

SUMMARY OF DISCUSSION: NATIONAL FRAMEWORK FOR SERVICE CHANGE

NATIONAL ADVISORY GROUP MEETING – 4 OCTOBER 2004

Present:

Prof David Kerr	Rhodes Professor of Cancer Therapeutics & Clinical Pharmacology, Oxford University
Andy Kerr	Minister for Health and Community Care (from agenda item 6)
Ian Gordon	Head of Department and Chief Executive (acting)
Peter Bates	Director of Health Service Delivery (acting)
Derek Feeley	Head of National Planning, Health Department
Prof Nora Kearney	Cancer Care Research Centre, University of Stirling
Dr Jillian Morrison	Professor of General Practice and Deputy Associate Dean of Education, University of Glasgow
Prof Gillian Needham	Post-Graduate Dean, University of Aberdeen
Lesley Summerhill	Director of Nursing and Patient Services, Tayside Hospitals Trust
Dr Charles Swainson	Medical Director, NHS Lothian
Jae Ferguson	Chair Mid Argyll Maternity Users Forum
Irene Sweeney	Chair Scottish Pensioners Forum
James Kennedy	Chair Scottish Partnership Forum
Paul Martin	Chief Nursing Officer
Roger Gibbons	Chief Executive, NHS Highland
Alexis Jae	
Steve Kendrick	Project Team, Health Department
Brian Dornan	Project Team, Health Department
Jane Gallacher	Project Team, Health Department
Una Lyon	Project Team, Health Department
Myra Duncan	Project Team, Health Department

1. Minutes of previous meeting agreed without changes

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2. Report from Health Committee

Professor Kerr reported that he had what he believed was a useful evidence giving session to the Health Committee. He was impressed by the collegiate approach of the committee and the to the point line of questioning. There was some pressure from the committee to agree that a moratorium on service change was required while this group prepared its report. Prof Kerr did not think that this was the best course of action and agreed to outline his position to the committee by letter (attached). That letter states that a moratorium “would be unrealistic and cause an unnecessary paralysis of decision making across the NHS”.

Professor Kerr was keen to let the committee know that patient expectations and interests were represented on the National Framework Advisory Group and that there would be a process to thoroughly involve the public in this work.

Discussion points:

- The debate that this group wants to have is now happening in the media. It is clear that there is a developing understanding of the issues in the media and the political system.
- The members of the group who represent public and patient interests expressed some concern that this process may become politicised, with the fundamental issues being lost sight of.
- It is important that this group manages to effectively set the context for the national debate by being clear about what the drivers for change are.
- Some clinicians have become disengaged from the public, this may have helped create the current climate of mistrust and needs to be addressed.
- Some of the media coverage of the issues has been very balanced. The media has linked a number of issues and campaigns across Scotland. We need to accept that in some cases Boards have not handled change well or have been short sighted. The expectations of this group are now high but the group should avoid becoming too involved in local disputes at the expense of the national picture.

The group was informed that it had been invited to take a closer look at some of the issues facing Argyll and Clyde Health Board.

Discussion points:

- Important that this group proceeds in the right order. We need to first of all be clear of the vision, then the required steps to get there, before we become involved in the issues in specific Board areas. We need to have a view of where NHS Scotland needs to go in the long term.
- This means a Scotland-wide discussion of the issues rather than getting involved in particular local issues.

3. Communication Update

Derek Feeley reported that the response to the Draft Statement of Values and Vision was largely positive. There were some concerns over whether the vision was deliverable, along with more detailed drafting points.

Discussion points:

- It is important that we get over the concept of continuous improvement in this document.
- We need to outline a more continuous and open culture of engaging the public, rather than sporadic consultation around specific exercises; this should be clear in our vision.
- We should be talking about “developing” rather than “extending” roles.
- Under the “closer” heading, more than 90% of contact is *already* with the primary care team.

- It is clear that we do not have a world class service at the moment, we therefore need to set out clearly where we want to go, this is a good basis for that.
- There is a growing trend towards personalised care, clinically and medically the focus is moving towards the individual, perhaps some more emphasis on personalised care.

Newsletter:

Pennie Taylor outlined a very accessible four page newsletter which could be emailed to local health systems for distribution. Group members were asked to feed specific comments to both Pennie and the national planning team to allow them to be included in the revised version of the newsletter.

4. Drivers for Change Paper

The draft paper was generally well received, with a number of suggestion of further work to strengthen the paper, as follows:

(a) Leadership/ Organisation

Need for some thoughts on the role of leadership, culture, values and beliefs in NHS Scotland.

(b) Scotland v. Elsewhere

Need international comparisons – quality and outcomes (sources: Scottish response to Wanless, Civitas report, ISD benchmarking work, Scotland v. England bed comparisons etc).

(c) Clinical safety

Some discussion around the clinical safety evidence base – how is it determined which procedures are “safe” in particular locations? A discussion around the unsatisfactory nature of the evidence linking volume to outcome.

(d) Inequalities

Pointed out that health inequalities can be described as a driver for change because of the political determination to close the growing health gap in Scotland. The project team agreed to send the draft chapter to Phil Hanlon and Harry Burns for comment, with further data on the characteristics of primary care practices in deprived areas to come from the Platform project (Matt Sutton).

(e) Demography, epidemiology, activity

Some concerns that this section is unnecessarily gloomy about the older population – need to emphasise more healthy older people and the possibilities of mobilisation.

(f) Workforce

This chapter remains very medically oriented and more work is required to expand the nursing and healthcare support workers section.

(g) Medical science

More focus on Scotland’s current position is needed here. Scotland was until relatively recently a powerhouse in the field of medical science, what is our current position? Are changes required?

(h) ICT

Need to be more positive about the potential for telemedicine, particularly for remote and rural communities where it will be absolutely crucial to the delivery of appropriate levels of care. Comparison of per capita spend on ICT in Scotland compared to England? Or proportion of health budget which goes on ICT in Scotland as compared to England?

5. Reports from Action Teams

Reports back from Action Team

Highly specialised care: paediatrics

Peter Bates reported that on the paediatric front a great deal of work had already been undertaken, and a consensus was now emerging on the model. It should start by identifying the majority of the paediatric work which could be done in primary care, then at DGH level and finally in the most specialised setting on a single site, at university teaching hospital/paediatric hospital level. The Expert Group on Child Health had agreed to look at the identification of the primary care element of the model.

Paediatric intensive care was an aspect of the model which required further thought. There were tensions around the current model, with Paediatric Intensive Care Units (PICU) in both Edinburgh and Glasgow. Peter Bates felt that the Department had for a number of years fudged the question of moving towards a single PICU, though he accepted this was not a simple issue. Many children required a short episode of specialist care and then to be looked after nearer home, and this indicated that there was a need to define what could or could not be done more locally.

The Chair was attracted to the idea of inviting the potential providers to make argued bids for the location of a single Scottish site for highly specialised paediatric services. Dr Swainson suggested that such a decision should be taken in the context of a planning framework which could assess value for money from a range of options, taking account of the drivers associated with cost, numbers and skill of staff, and accessibility and transport for children and families.

Peter Bates felt that the Action Team needed to take stock of the then Minister's decision the previous week on the future of the Queen Mother's Hospital, Glasgow, as that also dealt with issues concerning co-location with specialist adult services.

Highly specialised care: Neurosciences

James Kennedy reported that there had been difficulties with the composition of the Team, in particular the existence of tensions between the special advisors nominated by the Royal Colleges and CMO's Specialty Adviser. There was patient input from Epilepsy Scotland and the Neurological Alliance. The Action Team had looked at the relevant sections of the Acute Services Review, the follow-on work undertaken first by Sir David Carter and then by Professor Teasdale. At the end of Professor Teasdale's work, there had appeared to be consensus amongst clinicians about the way ahead, but that had dissipated quite rapidly when

there had been no immediate follow-up to the report. The present work was accompanied by a great deal of argument and counter-argument.

The Chair suggested that neurosciences was another area where the solution might be to have bids based on clear criteria. Dr Swainson pointed out that this approach had not worked in Scotland in the context of paediatric cardiac surgery, and argued that what was needed was a clear planning framework, rather than trying to reach decisions on the basis of a costed business case. Derek Feeley suggested that decisions by competition could lead to a random and disconnected system. At the end of the day, it was the Minister who was expected to take the difficult decisions, based on a view of the system as a whole. It would be a big step forward if the clinicians could agree on the way ahead, so that the group could then work out how to achieve that aim.

Dr Swainson made the point that it would be necessary to understand factors such as transport and access, and who used the service, in particular how many users were from deprived communities. The post-graduate education context needed to be covered. There needed to be some assessment of the academic context, in terms of research potential. The universities should therefore be asked for their plans on how they would support the Group's decision on reconfiguration of neurosciences. The Chair concluded that there was a need to develop criteria to allow a description of the service.

Professor Teasdale noted that 2 years previously the overwhelming consensus had been that one centre was needed for adult neurosurgery, especially if it were co-located with the paediatric service. There were unresolved questions, however, about emergency cases, and it would be necessary to look at how often those arose, so that plans could be made based on the separation of emergency from elective care. Dr Swainson commented that it would be necessary to be clear what constituted an emergency of the type that had to be dealt with by a specialist in a specialist centre. A local capability was needed in order to help decide what should be the next step in the care of each patient.

Care in Local Settings

Professor Kearney reported that this team was focusing on local cancer services, older people with mental health problems, especially dementia, because of the connection with delayed discharge, and children with complex needs, where the affordability and nature of support at home required to be looked at.

The work on local cancer services had raised the issue of the scope for Significant change to the care pathway that would enable more care to be managed and provided closer to the patient and indeed in some instances by the patient. The work on older people involved a group in Forth Valley which had organised a visionary day looking at issues such as the use of IT and 'smart' houses. The model it had begun to develop would not include hospitals, and only a small number of care homes. The work on children was looking at the whole care package for those with the greatest complexity of needs.

There were major issues about the long-term cost and sustainability of care, and the co-ordination of care between generalists and specialists needed to be looked at, as well as the role of CHPs and IT issues.

Chronic Disease Management

Professor Morrison reported that the Action Team had held 2 meetings, which had both been very positive and productive. It was looking at the whole spectrum of chronic diseases, with a focus on multi-disciplinary teams, the need to integrate primary and secondary care, information management and the creation of integrated electronic patient records. The Team was examining a range of CDM models and was likely to highlight the principles from these which could link in to current structures.

The fundamental principle was that care should be patient-centred, on the basis that the best type of management for individuals was community-based and primary care led, close to home and in partnership with the voluntary sector, with good lines of communication between health and social care. The Team's proposals would use a population approach, based on recognition, recall and review. It would also involve risk stratification and a case management approach for individuals at highest risk, involving a member of the primary care team looking after between 70-100 patients. The model was also likely to involve delegation of CDM to CHPs.

Professor Morrison had written to all Board Chief Executives asking for a brief description of CDM initiatives in their area. The Team was also keen to take account of the views of carers, as well as the possible use of the Assessment of Chronic Illness Care template produced by the MacColl Institute of Healthcare Innovation in Seattle.

The benefits of the CDM approach could be summed up as: encouraging patients to look after themselves was known to benefit the patients; and better CDM improved patient satisfaction and quality of life. The outcomes could be measured by using data from the 10 chronic conditions listed in the new GMS contract. While there was a general expectation that good CDM should also lead to a reduction in hospital admissions, Professor Morrison felt that the way in which the population was ageing might mean that CDM could help to achieve a plateau in the number of admissions but made it unlikely that there would be a reduction. Mr Kendrick suggested that the Team might like to find out more about a project involving ISD, NHS Tayside and Audit Scotland which was looking at assessing the impact of CDM on hospital admissions. Mr Kennedy suggested that the Team should also look at the experience which had been gained from managing complex needs in the context of mental health.

The Team was also aware that consistency of approach across Scotland was essential. This meant that the majority of primary care practices would have to adopt the same approach. There also needed to be consistency in GPs' access to diagnostic services. Professor Morrison felt that the new GMS contract represented a first step towards that consistency. There was also a need to marry benefits to the availability of resources. Evercare looked at those who had had more than 3 unscheduled admissions in a year and who were over 85, which was a comparatively small group. The Team wanted to be much more pro-active, and had agreed it should look at patients over the age of 65, to take account of the effect of health inequalities on mortality.

6. Change and Innovation in NHS Scotland

June Andrews, Director of the Centre for Change and Innovation, delivered a presentation of the work and methodology of CCI.

Discussion points:

- In England investment has been tied to redesign, additional funds follow evidence of redesign work, this should be the case in Scotland.
- We need to move beyond the period of persuasion to become more directive with Chief Executives where there is clear evidence that a particular approach provides efficiencies.
- Clinicians themselves need to become more aware of service redesign methodologies.
- How can CCI demonstrate sustainable changes?

Derek Feeley suggested that the work of CCI was important and that the group would need to ensure that it would pull together the work of both CCI and the National Workforce Team.

- A central deliverable for this group might be a recommendation that proven methodologies must be applied. In the past it has been possible for Boards and clinicians to ignore positive developments elsewhere, this group must ensure a greater level of accountability and scrutiny.