SUMMARY OF DISCUSSION :NEUROSCIENCES ACTION TEAM MEETING

1000 HRS Monday 10 January 2005
Management Centre, University of Stirling

Present:

James Kennedy (Chair)	Co-Chair Scottish Partnership Forum
Myra Duncan	Advisor National Planning Team SEHD
Adam Bryson	Medical Director National Services Scotland
Elizabeth Preston	Assistant General Manager NHS Lothian
Will Scott	National Planning Team SEHD
David Currie	Consultant Neurosurgeon NHS Grampian
Annie Ingram	Regional Workforce & Planning Co-Ordinator North of Scotland Planning Group
Hilary Mounfield	Chief Executive Epilepsy Scotland
Karen Bruce	Deputy Head Allied Health Professionals NHS Tayside
Andy Wynd	Chief Executive Scottish Spina Bifida Association
Aileen Keel	Deputy Chief Medical Officer SEHD
Kenneth Lindsay	Consultant Neurosurgeon NHS Greater Glasgow
Ian Whittle	Consultant Neurosurgeon NHS Lothian
Ian Bone	Consultant Neurologist NHS Greater Glasgow
Evelyn Teasdale	Consultant Radiologist NHS Greater Glasgow
James Steers	Consultant Neurosurgeon NHS Lothian
Callum Kerr	General Manager West Central Division Scottish Ambulance Service
Jim Miller	General Manager Regional Services NHS Greater Glasgow

Apologies:

Graham Teasdale	President Royal College of Physicians & Surgeons of Glasgow
Lynn Myles	Consultant Neurosurgeon NHS Lothian
Mark Hazelwood	Neurological Alliance Scotland
Uwe Spelmeyer	Consultant Neurologist, NHS Dumfries & Galloway
Robert McWilliam	Consultant Paediatric Neurologist NHS Greater Glasgow
David Mowle	Consultant Neurosurgeon NHS Tayside
Jennifer Brown	Consultant Neurosurgeon NHS Greater Glasgow
Martin Kirkpatrick	Consultant Paediatric Neurologist NHS Tayside

Meeting

The Action Team met for the sixth time to:

- Discuss and agree the:
  - Assessment criteria
  - Options for configuration of the neurosurgical service
- Consider a service model for neurosurgery in Scotland

1 Welcome

James K welcomed colleagues to the meeting.

2 Summary of discussion of 17 December 2004

David C requested that the discussion concerning the Specialised Paediatric Services Action Team opinion on a single centre for paediatric specialist be recorded. This was agreed.

The summary of the discussion should be amended to include:

"Deirdre informed the Team that centralising paediatric ICU from 14 units to 2 had improved outcomes and David C asked whether they would recommend a single unit in Scotland. Deirdre commented that they considered that reducing to one unit would not improve outcomes further and that other factors had to be considered including the impact on other specialties and keeping children as close to home as possible for their care. The experience of the move of paediatric cardiac surgery to Glasgow had shown that staff would not move"

3 Matters Arising

3.1 Release of Audit Data

James K informed the Team that Dundee had agreed to the release of their SAH and Shunt audit data.

3.2 Self Assessment Audit

Myra reported that the information from the last centre had been received and sent out to the "panel". It was agreed that the information would be submitted to Barrie White in Nottingham who would be able to provide a comparator with the other UK centres.

Liz reported that the "panel" will review the information and report back to the Team's February meeting.

Actions:

Myra will arrange for the information to be sent to Barrie White.

4 Assessment Criteria

Jim presented the background to the identification of the assessment criteria and confirmed them as those which had been further defined following the last meeting. He confirmed the agreed action as individual members of the team applying weightings to the criteria. He had received 16 responses, some of which were composite. He explained that one response had allocated the total weighting to one criterion which had skewed the aggregated weighting. He asked the Team to decide whether the median or the mean of the scores would be taken. The Team agreed that the median should be used. He confirmed that these values would be applied to each criterion as the weighting. (Copy of the presentation attached.)

5 Options for the Neurosurgical Service in Scotland

Myra explained that the paper set out a range of options for the configuration of neurosurgery. (Paper attached) She asked the Team to consider the two assumptions.

Discussion points:

The Team agreed that the Status Quo should be added and defined it as the current situation assuming that changes will happen as a matter of course. The other 4 locations option assumed that there would be a proactive, planned change to a different service model which concentrates certain types of activity to fewer sites, and that 4 sites remain.

The Team agreed that adult and paediatric neurosurgery should be considered together.

6 Assessment of Options

The Team discussed the process for assessing the options, whether they could be 'sifted' initially or whether each one should be considered. It agreed that each option should be considered systematically.

It was noted that this process should focus on services rather than buildings and that the current sites would not be able to absorb significant additional activity so some capital investment would be required whichever option might be preferred. It was agreed that there needed to be an element of pragmatism however that it should be done on a 20 year horizon. The issues of transport infrastructure and a sustainable workforce are also relevant. The transport issues have two dimensions – transfer of ill patients and the travelling involved for planned care for patients and their relatives. It was noted that from a transport perspective if the transport infrastructure is in place, then a single centre is possible, however this needed to be weighed with providing clinically safe care. The concept of the single neurosurgical service underpinned the configuration. This supports as much service being delivered locally as possible, but recognises that some elements of neurosurgery may only be provided in one or two locations. It was agreed that the facts concerning each of the current locations should be made known to all the Team to assist the option appraisal. The process should look to provide a plan for the provision of neurosurgery 20 years ahead which addresses the key drivers of providing the care on a 24 hour basis and ensuring that skills and expertise are maintained.

David C informed the Team that he had submitted a job plan which showed how 24 hour care is provided in Aberdeen and Dundee. Annie commented that job plans do not show compliance with the EWTR and that the work of this Team must demonstrate compliance with legislation.

At this point the Team agreed to take agenda item 9 The Neurosurgery Service for Scotland to inform the discussion on option appraisal.

7 The Neurosurgery Service for Scotland

Myra apologised for tabling the above paper. (A copy is attached to this note.) She explained that she had set out the areas where she thought the Team had agreement, which included the service being standards based, the single service model and MCN

approach to specific disease areas, the need for improved information and data across the service, the need to involve patients and carers in the development of the service and the need to develop e-medicine to support the service model. She explained, however that there was no agreement on how the consultant resource could be configured to deliver the service and specifically how much of this resource was required in individual centres to provide a 24hr/7day service, and hence how many locations could support 24/7 care.

Discussion points:

Ken commented that there would not be enough volume of work to sustain skills etc if an additional 5 neurosurgeons were appointed.

Aileen asked whether the Team could identify the common procedures and whether they required 24/7 care. Straightforward discs could be done electively and would not need 24 hr care, head injuries do need 24/7 care and gliomas could be done electively, but are becoming more sophisticated. It was agreed that the transport of head injuries should be reviewed and that they should be taken directly to the centre that can treat them rather than locally for resuscitation. The team recognise that there are few situations where immediate neurosurgical intervention is required. With reference to the levels of care in the service model it was agreed that level N3 was not feasible as there would only be spinal surgery that did not require 24/7 care.

It was noted that the number 19 in the paper should refer to a headcount of 19 neurosurgeons, not wte. Myra asked the centres to confirm their consultant resource in wtes, PAs and numbers.

The Team agreed that it would be useful to explore whether an adult retrieval team similar to the paediatric one should be developed.

Liz confirmed that level N2 requires a level of technology for resuscitation and to support assessment. She suggested that there are about 10 conditions where a pathway of care could be agreed across the levels which would set out the education that needed to be in place at each level.

The Team discussed spinal surgery and the need to keep care of this locally as it is commonplace; there is also unmet need and it has a significant lifestyle impact on patients. James S commented that a significant amount of activity is on an outpatient basis and good local assessment and diagnosis with image transfer and investment in neurology in DGHs would improve the service. Liz commented that the single service should look at how it can improve inpatient and outpatient waiting times across all the centres recognising issues around moving patient between centres. James S explained that there were c 1200 spinal surgery cases in Scotland per year, split roughly 260 each Aberdeen & Dundee, 400 Edinburgh and 325 Glasgow.

The Team returned to the Option Appraisal discussion

8 Asssessment of Options (contd)

It was agreed that the appraisal would rely on Team members' judgement and that it was to inform the process, it was not the answer. The criteria would be further clarified

following the discussion and the intelligence concerning the current centres and any plans there were for material change included for information. It was noted that

- paediatric neurosurgery required access to paediatric intensive care beds, which were located in Glasgow and Edinburgh
- neuropathology is required real time on site – theoretically it could be done by telemedicine, however neuropathologists advised on selection of the sample
- there is no neuroradiology cover in Aberdeen or Dundee
- the criterion Equity of Access should be changed to describe how far each option would support a managed clinical network and the care pathways approach to care delivery, ie integration.
- The travel time information should be used to assess the criterion on local services
- Currently the centres do not meet the standards; some of the SBNS standards might be easier to achieve with a larger resource in individual locations
- The context of a falling population and potential decreasing volume of neurosurgery should be considered

Team members should assume that all options will require a level of capital investment and that there will need to be flexibility in the workforce for all options.

The Team agreed that all the options should be appraised.

Actions:

Myra will re-issue the criteria, options, spreadsheet and a paper with further information based on the discussion and individual Team members will carry out an option appraisal and return it to Jim Miller by close of play on 17 January.

9 Meeting of the National Advisory Group and Action Teams

James K informed the Team that the Chairs and project leads from the Action Teams will be meeting together at the end of February to share their work and outcomes. Each Action Team is invited to send a couple of representatives and James proposed that Ian B, Ian W, Annie and Adam should attend for this Team. This was agreed.

Actions:

Myra will confirm this with Derek Feeley and confirm with those nominated.

10 SBNS Consultant Workforce Model

Myra reminded the Team that the centres had agreed to fill this in.

Discussion points:

Jim pointed out that some of the information appeared irrelevant and that further definition was required for some fields, eg home to work travel time, number of PAs for new consultants.

Annie commented that ISD was using the tool for the National Workforce Numbers Group and that it was attractive because it was transparent and provided a means of quantification. The number of PAs for a new consultant should be assumed as 10.

James S commented that it is the only tool available currently and takes into account support for junior staff and a realistic population base.

Liz said that she had worked it through and it indicated a shortfall of 2 consultants for Edinburgh, she had also used different methodologies and they gave the same conclusion.

It was noted that the information gained from the tool needed to be cross referenced to the requirements of the EWTR as the two do not equate. It was agreed that the tool could be worked through for some of the options for configurations and they could be compared with the requirements of the EWTR to give a view on sustainability.

Actions:

The four centres will complete the tool and submit it to Myra. They will include the assumptions they have made when doing this and any comments on the fields.

11 The Relationship between Volume and Health Outcomes

James K informed the Team that this paper (copy attached) had been commissioned by the National Advisory Group and presented to its last meeting.

Discussion points:

Aileen commented that nothing specific to neurosurgery is included but that in some surgical specialities there is evidence of an association between volume and outcomes. Since the Acute Services Review evidence is beginning to become available and the direction of travel is towards an association.

Ken commented that he was aware of some papers in this field that related to neurosurgery and agreed to give Myra the references.

The Team agreed that they should recognise the evidence becoming available and that the direction was towards an association between volume and outcome.

12 Action Team Report

James informed the Team that a first draft of a report of its work should come to its next meeting. He suggested it should include the following:

- Recommendation that neurosurgery should be regarded as a Scottish wide service and that it should be planned and co-ordinated in that way
- A description of the type of service – the service model with the different levels of care
- Some indication of the number of locations where surgery would be provided
- A view on how the workforce drivers might be addressed
- Recognition of the focus on neurosurgery with little attention to neurology

- The lack of data and recommendations for data gathering systems for the future, including clinical information
- The involvement of the Neurological Alliance
- The need to focus on patients and services and not organisations and structures
- The need for a long term view and short term action plan

He also commented that the report would need to comment on the process for future work and the need for action through identification of a mechanism to take the recommendations forward.

Discussion points:

Hilary commented that the Team was focussed on the best service for the future and that the patient perspective had been taken on board.

Annie recommended that the Team should be explicit about what services should be delivered locally and that transport issues and potential solutions should be included.

Liz commented that multidisciplinary aspects need to be emphasized.

Adam queried the status of the previous report from Sir David Carter and why its recommendations had not been adopted and that the Team should recommend a national system of meaningful data collection.

James S emphasized that outcome data is important in planning and that the Scottish Audit of Surgical Mortality is important in this respect.

13 Feedback from the National Advisory Group

James K informed the Team that the NAG has arranged a series of Frontline Forum for staff in the service. These will be interactive, evening events open to all NHS staff and will be held at the end of February/beginning of March.

14 Date of next meeting

Thursday 10 January 2005 2 pm – 5 pm Apex European Hotel, 90 Haymarket Terrace, Edinburgh Lunch will be available from 1.30 pm.