

Scottish Child Health Commissioners' Group

Note of meeting held on 9 September 2008
BMA, Queen Street, Edinburgh

Present:

Lorraine Currie (Chair)	NHS Grampian
Charles Clark	NHS Lanarkshire
Kathy Collins	NHS National Services, Scotland
John Froggatt	Scottish Government, Child and Maternal Health Division
Jennifer Milligan	NHS Dumfries and Galloway
Cathy Orr	NHS Lothian
Maxine Moy	NHS Fife
Alastair Philp	Information Services, NHS National Services Scotland
Mary Sloan	Scottish Government, Child and Maternal Health Division
Robert Stevenson	Scottish Government, Child and Maternal Health Division
Joy Tomlinson	NHS Ayrshire and Arran

In attendance:

Jonathan Sher	Children in Scotland
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1. Welcome and apologies

1. Lorraine Currie welcomed all in attendance. Apologies were received from –

Sally Amor	NHS Highland
Jim Chalmers	Information Services, NHS National Services Division
Emelin Collier	NHS Western Isles
Graham Foster	NHS Forth Valley
Elaine Grieve	NHS Orkney
Morgan Jamieson	Scottish Government, Child and Maternal Health Division
Catriona MacDonald	NHS Greater Glasgow & Clyde
Caroline Mackie	NHS Tayside
Grace Moore	NHS Ayrshire and Arran
Chris Ridley	Scottish Government, Child and Maternal Health Division
Dr Louise Smith	Scottish Government, Senior Medical Officer, Women and Children
Sarah Taylor	NHS Shetland

2. Lorraine informed the meeting that Cathy Orr was to retire shortly and this would be her last meeting. Lorraine thanked Cathy for all her work on behalf of the Child Health Commissioners' Group. Cathy thanked Lorraine and said she had enjoyed working with the Group and had welcomed their support.

2. Minutes of previous meetings

3. The minutes of the 9 April meeting were agreed.

4. The minutes of the 17 June meeting were agreed. Item 8, Child Psychotherapy - Charles Clark reported that training was an issue which was to be considered by NHS Education for Scotland. If Boards funded 5 training places, that would be sufficient to run a course in Scotland. It was difficult to obtain funding for Part 2.

Action: Invite Caroline Inwood to the December meeting to update on Hall 4 implementation.

Charles Clark to update the December meeting on the Health Plan Indicator (HPI).

3. Early Years Framework Progress

5. John Froggatt reported that an amended version of the Framework had been submitted to the Programme Board and would be circulated again. It would then be submitted to Ministers before publication in the late autumn. Implementation would be considered thereafter. The comments had been mainly positive, although the timescales had been a concern. Emphasis would be on the actions outlined in the Framework and the possibility of shifting resources into early years services. The Framework covered pre-birth-8 years and although provision was not just the responsibility of health, the importance of health was recognised in the Framework.

4. Review of Residential Care

6. Lorraine reminded the meeting that Bronwen Cohen, Chief Executive of Children in Scotland, had invited a health representative to take part in the review of residential care in Scotland. The Child Health Commissioners had invited Bronwen to its meeting to clarify what the health service was being asked to do. Jonathan Sher, Director of Policy, Research and Practice Development, Children in Scotland, was representing Bronwen at the meeting.

7. Jonathan began by giving a short overview of Children in Scotland. Bronwen Cohen was involved in developing the Early Years Framework, and had led an international conference on early years. Children in Scotland recognised the strong connection on how well children do in the early years and how likely they were to have to go into residential care.

8. Jonathan went on to say Children in Scotland had produced a variety of publications, eg:

- *Northern Lights* which explained the concept of nature kindergartens, ie nurture through nature with children being outdoors much of the time and who

were healthier than those who attended regular childcare centres. Kindergartens appeared to be particularly helpful for children with behavioural problems and those with special needs. Bronwen had been in Norway recently with the Minister for Children and Early Years to look at the Nordic model.

- *Working it Out* which looked at the children's sector workforce – a national conference had taken place in 2008 and another was planned for 2009. Children in Scotland are in favour of a Scottish pedagogue model, ie pulling together separate job titles which covered similar roles. It encouraged taking a holistic view of child health which encouraged both emotional and physical development.

9. Jonathan concluded by saying Child Health Commissioners were welcome to become members of Children in Scotland.

10. Turning to the Residential Care review, Jonathan reported the review was in 2 parts. He said a good deal of attention was now being paid to looked after and accommodated children – the Scottish Government had produced a new corporate parenting document. Educational statistics were easy to pull together for LAAC, their outcomes were poor, but it was not easy to extract health statistics although it was thought these would be equally concerning. A toolkit had been issued to NHS Scotland on caring for LAAC – Caroline Selkirk could perhaps be invited to a meeting to discuss it.

11. Jonathan reported that the Care Commission had focused on mental health issues in the past year and that physical health and wellbeing would be the focus in the coming year. He suggested Child Health Commissioners may wish to engage with the Care Commission.

12. The Scottish Journal of Residential Childcare (SIRCC) was to publish a special issue in 2009 on the health of children in residential care and was currently inviting papers – again the Child Health Commissioners may want to contribute. SIRCC's September magazine gave contact information, copies obtainable by emailing sircc@strath.ac.uk.

13. Jonathan reported the project Children in Scotland was helping to develop was in its first year. It would look at the "Truth and Consequences" for the boys in Paisley's Kibble Education and Care Centre. It had been running for 150 years and was now well-recognised and well thought of for residential care for boys from age 12 years. It took boys from all local authorities in Scotland who had significant problems or for whom other interventions hadn't succeeded. Kibble was expensive and was a last resort for local authorities. The research project would not be about evaluation or inspection – it would be about the boys themselves, ie

- What was true of the boys before going to Kibble
- What was true of the boys about their Kibble experience
- What was true of the boys after leaving Kibble.

14. No boy had had a serious medical evaluation before going to Kibble to detect underlying physiological problems which could have been caused by foetal alcohol, lead poisoning, trauma, abuse/neglect. The Chief Medical Officer, Harry Burns, and the Chief Scientist's Office were interested in this research, in particular in protocols.

Jonathan stated the research wouldn't be quick or easy. Consent would be important – children have the right to be informed, heard and heeded. Clarity was also needed on what was meant by a medical assessment – psychological, physiological, medical? Children are generally thought to be competent to give consent at 12 years and above. Consent is easier to obtain in an atmosphere of trust.

15. The research programme was still getting the right multi-disciplinary team together and was taking advice from the Chief Medical Officer and the Chief Scientist's Office. Child Health Commissioners were welcome to become involved.

16. Maxine Moy had agreed to be the Child Health Commissioner representative on the commissioning sub-group. The group was chaired by the Chair of NHS Highland, the only NHS representative. The group was looking at the commissioning process which was not just about procurement. The English system was being looked at and the sub-group was considering whether commissioning should be undertaken by the 32 local authorities or whether it should be done regionally. Guidance will issue to local authorities on how best to commission. She reminded the meeting of the difficulties of getting consent from children to undertake a medical examination and they may not attend appointments. Good communication was important, children should be told what to expect – a leaflet should perhaps be produced. The children may not have had the opportunity for a medical or they may not have consented.

17. During discussion, the following points were raised:

- The LA nurse was successful, with direct phone links. Perhaps better than having to see a paediatrician but an LA nurse wouldn't be able to cover all the issues a paediatrician could
- basic, non-invasive, neurological tests could be carried out, but by whom?
- It was still unclear what was being asked of the Child Health Commissioners
- SIRCC was running the project – volunteers would probably have to commit one day per month
- Local authorities did not think that the NHS engaged well with other partners: child health commissioners were not well-known
- The review was covering residential care for LAAC and not respite care
- Community family partnerships were critical
- Local authorities struggle to provide supported accommodation for children with extreme behaviour problems – whose budget should support them, NHS or LAs?
- Local authorities don't get together to plan/commission
- Community planning and integrated children's services planning are done separately
- The research must link in to the Early Years Framework (Jackie Brock, Scottish Government Education Directorate, was on the Commissioning sub-group).
- SIRCC was leading on the project.

Action: Maxine Moy to send her papers to Lorraine Currie. Maxine would welcome comments from Child Health Commissioners.

5. Specialist Children's Services – Update on National Delivery Plan

18. Robert Stevenson reported the National Delivery Plan (NDP) will be published in October. The timescale was challenging but the consultation exercise had been successful. Positive comments had been submitted – the right issues had been addressed – but questions had been raised on how best to take it forward and how to implement it. The NDP was being amended in light of the comments received.

19. Robert went on to point out that specialist children's services had been highlighted in the Scottish Government spending programme and were a Scottish Government priority. The issue of Child and Adolescent Mental Health Services (CAMHS) was still being raised and was being pursued by the Children and Young People's Health Support Group. Caroline Selkirk had discussed CAMHS with the Chief Executives' Group and their response was awaited.

Action: CAMHS representative to be invited to the December meeting.

20. Robert pointed out that the National Steering Group for Specialist Children's Services in Scotland had agreed the criteria for implementing the NDP and for allocating the specialist children's services funding. £2m was available in 2008-09. bids of £2.8m had been received. Allocations had been based on the agreed criteria. John Froggatt had chaired a meeting on 26 August to discuss lessons to be learned from the process. Allocation letters had been issued, Child Health Commissioners had been copy recipients. The funding had focused on Managed Clinical Networks (MCNs), direct service developments, telehealth, and Information Statistics Division (ISD) work on outcomes.

21. Bids for the 2009/10, £10m funding were to be submitted by the end of December. A National Delivery Plan Implementation Group, chaired by Caroline Selkirk, had been established and had met for the first time on 5 September. It had a challenging work programme. It was to meet 6-weekly and were likely to host a conference/workshop event early in the New Year. The Group had agreed key steps on communication and were to publish bulletins/newsletters. The membership would include professional representation. The Group would encourage better regional working to agree priorities and would identify leads.

22. John Froggatt pointed out that the criteria had been set out for the bids for Year 1 and that the bids had been judged against the criteria. The Children and Young People's Health Support Group (CYPHSG) had encouraged reconciliation of bids and good communication/cooperation among regions, NHS Boards, Special Boards etc.

23. During discussion, the following points were raised:

- The first meeting of the Implementation Group had been positive
- Pan-Scotland services referred to services being delivered by the regions: national services were those delivered by National Services Division (NSD)
- The Directors of Planning were leading a review on the gap between the NSD role in nationally-designated services and the services run by the regions
- It had been agreed at the 5 September meeting that regional planning directors would take a lead role, eg Annie Ingram – children's cancer: Myra Duncan – respiratory

- The consultation on cancer services had shown that more regional planning was required: a Managed Service Network (MSN) will be considered. MCNs deal with quality issues but don't deal with planning/commissioning. Pilots will be run to formalise and develop MSNs
- The Chief Executive letter (CEL 20) had set out that the CYPHSG were responsible for implementing the Best Possible Start chapter of *Better Health Better Care* (which referred to the NDP). The Support Group had decided to establish the Implementation Group. Malcolm Wright, Chair of CYPHSG and Chief Executive of NHS Education for Scotland (NES) linked into the chief executives: Derek Feeley led for the Scottish Government
- The aim of implementing the NDP and of the £32m funding for specialist children's services over 3 years was to get the best possible services for children
- There should be no lack of clarity on how the year 1 funding should be spent as a spreadsheet had been circulated: any lack of clarity should be put to the Implementation Group
- The work on CAMHS was welcomed but concern was expressed that Chief Executives seem to think the specialist services funding can be used for CAMHS: CAMHS need more investment but other specialist services do too
- ISD had a role in supporting the Implementation Group on outcomes/performance management: Deirdre Evans was the main link person, ISD could also be represented on sub-groups but ISD needed to know what was expected of it

Action: Mary Sloan to circulate the minutes of the Implementation Group meeting to Child Health Commissioners.

6. Representation on the Additional Support Needs Advisory Group

24. Charles Clark reminded the meeting that he was the Child Health Commissioner representative on this Group but would like to step down. The Group met twice a year. After discussion, it was agreed that as there was an Allied Health Professional representative on the Group, the child health commissioners need not be represented. However if the policy context should change, Child Health Commissioners would like to be invited back on to the Group.

7. Update on Action Framework

25. Robert Stevenson thanked the Commissioners for their returns. He hoped the summary table had been useful to allow Boards to compare themselves against others. CAMHS had a lot of amber, and some red: remote and rural was also a concern. The Action Framework would be reviewed to update it with new initiatives, eg eHealth, and to tie in with the Early Years Framework and with *Better Health Better Care*. NES was funding a team to address training and education for child health staff.

26. During discussion, it was suggested

- It would be useful for Boards with difficult areas to match up with more successful Boards in that area
- Child health was not high, or did not feature, in accountability reviews

- A presentation could be given to Chief Executives if it was thought that would be helpful
- HMIE were interested as they were still intending to undertake broad inspections but it was still unclear what they will be inspecting regarding child health services
- Discussions were ongoing with QIS on their role: there was still a commitment to undertake joint QIS/CYPHSG visits
- Concern was expressed that child health already had a lot of performance management, the visits would create a lot of extra work
- Patient safety had to be considered – Cincinnati Children’s Hospital had developed indicators – should a balanced score card approach be used or should outcomes be mainstreamed with HEAT targets?
- Data collection is a gap but discussions need to take place on what data should be collected.

Action: CHCs to suggest ideas to Robert Stevenson for improving presentation of Action Framework implementation.

Robert Stevenson to further analyse the themes and to go back to the Boards on the “red” issues.

A joint CYPHSG/CHC meeting to be arranged.

8. Palliative Care

27. Lorraine Currie reminded the meeting that 4 nurse consultants had been appointed to develop a paediatric palliative care strategy. They were based in Glasgow, Edinburgh, Tayside and Aberdeen. They had been appointed nationally.

Action: Invite Mags McGuire to update the Group on the work of the nurse consultants and on the Review of Nursing in the Community. If she is unable to attend, request a written report.

9. Paediatrician input to HMIE Inspections

28. John Froggatt reported that discussions were ongoing between HMIE and RCPCH regarding child protection. It was hoped a paediatrician with special interest would join the inspection team.

Action: CHCs to canvas paediatricians to work with HMIE on inspections. John Froggatt to check the level of commitment required.

10. Future Role of Child Health Commissioners

29. Lorraine Currie tabled a revised paper. She had inserted more background information about CHCs being a children’s champion and had strengthened the wording. The role of CHCs and Boards’ commitment to CHCs was different across Scotland.

30. During discussion, the following points were raised:

- The role of the CHC should be expanded significantly in the paper
- Job descriptions could be appendices to the paper
- The role and remit should be an appendix to the paper

- It had to be clear who the paper was for – guidance to Boards on the function of CHCs? Once endorsed by the CYPHSG (at its December meeting) it could be issued to Boards as an aide memoire and to highlight the importance of a lead officer for child health
- The 2005 paper could be updated to include the new child health initiatives.

**Action: Lorraine Currie and Charles Clark to amend the paper.
CHCs to forward comments to Lorraine Currie.**

11. AOB

31. Kathy Collins reported that the HDU Audit had been completed and the report was being finalised. It would be submitted to the Implementation Group. Critical care guidelines were awaited, although guidelines based on the West Midlands model had been distributed to Boards as a “checklist”.

32. Kathy went on to report that there were significant developments in the pregnancy and newborn screening programme, although there were concerns that screening was being introduced without a corresponding service being available, eg sickle cell and non-malignant haematology.

33. Joy Tomlinson reported she was having difficulty developing a needs assessment for children and young people with drug and alcohol abusing parents.

Action: CHCs to enquire locally if they have anything available.

Cathy Orr to supply Joy with the name of the person who has undertaken work in Glasgow on children of drug abusers.

Jennifer Milligan to send Aberlour information to Joy.

12. Dates of Future Meetings

34. The next Child Health Commissioner Group meetings will take place on 9 December 2008 and 12 March 2009, venues to be confirmed.