The group met for the second time to discuss the following issues:

- Draft recommendations from the Review of Tertiary Paediatric Services in Scotland
- Continuity of Care
- Paediatric Intensive and High Dependency Care
- Paediatric Services – age ceiling
- Other current Scottish Executive work on children’s services
- Information on paediatric services – availability and gaps

1 Welcome

Peter welcomed Morag Dorward to the group. Morag is about to take up a joint post with the Health Department and the Education Department as Allied Health Professions Development Officer.

2 Summary of the meeting held on 16 August 2004

These were agreed.
3 Matters Arising not on the Agenda

3.1 Peter drew the Group’s attention to the development of a national debate in the press on health service reconfigurations over the last few weeks. He commented that the work of the Advisory Group and its sub groups, ie this group, has grown in significance and expectation.

Action:

Myra to circulate the interview with Professor David Kerr that appeared in the Herald and the report of the Health Committee at which Professor Kerr and Derek Feeley appeared.

3.2 Peter informed the group that since its last meeting, he and Derek Feeley had met with the Child Health Support Group (CHSG), who have been commissioned to progress the workstream on children, excluding specialised services which this group will focus on. It is important that the work of the two groups is integrated.

He also informed the group of several initiatives which will take place between now and November:

- In conjunction with the Royal Colleges there will be a series of debates with clinicians which will give an opportunity to test the thinking of the groups. The RCPCH debate will take place in October.
- In conjunction with local health systems there will be a series of meetings across Scotland for the public to meet members of the Advisory Group and local clinicians to discuss issues.
- A newsletter will go out to NHS staff and be distributed through local and regional newspapers and the website.

Discussion points:

There will be a need to supplement the discussion through the RCPCH to ensure that surgical paediatrics is included. The Scottish Colleges Committee on Children’s Surgical Services (SCCCSS) could be used. It is also important to include clinicians other than doctors ie Allied Health Professions and nurses. These do not have the same college structure as medicine and it will be important to engage these clinicians locally.

Action:

Peter agreed to raise these points at the meeting of the Advisory Group on 4 October when the communication strategy is being confirmed and to write to George Youngson as Chair of the SCCCSS to invite them to participate.

All members of the group confirmed that they are willing to participate in the local meetings.

3.3 The importance of ensuring that as much care as possible is delivered in local settings was emphasized. It was confirmed that there is GP representation on the
CHSG and that a sub group of the CHSG is working with the SEHD on supplementary guidance for Community Health Partnerships.

4 The Review of Tertiary Paediatric Services in Scotland

George gave a presentation on the draft recommendations of the Review which is one of 5 streams of work being carried out under the auspices of the CHSG. The report is due to be considered by the CHSG in October.

A copy of the presentation is attached as part of this note.

He emphasized that there were a large number of specialties to be reviewed and the work would be phased. The first phase is the subject of the report and piloted a methodology to be refined for later phases. He stressed that the desire is for a single service in Scotland which responds to the particular issues Scotland has regarding geography and the demography of children. Patients want local services provided by skilled practitioners. The sustainability of paediatric services in Scotland is particularly vulnerable due to the small numbers of patients and appropriately trained staff and the lack of training programmes. The financial strategy does not support the reality of the service, eg where a centre provides a service it often becomes a national service, however is not formally designated as such and thus funding is not secured. Some of the key points of the presentation included:

- The lack of data available – the services produced their own for each review
- The potential to use option appraisal tools in later stages
- Difficulty in getting proper patient and parent representation
- Child health should be restored to a national priority, which would support the academic element
- Care should be disease specific and age specific
- The raising of the age ceiling to 16 years of age may create capacity in the system, however the disease profile is growing
- Workforce planning should take account of the number of clinicians being trained and succession planning
- A single service would promote a team identity for staff and treatment could be delivered through protocols
- The service could be delivered on a regional basis, with regionalised referrals
- The recommendation of the Kennedy report regarding the location of acute paediatric services alongside acute adult and maternity services should be adopted. Some models from the first phase of the review may be transferrable to other specialties
- Children’s cancer services and paediatric home ventilation should be designated national services, paediatric cystic fibrosis should be a national Managed Clinical Network, paediatric neurology should be delivered on a consistent basis across Scotland
- There should be specific reviews of PICU/HDU services, general surgery of childhood and the 2ndry(secondary)/3ry(tertiary) interface

Discussion points:

There was discussion on the development of MCNs. Initially some had been established with pump-priming money, however the Regional Planning Groups
(RPGs) were now looking at sharing support for these. The process for establishing MCNs requires strategic planning, many have been borne out of the need for collaboration and to sustain services. Health Boards are considering their strategies for MCNs and working on governance issues through RPGs.

Networks are essential to maintaining services locally. In University centres 2ndry care clinicians work across the interface with 3ry care and can maintain their specialist skills due to larger volumes of patients. Each care setting should identify what they should not be providing, particularly specialised care, and to set out what their contribution to certain speciality provision could be, including the role of the 2ndry Paediatrician in, eg shared care models. The approach should be multidisciplinary giving clarity on advanced roles for AHPs and nurses. The cleft lip and palate model is a good model. It was agreed that this group might wish to comment on the development of MCNs as part of its work.

**Action:**

Peter agreed that the Advisory Group should be asked where the work on MCN development was being carried out.

**Discussion points:**

The group confirmed that it wished to use the work and report of this Review as a basis for its work.

**Action:**

Peter agreed to approach Malcolm Wright, Chairman of the CHSG to ask for his authority to do this.

**Discussion points:**

The Group discussed how to progress the differentiation between what could be done locally and what needed to be done in specialised centres. A number of bases were suggested:

- health systems would need criteria to work with, eg sustainability, affordability, quality, access
- the generic issues identified in the Review’s report could act as a framework for local systems
- the strategic decisions, eg staffing, PICU need to be identified and recommendations made

It was confirmed that specific recommendations concerning the disposition of services is expected of the Group; locations for services identified with descriptions of the services provided in those locations as part of a single specialist paediatric service.
5 Continuity of Care

Zoe gave a presentation on the links between 3ry centres and local child health systems. She identified the differences in the nature of specialised care from relatively short periods of care of one or two episodes to children spending long periods receiving care away from home and that specialised care included nursing care.

A copy of the presentation is attached as part of this note.

Children require different types of care and the family are often a key link, however individual competence needs to be considered. The community children’s nurse is critical, particularly in the care of children with complex needs and other agencies links are important, eg social work, education, voluntary sector.

Jackie Sansbury and Morag Dorward left the meeting at this point.

Discussion points:

It was agreed it would be helpful to identifying what the 5* practice is.

Communication with primary care was identified as a significant issue, antenatal shared care and child health surveillance are examples of good communication.

Communication at entry to and exit from the specialised episode of care is important. Discussion confirmed that communication on clinical issues at point of entry is clear, however sometimes more general information is not immediately available, eg ward layout. Web based information systems would provide a solution, however currently there is a lack of IT infrastructure to support clinicians moving around in networks.

The group agreed that there was a need for some facility to get local Boards to commit to children in terms of priority and resources. Children needed to be a national priority.

There was discussion about the need to ensure support to and within primary care and consistency of expertise available, identifying this was an area for development. There are opportunities for consultant support to care at local levels and for the development of specialist nurses and advanced practitioner roles; NHS Education Scotland (NES) would need to look at developing advanced practitioner roles on a generic basis to allow transferability.

6 Paediatric Intensive Care/High Dependency Care (PIC/HDC)

Deirdre gave a presentation on issues and activity in PIC/HDC. She explained that it had been identified as an issue that needed to be addressed and had drawn her presentation and paper (which had been circulated) from information she had requested from the service.

A copy of the presentation is attached as part of this note.
She highlighted the importance of the interface with neonatal intensive care and the need to collect information on neonatal intensive care and paediatric high dependency care across Scotland alongside ICU information to inform discussion on criteria for admission to these types of care.

**Action:**

Ian agreed to provide a copy of the SPICA report on the audit of HDU admissions from 1997/8/9.

**Discussion points:**

The group agreed that this is a strategic issue and considered what work could be completed during the timescale of this group. It was agreed that the work should be scoped taking a 5/10 year view on the need for the different levels of intensive/high dependency care.

**Action:**

Deirdre agreed to develop a draft remit for this work in conjunction with colleague on the group.

7 **Other Agenda Items**

It was agreed that the remaining agenda items would be deferred to the next meeting.

**Action:**

Myra agreed to produce a paper for discussion at the next meeting, setting out the key issues the group needs to address.

It was agreed that the next meeting will start at 1030 and conclude at 1400.