

SUMMARY OF DISCUSSION: NATIONAL FRAMEWORK FOR SERVICE CHANGE

NATIONAL ADVISORY GROUP MEETING – 9 NOVEMBER

Present:

David Kerr	Rhodes Professor of Cancer Therapeutics & Clinical Pharmacology, Oxford University
Andy Kerr	Minister for Health and Community Care
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
Nora Kearney	Cancer Care Research Centre, University of Stirling
Jillian Morrison	Professor of General Practice and Deputy Associate Dean of Education, University of Glasgow
Gillian Needham	Post-Graduate Dean, University of Aberdeen
Lesley Summerhill	Director of Nursing and Patient Services, Tayside Hospitals Trust
Charles Swainson	Medical Director, NHS Lothian
James Kennedy	Chair Scottish Partnership Forum
Alexis Jae	Director of Social Work, West Dunbartonshire Council
Roger Gibbins	Chief Executive, NHS Highland
Jae Ferguson	Chair Mid Argyll Maternity Users Forum
Irene Sweeney	Chair Scottish Pensioners Forum
Graham Teasdale	President Royal College of Physicians & Surgeons of Glasgow
Mac Armstrong	Chief Medical Officer
Jane Gallacher	Project Team, Health Department
Rosie Hewitt	Project Team, Health Department
Emma Fulker	Project Team, Health Department
Brian Dornan	Project Team, Health Department

1. Minutes of previous meeting

Minutes tabled at meeting, views sought from group members by email.

2. Communications update

Professor Kerr reported that he had a useful visit to Argyll and Clyde and that engaging with the views of the public is going to be critical to the success of the group.

Professor Teasdale's appearance on Radio Scotland had allowed discussion of national issues rather than the detail of particular local issues.

Derek Feeley introduced two new members of the National Planning team to the group. Emma Fulker has taken over as Derek's PA while Rosie Hewitt has joined the team to work on the communications strategy. Derek reported that the launch of the advisory group's newsletter at Leith medical centre had gone well, with both the Minister and Professor Kerr in attendance.

Discussion points:

- There is a need to secure clarity on the role of the 120,000 staff of NHS Scotland in this engagement process. The team should ask directors of finance put a note on staff payslips to make staff aware of the newsletter and the project.
- All Health Boards, directors of patient focus and communication managers have been made aware of the meetings.
- Some discussion around the format for the regional consultation meetings. The group agreed that details will be resolved over the coming month as Rosie and Jane scope the venues and discuss the details with Pennie Taylor, who will be facilitating these events.
- More effort is needed to engage staff organisations in the group's work over the coming months.
- The communications team should target elements of the specialist health media regarding the exercise.
- Health Boards in outlying areas will be able to run buses to the regional meetings, the cost of which will be covered by the department.
- A further round of meetings will be held in other areas depending on demand for them.
- Jane and Rosie to produce a communications update on a weekly basis.

3. US Study Trip

Derek Feeley produced a paper summarising some of the main points arising from the American visit.

Discussion points:

- A common feature of both the Veterans Health Administration (VHA) and Kaiser Permanente was a set of shared goals for the organisation, patient focused, simple, and clear to everyone in the organisation.
- There is a real drive towards more care being delivered as locally as possible – hospitalization is viewed as “system failure”.
- A less positive feature was the very doctor focussed nature of the systems.
- The VHA ICT system is hugely impressive. Consisting of Electronic Patient Records, digital imaging, health information, direct access for patients to their records etc. VHA has offered to make this software available free of charge, leading to its adoption in a number of countries.
- The pace of change in these organisation is striking. The roll out of a new ICT system should take 18 months to 2 years.

Presentation

Derek Feeley gave a presentation on the ICT system of the VHA:

- This system allows all financial allocations to be based on real patient data and activity and can take account of additional costs caused by such factors as remoteness and rurality.

- Provides *real time* lab results, prompts etc
- Our systems in Scotland often provide information on a patient only in relation to a single condition. The VHA system covers *all* conditions, essential given the trends in co-morbidity etc.
- Bar code medication administration: as medicines are distributed a barcode is swiped, automatically updating the patient's record to indicate exactly how much of a medicine has been given when.

Discussion points:

- Questions around the need to develop a unique clinical system in Scotland when a working system is available now.
- At the moment in Scotland we cannot send information from primary care to secondary care; separate systems are still being developed across the country for a number of different conditions and providers of care. The current disparate systems prevent any meaningful integration of services and help to reinforce traditional barriers in NHS Scotland.
- The re-procurement of a primary care system is now due in Scotland. We should look at whether it remains sensible to procure a purely primary care focused system when an integrated system for all providers of care is what is necessary.

It was generally agreed that it would be useful to consider the applicability of the VHA system in Scotland. A meeting should be arranged between officials working on the eHealth strategy and interested members of the advisory group to discuss these issues.

4. Hanly Report

Derek Feeley introduced the Hanly Report, the work of a task force commissioned by the Government of the Republic of Ireland and chaired by David Hanly. That group was asked to look primarily at medical staffing issues but also considered the organisation of acute hospital services.

Discussion points:

- The evidence linking higher volume to better outcomes is not clear. Any assumption that bigger is necessarily better will be rigorously questioned.
- It is clear that the extensive public consultation strategy adopted by the National Framework Advisory Group will be crucial in engaging with the concerns of the public and taking account of them in the final report.
- Alongside the arguments against some "centralisation" it should be remembered that there is evidence that unscheduled care in Scotland could be delivered in different places and types of facilities more appropriate to the type of need.
- It is clear that the framework will have to allow services to be delivered differently in remote and rural areas.

5. The Emerging Picture

The group was asked to consider a number of key questions which it is important to revisit and clarify at this stage of the development of the framework. The group was asked to consider what the vision for Scotland's health service is?

Discussion points:

- Suggested that the fragmentation of the service in Scotland into a plurality of providers would feel like a failure. American healthcare providers give an example of an efficient integrated service.
- The health service in Scotland should be collective, based around networking and integration while providing certainty and quality for patients. This might be summed up as “integration, certainty, quality”.
- Some suggestions for improving integration and networking in NHS Scotland:
 - Clarity on which catchment health boards are providing which services for. Health boards could be asked to provide particular services for more than one Board area.
 - Doctors don't have possession of waiting times and this should be the case. The group might consider how doctors can be made more directly responsible for their waiting lists.
- It is crucial that the group takes steps to re-connect the clinical community with the public.
- There are a number of pressures for centralisation in NHS Scotland as currently constituted – national pay, the national character of the professions, top-down control and national accountability through parliament. The main pressure for local services is from the public. Kaiser Permanente use financial mechanisms to incentivise local care. Community Health Partnerships (CHPs) should provide an emphasis for local care, but will they be strong enough? We need to come up with the means to push the service out and down.
- Shifting the location of care out and down in Scotland is made difficult by the current system of financial allocations where local bodies spend money rather than earn it. The Kaiser Permanente model is based on providers earning money. The VHA model is based on healthcare sector tariffs which determine what it ought to cost to provide particular treatments or procedures. Any efficiencies then free up cash which can be reinvested in service change.
- CHPs could play a significant role in carrying forward public health issues in Scotland.
- There is still the assumption in some parts of the service that control of diagnostic services will remain where it currently is, i.e. with hospitals. However control could be devolved to CHPs – change in control can itself be a lever for change.
- The group should ask the relevant official to discuss the development of CHPs, with the group posing specific questions.
- It is possible to provide a far greater range of services in primary care, but there needs to be both strong incentives and the right leaders if this is to happen.

Professor Kerr asked the group members if they remained confident that the report could be delivered to the current timescale. The group felt that some additional time is necessary if the views of the public and professions are to be genuinely taken into account.

The advisory group discussed the organisation and structure of the health boards in Scotland and agreed that the group would not make recommendations on these issues unless specifically asked to do so by the Minister.

The group agreed to send responses to the national planning team to the explicit questions raised in the “Emerging Issues” paper.

6. GIS maps

The group was shown some Geographic Information Systems (GIS) maps which are being developed for the unscheduled care group and asked to consider if these could be useful in any of the other work-streams.

7. Reports from Rural Access and Older People groups.

Roger Gibbins reported on behalf of the Rural Access group. The group has been looking at a number of issues, including what are the necessary services in remote and rural areas and how the best can be made of that necessary infrastructure. The group needs to consider a number of issues and needs to engage with the other work-streams. For example what are the minimum standards for unscheduled care in rural areas and what is needed in remote and rural areas to deliver that?

See attached Rural Access Action Team papers.

Lesley Holdsworth provided a report on the Older People’s Services Action Team. The group has been looking at various scenarios for the type of services provided for this section of the population. A model that embraces more care closer to home has been identified as the way forward. The group has developed a tiered model which identifies where different types of care should be delivered, based on the complexity of that care. The group is also looking closely at the role of self-care and carers in supporting older people in their home or local community.

See attached Older People’s Services Action Team paper.

Project Team
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