcing and spell out what should be delivered at national, regional and local level. Coherent planning and resourcing, developing the workforce, performance management, training and education would also be crucial in delivering the overall aims of the project.

6. The Health Economics Research Unit was working with the Steering Group on the cancer services option appraisal. The intention is to roll out the lessons from this exercise to identify baseline costs and activity for services and to carry out an economic evaluation of the final Delivery Plan. The links with business planning for the new children's hospitals remain an essential element of the overall approach. Robert suggested the Steering Group had a real opportunity to get specialist child health services right, however we shouldn't underestimate the challenges involved. .

7. Once the interim reports had been received they would be pulled together, distilled and the key messages would be identified at local, regional and national level. They should suggest what would be sustainable in the 4 main centres. Coherent, simultaneous decisions would have to be taken on, for example, cancer, general surgery, neurosciences.

8. During discussion it was pointed out that, due to the problems of data collection, the workforce interim report would not be available by the end of March. A key issue would be the sustainability of community services which rely on child health doctors. Concerns were raised about the availability of data in relation to service provision and how workforce recommendations that are made will be validated. Malcolm assured the project leads that any issues in relation to support should be discussed as early as possible so that steps could be taken to ensure that is provided. The amount of work that was underway in this Delivering for Health workstream was recognised as being particularly challenging and that extra resources were being sought to support the work of the Steering Group. Project leads were asked to contact Malcolm or Robert to discuss what extra support could be given. Malcolm reinforced his appreciation of the support that members of the Group and the clinical leads had shown in taking this project forward.

9. The meeting was reminded that the Scottish Association of Community Child Health was also considering the issue of workforce. This was a serious issue due to Modernising Medical Careers and an ageing workforce. Zoë Dunhill was to write a short paper on Community Child Health for the main Children and Young People's Health Support Group. It was pointed out that the Steering Group should engage with NHS Quality Improvement Scotland (QIS) to discuss governance and standards of care. NHS Education for Scotland (NES) was also addressing the workforce issue.
Action: Consideration to be given how the Steering Group can support the work of the sub-groups. Robert Stevenson to discuss with SEHD how it can provide further support.

10. The service in Edinburgh was being redesigned by 9 sub-groups. A conference would be held in April. Some Steering Group members were to meet soon with those planning for the new children's hospitals in Edinburgh and Glasgow.

11. It was pointed out the laboratory/diagnostic workstream hadn't yet started although some decisions had already been taken in Edinburgh and Glasgow – laboratories would be integrated with adult services , however concerns were raised about maintaining the specialist knowledge required for children's services in the new configuration. It was queried whether child health diagnostics, and neurosurgery, could be fast tracked. Bottlenecks in paediatric diagnostics were impacting on waiting times. It was suggested the Steering Group could engage with the National Pathology Network.

12. It was also pointed out that some project leads, for example dermatology, haematology and rheumatology, were having to play "catch up" as they had not undertaken work for the Steering Group, or the CYPHSG, before.

13. Malcolm summed up by saying the interim reports should give the main messages, highlighting the themes and challenges which had come out of the work so far, and what services each centre should provide. Thought would then be given on how to pull the reports together.
Action: Workstream leads to be informed of the timetable and what the interim reports should contain.
Interim reports to be submitted by the end of March. They should address resource implications, workforce and training and what steps need to be taken to complete the full reports,.
Next meeting to consider the content of the National Delivery Plan in workshop format.
Consideration to be given how to take forward paediatric diagnostics.
Invite all sub-group leads to the June meeting.

ITEM 4: MANAGED CLINICAL NETWORKS

14. Morgan Jamieson reported that a report from the Working Group had been passed to National Services Division last year and that discussions had taken place with Regional Planning Groups. The report was now nearly in final form and it was hoped to issue it in the near future. Deirdre Evans reported that she was awaiting comments from the Regional Directors – a revised version would be circulated to the Steering Group.
Action: Deirdre Evans to revise MCN strategy in light of comments received from Regional Directors.

ITEM 5: MODELS OF CARE

15. This item was not taken as Stewart Forsyth was unable to attend.

ITEM 6: PLANNING AND COMMISSIONING

16. Morgan reminded the meeting that he had produced a paper for the May 2006 meeting and it had since been circulated for comment. Morgan had provided a resume of the comments he had received but was still awaiting further substantive comments from Glasgow. The paper had been discussed with Derek Feeley of the Scottish Executive Health Department who had emphasised that the statutory role of Health Boards should be reflected in the approach and Regional Planning Guidance had to be acknowledged.

17. The comments Morgan had received had been generally supportive of bringing planning and commissioning together at a regional level. There had been less interest, and some resistance, to the operational model, for example the specialist hospitals being responsible for District General Hospitals (DGHs). There had not been a lot of response to the proposal to bring together supra-national planning and commissioning – how would national planning be done for the national services run by National Services Division (NSD) and how should regional commissioning for children's services be taken forward?

18. Morgan had also circulated an English paper which recognised the value of a consortium approach to regional planning.

19. Helen Byrne tabled the response from Glasgow with apologies for the delay. She commented that Glasgow

- had an issue around MCNs, in particular with lines of communication. The role and purpose of an MCN had to be clear
- saw no merit in the unification of operational management. Greater accountability would exist with a hub and spokes model
- Saw merit in combined planning and commissioning for national services
- Wondered how local arrangements for planning would play in to the wider agenda.

20. Deirdre pointed out that Paediatric Intensive Care Units (PICU) were an example of how operational management could work – a single service run across 2 sites with no one Health Board having lead responsibility. For a number of national services national commissioning is the link, one service being delivered across a number of sites.

21. During discussion the following points were raised:

- Who would take responsibility for one service running across different sites?
- One centre operationally managing DGHs was probably not workable
- The specialist centres would not want to operationally manage the DGHs – DGHs and their hub should work more formally together
- The key word was "formal": some regional structures were not formalised – more resources were needed
- In small populations, eg the islands, professionals did not have the expertise to know what should be commissioned – there was ambiguity where responsibility began/ended
- In North America, the main hospital ran inpatient facilities in local hospitals – ie one service run over a number of sites, this model could strengthen DGHs in Scotland
- No one person is responsible for neonatal transport – this wasn't ideal, Scottish structures weren't ready
- How different was the formal hub and spokes model compared to regional arrangements?
- The paper had not been tested against the 2009 Working Time regulations challenge – this was important. A coordinated approach was needed because specialists would probably only be based in the main centres – acutely unwell children may need to be managed outwith these centres for up to 24 hours before being transferred
- Scotland did not have commissioning in the same sense as England, with the exception of NSD
- The National Steering Group should work with Derek Feeley who was doing work with the Directors of Planning
- Community children's services, for example neurodisability and child protection, needed to be considered at a high level and needed quality assurance
- Good models existed for hearing impairment and autism
- Health Boards had the statutory obligation to plan, commission and provide services and were ultimately accountable. Difficulties arose on getting Health Boards to agree to regional planning decisions. Decisions had to go through a process to get Health Boards signed up to invest in services
- Problems could arise if a Board didn't want to sign up to national and regional recommendations.

22. Malcolm summed up by querying the purpose of reviewing planning and commissioning. Where would the benefit to patients derive from? DGHs would have to align planning and commissioning with pathways of care, linking with MCNs. Operational management had to recognise the statutory responsibility of Health Boards and the role of the regions. Support had been expressed for formalising the hub and spokes model on a regional basis. Because Scotland did not have the same commissioning arrangements as England, Boards had to concentrate on planning but resources would be needed.

Action: Morgan Jamieson to revise planning paper in light of comments made with the aim of firming up recommendations for discussion at the next meeting of the Steering Group in June.

ITEM 7: TELEMEDICINE

23. Morgan reminded the meeting that telemedicine was included in the Steering Group's workplan. He wanted to flag up to the Group though that there was an ongoing Paediatric Telemedicine Project. The Centre for Telehealth had agreed to the setting up of a Paediatric Telemedicine Network which would link up and improve access to services around Scotland. A meeting had been scheduled for April to set up a Steering Group to take forward the organisational arrangements for the Network

ITEM 8: INFORMATION SUB-GROUP

24. Anne Leigh-Brown informed the meeting that the majority of the work had been completed although some tasks were still in progress. There was still some outstanding cancer work – looking at the impact on other services. She was also working with regional groups eg with Tom Beattie re paediatric trauma. She was also looking at data on workforce and working with Deirdre Evans on the High Dependency Unit (HDU) Audit.

25. As all the workstreams' work should be informed by data and be evidence-based, it was surprising Anne had not been requested to provide more data.

26. Mike Bisset brought up the related issue of information technology. He reported that the Scottish Executive was rolling out a toolset to support Networks. 53 declarations of interest had been received, 7 from paediatric/neonatal networks. There was local and regional buy in but national support was needed. Every Network should use these systems and Mike wondered how NSD or the Steering Group could support this work.

27. Deirdre reported she was awaiting the forthcoming MCN circular. Every Network required funding to set up, this funding had not been top sliced from Boards to date. A second funding stream to backfill for the lead clinicians working with Networks would be required.

28. During discussion it was pointed out:

- A requirements gathering exercise for child health would be undertaken by ISD
- Specialities should be able to communicate with each other
- One core national system with individual Networks should be set up
- Thought would need to be given on how best to take this forward.

ITEM 9: WORKFORCE

29. Workforce census forms had been developed to obtain a baseline of the specialist workforce. A colleague, Sandra Hay, was looking at nursing: a meeting with AHPs was scheduled for May. The workforce sub-group was not progressing as quickly as had been hoped because of the lack of data and staff changes. This sub-group would probably be unable to produce an interim report by the end of March.

30. During discussion the following points were made.

- The Workforce Planning Project had produced a final report which contained a paediatric tool
- The Scottish Executive had commissioned a mapping exercise of children's community based care – a report was due in July
- A fit-for-purpose workforce was dependent on the development of the specialist nursing roles within Community Health Partnerships (CHPs): pay, rewards and contractual issues had to be addressed
- The enhanced skills of specialist nurses was not being recognised
- The job descriptions developed in 2004 for nurse specialist roles had not been pitched properly
- A lot of angst existed re the Agenda for Change banding – training and support was needed.

ITEM 10: PROJECT PLAN SUMMARY

31. Robert Stevenson said the project plan summary gave an overview of the current state of play and included key dates. This workstream was the most complex of all the Delivering for Health workstreams. This work had to tie in with the development of the new children's hospitals. The specialist services workstream was broadly on track, the next 6 months would define what could be achieved.

32. The meeting agreed this was a big chance to get specialist children's services right, although difficult decisions would have to be taken.

ITEM 11: METABOLIC SERVICES

33. Zoë Dunhill wanted to acknowledge publicly the help the Sick Children's Hospital in Edinburgh had received from the Sick Children's Hospital in Yorkhill, Glasgow. She reported Lothian were on target to recruit a paediatrician who would link in with colleagues in Aberdeen and Dundee. The Managed Clinical Network (MCN) had been approved. Dietetic support remained an issue – some patients had to be referred to Glasgow – but Zoë was optimistic this problem could be resolved.

34. During discussion the following points were raised:

- This service needed a national approach. Boards had to be committed to replacing staff.
- Some specialist services were provided by academic staff who were not funded by the NHS: universities could pull out at any time
- It would be worth considering a model of how to work together in the future.

35. Malcolm acknowledged that this service had moved on and welcomed the action taken by the South East and Tayside (SEAT) and NHS Lothian and the support from colleagues in Glasgow.

ITEM 12: AGE APPROPRIATE CARE

36. Morgan Jamieson reported that the boundaries for age appropriate care were not clear cut, issues around adolescent care had to be taken into account too. He hoped to hold a conference at the end of the year/beginning of next year on adolescent care. He said the work of the group included or would include:

- A meeting with Information Statistics Division (ISD) to discuss available data
- Consideration of training issues in secondary care
- Engaging with young people
- Developing good practice models
- Conducting a telephone survey with the lead Child Health Commissioners
- Working with Chris Kelnar re transition from paediatric to adult services
- Producing an interim report by early April.

ITEM 13: GENERAL SURGERY

37. Ken Mitchell reported that he had now received the baseline data he had requested and that had included some workforce information. Three visits had been undertaken – these had been interesting and had provided an opportunity to tease out some of the challenges, eg rural issues. Some potential models of care probably involving inreach/outreach had been identified. In remote and rural areas only simple surgery is carried out on children - emergency care was also an issue.

38. George Youngson and he were to meet with Annie Ingram to discuss models re a rural team approach in District General Hospitals (DGHs), and paediatric and specialist nursing roles, eg surgeons carry out the operation but medical paediatricians and medical staff look after the children afterwards. Three more visits were planned, as were discussions with some other specialties, eg orthopaedics and ophthalmology.

39. In its report, the Sub-group will comment on adult anaesthetists treating children. Experience could be gained through dental paediatric anaesthesia.

ITEM 14: PAEDIATRIC INTENSIVE CARE

40. Deirdre reported the PICU MCN would be under national coordination for 5 years, thereafter the long-term operational management would come from 2 sites. It would be a national service from 1 April 2007 until 31 March 2012. It would then be delivered by Boards as a single service but on 2 sites. The estimated additional cost would be £3.8 million: 73 additional nurses would be needed but they wouldn't all be recruited in the first year.

41. Governance might be an issue with both, NHS Lothian and Greater Glasgow and Clyde wanting to retain operational management for their service. The solution might be to bring in a third Board. Transport and repatriation were also difficult, but not impossible, problems. It was suggested that the Paediatric Critical Care Network might have a role to play. The experience of established MCNs should be taken into account.

42. During discussion it was pointed out:

- A robust evidence base must be included in all the workstreams' reports

- Work was being done on the financial implications for the cancer workstream
- There was a direct link between paediatric and neonatal intensive care
- It was difficult to get academic institutions on board – post-registration courses were not run in Scotland.

ITEM 15: CANCER SERVICES

43. Andrea Cail stated that work on the cancer services review was ongoing. She acknowledged the frustrations expressed at the 7 February non-financial option appraisal meeting. She also acknowledged that not enough detailed information had been available but one of the difficulties was that no clear model of care had yet been identified. The NICE guidelines had to be taken into account. Andrea suggested the ideal solution would be for an MCN over the 4 sites but this would require one person to lead, manage etc the MCN. The 7 February meeting had not produced a clear result on whether there should be one or 2 main sites. It had been agreed that the meeting would be reconvened in June at which the economic appraisal and cost implications would be discussed.

44. The next stage of the sub-group's work would be to meet with Directors of Finance, Medical Directors etc to decide on future provision. Andrea reported that she expected a conclusion to have been reached by June. The recommendations would be included in the National Delivery Plan.

45. The following points were raised during discussion:
- It would be helpful to tie in with regional planning colleagues
- A children's nursing representative should be on the sub-group
- It would be helpful to discuss with Deirdre Evans the problems of setting up the PICU MCN
- It was clear what services should be provided in Level 1, 2 and 4 centres but what should be provided in Level 3 centres was less clear
- No agreement had yet been reached on levels of shared care
- Clarity on the future model of care was essential and costings on the new model was also essential.

ITEM 16: LINKS WITH OTHER *DELIVERING FOR HEALTH* WORKSTREAMS

16.1 Neurosciences

46. Malcolm Wright reminded the meeting that the neurosciences timetable differed from that of this Steering Group. He had spoken with John Glennie who was leading on the neurosciences review. He was agreeable to the Steering Group taking the lead for paediatrics - John Glennie, Malcolm Wright and Derek Feeley were to meet shortly. Paediatric neurosurgery was integral to many of the Steering Group's workstreams – the review of paediatric neurosciences may need to be brought forward.

16.2 Remote and Rural

47. Annie Ingram reported that the work of this sub-group was progressing and that an interim report would be submitted by the end of March.

ITEM 17: MINUTES OF PREVIOUS MEETING: 5 DECEMBER 2006

48. The minutes of the previous meeting were approved.

ITEM 18: MATTERS ARISING

49. There were no matters arising.

ITEM 19: DATE OF NEXT MEETING

50. The next meeting will take place on Wednesday 6 June in Dundee – venue to be confirmed. This meeting will be run in a workshop format focusing on the development of the National Delivery Plan.