SCOTTISH EXECUTIVE HEALTH DIRECTORATES

MINUTES OF THE FOURTH MEETING OF THE NEUROSCIENCE IMPLEMENTATION GROUP HELD AT 10.30AM ON WEDNESDAY 6 JUNE 2007 AT ROYAL COLLEGE OF PHYSICIANS, QUEEN STREET, EDINBURGH

Present: Mr John Glennie (in the chair)

Dr Peter Andrews (Neuro-anaesthesia & critical care)
Ms Carolyn Annand (Neuro-nursing)
Miss Jennifer Brown (Paediatric Neurosurgery)
Dr Sue Copstick (Neuropsychology)
Professor Martin Dennis (Stroke Medicine)
Mrs Myra Duncan (Regional Planning Groups)
Dr Alan Forster (Neurophysiology)
Professor Stewart Forsyth (Paediatrics)
Mr Mark Hazelwood (Scottish Neurological Alliance)
Ms Loraig Hunter (Speech & Language Therapy)
Dr Harpreet Kohli (Directors of Public Health & NHS QIS)
Dr Alan McLean (Spinal Injuries)
Professor Stuart Macpherson (Post-graduate Deans)
Dr Robert McWilliam (Paediatric Neurology)
Dr Richard Metcalfe (Scottish Neurosciences Council)
Dr Colin Mumford (Adult Neurology)
Professor Roy Rampling (Neuro-oncology)
Dr Richard Roberts (Academic Neuroscience)
Dr Colin Smith (Neuropathology)
Dr Robert Taylor (Neuropsychology)
Dr David Watson (Primary Care Neurology Society),
Professor Ian Whittle (Academic Neurosurgery)
Mr Andy Wynd (Scottish Neurological Alliance)

Secretariat: Dr Aileen Keel
Mr Will Scott
Mrs Fiona Warner
Mr David Brackenridge
Ms Fiona Maxwell

Item 1 Welcome and apologies for absence

1. The chairman welcomed everyone to the meeting, in particular Professor Gillian Needham who was attending her first meeting as a representative of the Postgraduate Deans and Mr Mark Brady who would be joining the Department on 25 June as Project Manager. Apologies for absence had been received from Mr Colin Cook, SEHD, Dr Rolf Dijkhuizen (NHS Board Medical Directors), Ms Fiona Farmer (Scottish Partnership Forum), Mr Douglas Gentleman (Neurorehabilitation), Professor Donald Hadley in whose absence neuroradiology was being represented by Dr Robin Sellar, Mrs Rosie Hewitt (Communications, SEHD), Mr Adrian Lucas (Scottish Ambulance Service), Mr James Steers (British Neurosurgical Society) and Mr Malcolm Wright (Specialist Children's Services).

Item 2: Minutes of the third meeting

2. The minutes of the third meeting were accepted as a correct record.

Item 3: Matters Arising

3. Health Inequalities The chair noted that Mr Steers had not yet provided a copy of the paper on neurosurgery and deprivation, particularly in relation to children. It would be circulated to the Group in due course.

4. Mrs Duncan referred to a paper published in Intensive Care Medicine entitled "Effect of deprivation and gender on the incidence and management of acute brain disorders" and undertook to make it available to the Group.

Action: Mr Steers; Mrs Duncan; Secretariat

5. Paediatric Neurosurgery It was noted that Professor McWilliam had volunteered to join the MCN sub group.

6. Professor Williamson mentioned that at a recent meeting with Health Board Chief Executives it was reported that change was accepted by neurosurgeons. However, emails which he and Dr Metcalfe received did not bear that out. It had been a useful meeting and while it was recognised that a degree of change was necessary there remained a division of views on how neurosurgery should be delivered in Scotland. It was accepted that there were differing opinions but it had to be recognised that the process was now have way through.

Item 4: Liaison Group Update

7. The minutes of the second meeting of the Liaison Group, which had taken place on 1 June, were not yet available but would be circulated as soon as possible. It was a useful group which consisted of Chief Executives of Boards with neurological units and was a good sounding board.

Action: Secretariat

Item 5: Patient and Public Consultation and Engagement

8. Mr Scott said that he was conscious of the time taken to progress this. Discussions had taken place with colleagues in the Department who dealt with Patient Focus and Public Involvement and it had been suggested that the PFPI person in each of the Boards with a neurosurgical unit should be involved in the sub-group. The NHS Borders PFPI person would also be invited to be a member because of her recent experience of public consultation.

9. The sub-group would have 2 main tasks: to prepare a final version of the paper to aid the public and patient consultation process and to organise open space events in the autumn. Mr Scott commented that it had been a difficult paper to develop but it had been helpful having comments from the Implementation Group. The paper still required some further working and more examples of specific conditions might make it more accessible to those outwith the service. Professor Needham stressed the importance of all Boards being involved in the consultation process.

Action: Secretariat

Item 6: Managed Clinical Networks

10. A network steering group had been established and a report would be given to the next meeting on the remit and membership of the sub-groups. To allow progress between now and the next meeting the Group would be consulted by email.

Action: Secretariat

11. Dr Dennis said there was a need for a close relationship between standards and audit group to ensure that standards could be measured. Dr Metcalfe commented that his concept of networks was focused on small symptoms. That was the approach devolved down to network and patient pathways. Pathways were different depending on the specific neurological disorder.

12. Miss Maxwell reported that pathways for spinal, trauma and pituitary disorders were being looked at. There were some concerns that informed decisions could not be made unless evidence was made available before the Group was due to report. Mr Brackenridge countered that pathways were not the only evidence. Ideally it would be good to have these worked through and finalised but he recognised that the timescale did not allow that. There were pressures on the Group to find a way to do it.

13. Mr Scott reported that spinal was chosen it was one of the highest volumes and trauma because of the need to know how the model coped with emergency paediatric cases. Development of the pathways was based on standards. One of the main tasks was to look at [?] documents in the Scottish context.

14. There were some concerns about the purpose of the Group. Was it predicated on an existing model or on doing further work such as needs assessment. Dr Keel pointed that the model was MCN approach in a prime site. Patient pathway work was crucial as regards what should be done and by whom. The model was clear in Kerr and was well documented and articulated in the previous report. Needs assessment would help to refine the model.

15. Professor Needham referred to the model being tested through the patient pathway approach and said she was less clear about work being carried out at other sites. The chair pointed out that there was still a need to recommend where the prime site would be located. The Group was advised that the way forward was to start with what was being done at the prime site before looking at what could safely be done at a more local level. It was agreed to send papers from the earlier Group to Professor Needham.

Action: Secretariat

16. Miss Brown expressed concern about whether the prime site would undertake the whole breadth of procedures or specific ones. It was felt that the lack of these definitions was hampering the work of the Group. Spinal work was not necessarily suited to centralisation. The Group accepted that some highly specialist procedures should be undertaken on one site but also that some should only be done in one place.

17. Concerns were expressed about patients with a mental disorder who presented with a neurological disorder. In moving such a service to a prime site could mean huge implications for all clinical leads. Professor Dennis commented that either everything should be in one place or in a distributed prime site. It was not possible to have a site for all specialisms. There followed a discussion on spinal surgery when it was reported that it was necessary to focus on the patient. There was a need for a surgeon who was interested in a particular condition. If neurosurgeons did not want to carry out spinal surgery then there was a need to find someone else.

18. Dr Keel reported that the pathway work was not the only piece of work on which the Group would have to deliberate. EWTD and patient safety had to be the main driving force. There were some concerns among the Group that EWTD was not designed as a safety standard for the medical profession. Dr Keel pointed out that the UK had signed up to EWTD and disagreed with the view that patient pathway came up against it. The Directive was inescapable.

19. It was suggested that subarachnoid haemorrhage might be a useful pathway to look at. It had evolved from four centres to two and had many links to other specialties. It was agreed that the pathways paper would be fleshed out for the next meeting.

Action:

20. It was suggested that if the Group had a little more time it would help in order to come to a proper conclusion. The Chair agreed that it would be raised at the Delivering for Health Board on 1 August. If the remit of the Group was changed now there was a risk that the new Ministers would not accept the outcome of the Group's work. There was no indication that the new Ministers were taking a different approach from the previous administration.

Action: [?Mr Glennie]

21. Dr Keel pointed out that the Group's recommendations would need a strong evidence base. The Chair reported that he wanted to use the Liaison Group to produce as much of a baseline as possible in order to say where the centre and compliance was at now.

Item 7: Activity Data Sub-Group

22. Mr Brackenridge spoke to his paper and gave an update on the work of the data sub-group. The group had now met 3 times with the neurosurgeons at Dundee, Aberdeen and most recently Glasgow, to discuss the quality of data on diagnoses and procedures generated by their work. The findings so far were that the ISD data were broadly accurate although there were more concerns expressed at the Glasgow meeting where some of the breakdown of data did not match what had actually happened. The quality and coding both by clinicians and medical records staff was problematic with excessive use of the dump procedure code X55 – other operations on unspecified organ. It was felt that the use of local data could help resolve that.

23. Coding guidelines to simplify coding were produced in late 2003 in response to concerns raised at that time. It appeared that these were not being followed. The 50:50 split between elective and emergency work at Aberdeen and Dundee was also reflected in a similar split at Glasgow. The amount of spinal work at Glasgow needed to be reconsidered to take into account Spinal Unit activity. A number of areas of activity not covered by ISD data were being identified and where possible quantified.

24. The Group was advised that since the last meeting considerable work had been done to relate diagnoses to procedure codes fitting in with the initial approach suggested by Professor Dennis. The table was being finalised and would shortly be sent to lead neurosurgeons for comment. The intention was to have the spreadsheet populated with activity by the end of July.

25. The sub-group were meeting with Edinburgh neurosurgeons on 21 June and on 17 July the sub-group were meeting to finalise a report on the quality of data. Other deliverables identified were additional activity data identified and quantified by the end of August and proposals for audit arrangements, to be presented jointly with the Audit sub-group, by the end of September.

26. Miss Brown reported that there were sporadic patient reviews at Yorkhill with no neurosurgery out patients. If the purpose of information gathering was for further planning them that had to be captured. Mr Brackenridge said that he would like to have access to the shunt registry data but was not sure if Yorkhill shunt data was included. The Group questioned whether the Data sub-group had a handle on things that were not done. In response Mr Brackenridge commented that the sub-group had not been collecting data to compare units but was looking at neurosurgery activity in each site. It was not looking at what had not been done. Diagnosis codes and neurosurgery procedure codes going against that were also being looked at. There was some concern in the Group that if it was not looked at then a substantial piece of activity could be missed.

27. Dr Keel commented that the underlying question was unmet need but there was no known evidence that was the case. It was noted that the sub-group was also looking at outpatient data. There was, however, a huge amount of work required to compare different practices in different units.

Item 8: Scott-Moncrieff Report

28. Dr Kohli spoke to the Scott-Moncrieff Report, which had been circulated as paper NSIG/08/07, and advised the Group that it had been circulated on a confidential basis as it was yet to be published. He said that Scott-Moncrieff had pointed out shortfalls in the information gathering and the Group was invited to send a note of any inaccuracies to Dr Kohli. **Action: All**

29. It was suggested that it might be circulated to the [? Association of Neurologists] but Dr Kohli indicated that he needed to discuss it first with the Scottish Executive before he could give an answer. It was noted that the Report had not looked at neurosurgery but rather the focus had been on neurology. The next steps were for NHS Quality Improvement Scotland to digest and decide on the way forward.

30. There was general dismay amongst the Group over the content of the Report which was felt to be very disappointing. No examples had been given in conclusions nor had services been mapped. It was pointed out to the Group, however, that that did not absolve Boards from their duty of mapping services in detail.

31. Some members of the Group did welcome the Report commenting that it highlighted serious deficiencies and should therefore lead to the gathering of better data. It was noted that the focus on disease omitted people with disorders. Dr Kohli recognised the Report's omissions but suggested it was a useful starting point. The issue now was how to use it to fill in the gaps and move on.

Item 9: Neurosurgical Activity Grid

32. Mr Brackenridge gave a PowerPoint presentation showing the work in progress. It was hoped that it would be finalised by the end of June. The Group questioned whether information was captured in the case of a distressed patient where a neurosurgeon was called but no action required. The Group was advised that if the sub-group knew what to look for it made it easier.

Item 10: Needs Assessment of Neurological Services

33. Dr Kohli spoke to his paper, which had been circulated as NSIG/09/07. Needs assessment should be seen to be independent of the Implementation Group. There would be a working draft by September/October. The Chair commented that it would be helpful to advise SPHN that the Implementation Group was expecting the draft at the end of September.

Action: Dr Kohli

Item 11: Outline Project Plan

34. Mr Brackenridge spoke to his presentation and advised the Group that discussions had taken place with HERU about the development of a business case. It was agreed that a note of high level options would be prepared for the next meeting of the Group.

Action: Mr Brackenridge

Item 12: Any Other Business

35. The Group agreed it would be helpful if the minutes could list early problems which needed to be addressed.

Date of Next Meeting

36. The next meeting would be held at 10.30am Thursday 16 August 2007 in Victoria Quay, Edinburgh.

Secretariat
June 2007