NHS SCOTLAND

Final Report of the Neuroscience Implementation Group

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1 Recommendations

1.1 Management arrangements for a Neurosurgery MSN

1.1.1 NHS Scotland should immediately establish a Managed Service Network (MSN) for Neurosurgery in Scotland according to the detailed arrangements set out in section 3 of this report. The Network should commence in shadow form on 1 January 2009, and formally on 1 April 2009.

1.1.2 The structure of the Network should include:

- A Network Board (strategic group), the Chair of which should be appointed by the Cabinet Secretary for Health and Wellbeing;
- An operational management group;
- A National Clinical Director;
- A Network Manager;

  and the Network should have control of a budget for its own activities, in particular in relation to data and audit development.

1.1.3 The Scottish Government should provide, on a pump-priming basis for 2 years, the budget needed by the Network.

1.1.4 As a pre-requisite of the establishment of a single service for Scotland, a Framework should be developed, setting out in detail an action plan for the development of the service.

1.1.5 NHS Boards with a neurosurgical unit will continue to be accountable bodies for all governance arrangements in those units. This will include clinical governance. Any concerns regarding clinical governance identified by the Network Board will be dealt with through NHS Boards' clinical governance arrangements.

1.1.6 The service should work in partnership with the Neurological Alliance of Scotland to ensure patients, users and the public are fully engaged in the delivery and planning of neurosurgery services in Scotland.

1.2 Transitional arrangements

1.2.1 The Cabinet Secretary for Health & Wellbeing should impose a moratorium on any further substantive appointments to the four current neurosurgical units until the MSN commences operation on 1 April 2009. This applies both to new posts and to replacements posts resulting from retirement.

1.2.2 The Cabinet Secretary should appoint the Chair of the Network Board, as referred to in paragraphs 3.12.1 and 3.12.2.

1.2.3 The post of National Clinical Director (see paragraph 3.14.1) should be advertised as soon as possible.

1.3 Data and audit arrangements

1.3.1 All neurosurgical units should be required to participate fully in nationally consistent collection of clinical data.

1.3.2 Pump-priming funding should be made available from the Scottish Government to enable the Network Board to take forward the development and maintenance of a national clinical database, to cover all neurosurgical activity including adults and children, and outcome measures where appropriate and clinically relevant. This will include the development of nationally agreed datasets which are in line with the National Clinical Dataset Development Programme (NCDDP), ISD, OPCS and ICD-10.

1.3.3 The funding should also cover initial system development, and opportunities for developing pre-existing resource (such as the e-case system) should be explored.

1.3.4 The funding should in addition cover ongoing dedicated audit support in all four centres. Opportunities for sharing, or developing shared, resource with other neurosurgical audit (such as neuro-oncology) should be taken.

1.3.5 The MSN should be responsible for the selection, recruitment and training of audit personnel to ensure consistency of approach, and, where the post holders are employed by an NHS Board which hosts a neurosurgical unit, ensure they have appropriate local support.

1.3.6 The MSN should have a framework for quality assurance and validation of the data collected.

1.3.7 The MSN should develop or adopt pre-existing policy on access to the data collected and should consider requests for access to activity and outcome data for future research against this policy, with appropriate reference to data protection legislation.

1.4 Clinical standards

1.4.1 The MSN should work closely with NHS Quality Improvement Scotland (NHS QIS) in the next stages of development of the clinical standards for neurosurgery, which should form part of an agreed, validated set of clinical neuroscience standards.

1.4.2 The MSN should ensure achievement of the clinical standards in all units and should work towards the developmental standards.

1.4.3 The MSN should take responsibility for facilitating and supporting regular and ongoing review of compliance in all centres against these standards. It should discuss with NHS QIS the Network Board's role in formal reviews of performance against the standards. The Network Board should act on recommendations based on the outcome of such review and have the power to ensure that such recommendations are acted upon. The outcome of these reviews should inform the next iteration of the neurosurgery Framework as described in section 3.4.

1.4.4 Where such action has local resource implications, the view of the MSN Board should influence NHS Boards' decisions on the prioritisation of funding within their development budgets.

1.5 Workforce and training

1.5.1 There should be a nationally co-ordinated programme of Neurosurgery specialty medical training managed by a Lead Scottish Dean and Host Deanery, with advice through the Surgical Specialties Training Board.

1.5.2 The Managed Service Network should take an active role in monitoring European Working Time Directive (EWTD) compliance of Junior and Consultant staff rotas. It should encourage the units to collaborate with the workforce planning team within the Scottish Government to find new ways to overcome any compliance issues and share best practice between the units across Scotland.

1.5.3 Where it is proposed to recruit additional clinical staff to meet EWTD legislation, the MSN should review the impact that this might have on quality of training and experience of the staff involved.

2 Introduction & background

2.1 Introduction

2.1.1 The Neuroscience Implementation Group submitted its previous report to the Cabinet Secretary for Health and Wellbeing in January 2008. That report is available at: www.scotland.gov.uk/neuroscience

2.1.2 The report made the following recommendations:

- That work to establish a common data set and arrangements for prospective national audit to provide meaningful data be given a very high priority.
- That the Network through its standards sub-group, should focus its initial efforts on the key area of standards development.
- It is essential on grounds of patient safety, quality of services and equity of access to treatment that the future service should be compliant with agreed clinical standards, once they have been finalised and accepted, and that data are identified to allow performance against the standards to be measured.
- The Implementation Group endorses the view that for neurosurgery, the status quo is not sustainable in terms of workforce and equity of access to treatment. It further believes that maintaining the status quo, for whatever reason, might hinder the realisation of benefits in terms of improvements in quality of services that could be achieved from a greater degree of integration and/or co-ordination across Scotland.
- The Implementation Group therefore recommends that it develops proposals for the operation of a Managed Service Network that could be submitted to the Cabinet Secretary within 6 months.
- The Implementation Group believes that the Managed Service Network should cover all of neurosurgery, both inpatient and outpatient. While it would need to relate to the closely-associated neuroscience disciplines, it would not be practicable to bring these within the service Network at this stage.
- The Implementation Group recommends that the work of the developing Managed Clinical Network and its sub-groups should be subsumed within the responsibilities of the Managed Service Network. Key principles of MCN working should apply to the development of the MSN, which must be able to ensure these are applied across the national service. In practice, however, the management of the whole service will require a more formalised and influential structure than a traditional MCN, which is more suited to deliver benefit to smaller, more easily defined patient groups.

2.1.3 The Implementation Group set out the following responsibilities for the MSN:

- Workforce planning, including succession planning across all four units, with the Network being responsible for approving the appointments of key personnel to neurosurgical units. New appointments would be made to the Service Network rather than to an individual NHS Board and the costs shared by all four Boards;
- Supporting a single Scottish national training programme for neurosurgery (replacing the two programmes that operate currently);
- Planning and managing sub-specialities, including paediatric neurosurgery, on a pan-Scotland basis;
- Working with NHS Boards to make sure the single service would achieve compliance with the provisions of the EU Working Times Directive;
- Ensuring that each unit met the Society of British Neurological Surgeons' (SBNS) standards;
- Ensuring that each unit collected data and participated in national audit arrangements, in accordance with the revised SBNS standards;
- Identifying specified improvements in outcomes, in conjunction with the Scottish Government, and agreeing delivery plans to realise these improvements;
- Enhancing arrangements to manage emergency neurosurgical cases;
- Implementing clinical care pathways;
- Working with NHS Boards in the planning and delivery of the local neuroscience services as envisaged in the model described in 'Building a Health Service fit for the Future' , linking effectively to the neurological standards being developed by NHS Quality Improvement Scotland and the implementation of the Rehabilitation Framework, and taking account of innovative models being developed in local communities, such as the Towpath Trust in Glasgow;
- Ensuring ongoing comprehensive patient and public involvement in its work.

2.1.4 In her letter of 25 March 2008 to the Chair of the Group, the Cabinet Secretary accepted these recommendations and agreed that the Group should be given a further six months in which to elaborate the Network's functions and constitution. This report sets out the results of this work. It is the culmination of an extensive engagement process with the Scottish Neurological Alliance, clinicians, officials in the Scottish Government, NHS Board Chief Executives, NHS planners, operational managers and other key stakeholders from across and outside the NHS.

2.2 The Neuroscience Implementation Group

2.2.1 The composition of the Implementation Group is shown in annex 1. The representatives of each discipline or sub-specialty of neuroscience were chosen and then endorsed by their peers, and undertook to act as channels of communication between the Implementation Group and their colleagues. On the occasions when they were unable to attend meetings, they were encouraged to send substitutes to ensure that each subspecialty was always represented.

2.2.2 In addition, a Managed Clinical Network was established to promote cooperative approaches to some of the key issues within the neurosurgical service, such as the lack of consistent data collection, agreed pathways of care and common standards. The MCN brought together various sub-groups tasked with taking forward these areas of work.

2.2.3 The Implementation Group was chaired by Mr John Glennie, Chief Executive, NHS Borders. Support was provided by a full time Project Manager and a Managed Clinical Network Manager.

2.2.4 Links were created with the work of other groups looking at a similar managed service network approach, in particular the National Steering Group for Specialist Children's Services and the Diagnostics Steering Group of the 18 week Referral to Treatment Programme Board. It was recognised, however, that while it was desirable to have a broad consistency of approach, each of these work streams needed to take account of particular factors affecting the service which they were considering.

2.2.5 The letter of 25 February 2008 to the Chair of the Group from the Cabinet Secretary was taken as the remit for the next six months' work. From this remit, a Project initiation Document was produced to identify exactly what work would be required over the following six months. This document is attached as annex 2.

2.3 Approach

2.3.1 Since much of the work in this second phase needed to be carried out with in cooperation with a wide range of stakeholders, it was agreed that the Implementation Group would take on a supervisory role, with a smaller Project Team responsible for taking forward the work of the project on behalf of the Implementation Group.

2.3.2 The Implementation Group met on 6 March 2008 to agree the remit and approach for the project. A further meeting took place on 22 May 2008 to review the work carried out to date and discuss any issues around the project. A final meeting of the group took place on 18 September 2008 to review the work and agree the final recommendations to the Cabinet Secretary. Minutes of these meetings are attached as annex 3.

2.3.3 The Project Team met frequently during this phase of work, and also, at the request of the NHS Board Chief Executives, had a meeting with the Chief Executives of the 4 Boards with responsibility for one of the neurosurgical units, referred to in this report as 'the provider Boards', to discuss the details of the emerging MSN. Two facilitated workshops involving a wide range of stakeholders were held to help develop ideas about the MSN. These were attended by a wide range of stakeholders; Board Chief Executives, operational managers, neurosurgeons, and others. Invitation and attendance lists for these events are attached as annexes 4 and 5.

2.3.4 As the output from these meetings and events developed into the final recommendations, the project team continued to consult with stakeholders by circulating several successive drafts of the report to the members of the implementation group and others.

2.4 Workstreams

2.4.1 The workstreams of the Implementation Group from January 2008 to September 2008 were defined as:

- To describe the new management model for neurosurgery services in Scotland including:
  - » the nature and composition of management structure
  - » roles, responsibilities and reporting arrangements
  - » governance issues
  - » key relationships to other stakeholders and organisations
  - » performance management arrangements
  - » financial arrangements
  - » links with the QIS neurology standards being produced
- To describe appropriate prospective data collection processes including specifying required data and potential options and costs for collecting this data. Data collection should be planned in co-operation with the emerging Managed Clinical Network (MCN).
- To describe the current service baseline including identification of which neurosurgical services are provided on each site, the equipment and support services available and clearly describe the neurosurgical service to be managed by the MSN.
- Through representation from the Neurological Alliance of Scotland, to ensure that patients' views and those of their representative organisations are incorporated in the design and specification of the Managed Service Network model.
- To seek solutions to workforce issues including EWTD compliance, support the development of a single national training programme for neurosurgery and consider the possibility of rotation across units and outreach arrangements and relationships between neurosurgery and other disciplines such as interventional neuroradiology and orthopaedic surgery.
- To continue to support the work (on data, audit, standards and patient pathways) undertaken as part of the Managed Clinical Network approach to neuroscience until a Managed Service Network can be established.

2.4.2 The results of each of these workstreams are set out in the following sections of the report.

2.5 The need for change

2.5.1 The need for change in neurosurgery in Scotland has been identified in a range of documents including the Neurosciences Action Team report (2005) and the interim report of the Implementation Group (2008). The table below sets out the results of a workshop held with a wide range of stakeholders which took place on 27 June 2008, at which the following factors were identified and discussed as drivers for change in neurosurgery:

Table 2.1 The need for change

The need for change	Factors to consider
Data/audit	
Data are required to provide evidence to inform service planning and development	Agreement in principle required to take forward any development(s)
Current lack of clear data on clinical activity/ audit, even locally	Agreed national datasets will need to be adopted
Inconsistency across sites (coding etc)	Need to find a nationally agreed and resourced solution
Data need to be of clinical use/relevance and also allow effective service planning and comparison of patient management across sites	Must be able to identify patients/processes for audit/follow-up
Service development	
Better national management of sub-specialisation to improve the patient experience; enhance consultant recruitment, etc.	Will need clear referral guidance for referring centres. Patient travel/transport issues if any single-centre sub-specialties develop
Effective management of resources across the four sites for developments in neurosurgery could avoid duplication of effort	The MSN has a clear role to play in ensuring investment in new technology and service developments in neurosurgery are planned on a national basis. This should allow the service to develop in a planned and managed way
Establish clear profile of 'core business' at each provider unit and descriptor of lower volume activity which may vary between centres	Will need clear shared care arrangements (clinics, o/p appt) and clear clinical governance arrangements for follow-up care
Equity of access	
Service must meet waiting times guarantees	Consider a common waiting list
'Equity' applies to entire patient journey, not just entry point e.g. follow-up, rehabilitation, etc.	Agreed pathways, and effective monitoring will point to areas of potential inequity

The need for change	Factors to consider
Access is often determined by local resource/ geography	Resources required to meet agreed standards. Particular needs of remote/rural and the effect on auditable measures, e.g., length of stay, referral pathways
Patient involvement	
Need for common pathways and assessment of outcomes to ensure that patient experience can be audited fully and allow standardisation of care	Patient satisfaction and the audit of their experience need to be embedded within management responsibilities. Systems for collecting audit data needed
Equity of access should not always be target driven – ideally should be what best suits the patient.	Needs to have effective links and be able to make participation easy, especially for hard to reach groups
Need to recognise and effectively manage patients' priority issues	Local v national management of resources, e.g. access to neurorehabilitation
Workforce planning	
Clear understanding of the national workforce requirement is lacking and there is a need to plan for replacement of consultant retirements, particularly in sub-specialties	National service to have responsibility for all key appointments including consultants. Need to consider issues of accountability and clinical governance, taking account of other regional appointment precedents A single nationally managed training scheme

Table 2.2 Potential benefits of a managed service network in

Benefit Title	Description
National management of service capacity	Ability to manage capacity nationally by identifying national solutions to local pressures; allowing patients to travel if they wish to take advantage of shorter waiting times in a more distant neurosurgical unit.
Improved access to specialist services	Patients have equitable access to services provided by scarce highly specialist staff.
Sub specialisation	The ability to plan and manage sub specialties nationally, including paediatric neurosurgery and low volume highly specialised neurosurgery, allowing all four units to have a 'critical mass' population of circa 5 million. This should support the sustainability of individual sites. A priority should be to encourage the utilisation of existing subspecialty services such as the National Spinal Injuries Unit, the Craniofacial Service, and the Neurosurgery for Mental Disorders service.

Benefit Title	Description
National workforce planning	The ability to agree nationally on consultant and other key appointments, succession plan and support a single Scottish national training programme for neurosurgery. The promotion of managed sub-specialisation will provide a basis for service development and improvement across Scotland. Promotion of multi-disciplinary neuroscience training, especially for associated specialties such as trauma and A&E medicine.
National planning of service developments	The ability to plan and prioritise service developments and improvements nationally in conjunction with the Scottish Government, and agree delivery plans to realise these improvements. This could include agreeing on the purchase of highly expensive equipment, avoiding duplication of effort and demonstrating value for money.
Nationally agreed standards	The implementation of agreed clinical standards will promote consistent approaches to patient care and allow for national audit.
Clinical data collection	A national system will ensure consistency of clinical data collection between the centres to provide more accurate measures of activity. It will also provide data and outcome measures for clinical audit and allow bench marking of centres.
Patient pathways	Standard referral protocols and pathways should be promoted where appropriate, recognising the effect of resource and geography, particularly on non-specialist elective work. Patients should have access to the same high quality standard of care and should benefit from whatever treatment/specialist advice/ follow-up etc., is most appropriate to their needs. National approaches can identify both examples of good practice for sharing and local service gaps or issues which could be resolved or improved.
PFPI	Ability to ensure effective patient and public involvement in its work.
Promote R&D and academic neuroscience	Play a key role in encouraging co-ordinated multi-site research and development.

2.6 Potential risks associated with the MSN model

2.6.1 The Implementation Group recognised that as the MSN model is a new and innovative approach to managing services, it would be vital to identify and analyse the potential risks associated with it and mechanisms which could put in place to overcome them. The risks identified are set out below:

2.6.2

Risk	Description
Lack of engagement with clinical and managerial staff	Vital to the project's success will be cooperation and collaborative working among the staff who run the service. To ensure the success of the new model, both groups of staff at the units must be able to accept the new model and should feel that the model will support them rather than be imposed on them.
MSN lacking sufficient authority	The network must have sufficient powers to implement change at provider board level. The viability and sustainability of neurosurgical services on a particular site may be called into question if all four sites cannot be planned on a national basis.
Not cost effective	It cannot be assumed that additional funding will be available for the establishment of the MSN, so the development of the new structure should not consume valuable financial resources or take up excess clinical time.
Lack of clear clinical leadership resulting in insufficient authority to implement decisions	The leadership of the managed service network must be able to implement the decisions it makes.
Lack of decision making and efficiency within the management board	Must ensure appropriate representation within the management board, without its size and scope becoming so large and overly bureaucratic that it is difficult to make decisions effectively.
Potential detrimental impact of MSN on other closely linked services locally	Loss of local autonomy over neurosurgical services could have a detrimental effect on other closely related services. Allowing as much autonomy to remain locally at board level whilst ensuring the MSN has enough authority to implement change and influence decisions will mitigate this risk.
Governance arrangements	Any Managed Service Network must have clear clinical and managerial governance arrangements and must be clear where governance responsibilities lie.
Timescale and implementation	The complexity of the project and range of services covered by neurosurgery mean that the realisation of potential benefits could take a considerable amount of time.

2.7 Previous findings and recommendations

2.7.1 To avoid duplication and ensure previous work was fully taken into consideration, the work of the Implementation Group has been carried out with reference to previous reviews of neurosurgery in Scotland and elsewhere. The recommendations set out in this report are consistent with delivering the main benefits identified in the Neuroscience Action Team Report (2005) and address many of the issues identified in that report. Many of its recommendations have remained key drivers in taking forward this phase of the Implementation Group's work.

3 Constitution of the Managed Service Network

3.1 Approach

3.1.1 Existing management models within the NHS were identified and reviewed by the Implementation Group and their various benefits and disadvantages considered. These are set out in annex 6. It was agreed that while each of these models met some of the criteria required, further work was necessary to identify a new and innovative approach which would ensure the benefits to patients were fully realised.

3.1.2 While the establishment of new arrangements for the national management of neurosurgery in Scotland should aim to deliver improvements and service development, any suggested model must also be designed to ensure that sustainable core services and emergency capacity can continue to be safely delivered on each of the sites.

3.1.3 To help design the MSN, a transparent and co-operative approach was taken with a wide range of stakeholders. Two independently facilitated workshops were held to discuss the new model.

3.1.4 The first of these workshops took place on Friday 27th June 2008, and the full report is attached as annex 4. The main focus was to:

- to confirm the need for change in the delivery of neurosurgery services in Scotland
- to agree approaches to the issues that need to be addressed (e.g. training, workforce planning, developing and implementing agreed clinical standards of service)
- to consider what management arrangements for the service would best meet the delivery of those approaches
- to agree a programme of work to develop and put in place the new arrangements, including arrangements for their periodic review

3.1.5 A second workshop, with a wider range of participants, was held on Monday 4th August 2008. The full report of this workshop is attached as annex 6. The main focus of this workshop was to:

- Identify what the Managed Service Network should do
- Identify how the Managed Service Network should work.

3.1.6 In considering these reports, the Implementation Group has kept in mind the need for devising those arrangements which are most likely to drive forward change and provide the best possible outcomes for NHS Scotland, while working within the responsibilities of NHS Boards. The following sections set out the detail around this model.

3.2 Purpose and powers

3.2.1 The purpose of the Managed Service Network is to improve services for patients by establishing a single neurosurgery service for Scotland. The establishment of the Network will allow all four existing units to continue to provide services locally while promoting patient safety and uniformity of clinical standards and management, with clear referral pathways to and from other specialties and for those who may benefit from referral to one of the other neurosurgical units managed by the MSN.

3.2.2 In order to establish a single service for Scotland, the Managed Service Network will need the necessary powers and ways of working to allow it to take robust planning and operational decisions. The Network will need to earn the confidence of patients, the Scottish Government, NHS Boards, consultants, other clinical and managerial staff, carers and the public. It must demonstrate that it can achieve the appropriate balance between highly specialised services which need to be developed on a national basis and those which can be safely provided at local level.

3.3 What the Managed Service Network will do

3.3.1 In order to establish a single service for Scotland, the Managed Service Network will need to undertake the following functions:

- Develop a framework to guide service development.
- Develop and monitor clinical and operational standards, referral and management protocols and guidance including patient pathways.
- Develop sub specialisation, for example through the approval of job plans of existing consultants and all new consultant appointments.
- Ensure adequate and appropriate engagement with patients, the voluntary sector and other stakeholders at all levels including Network activities and monitor patient satisfaction.
- Lead on workforce issues, including implementation of the European Working Time Directive and development of staff training programmes.
- Arrange mutual support between units optimising use of capacity and staffing.
- Develop data standards and systems to support audit and other information requirements, using audit facilitators to ensure consistent collection of data.
- Strengthen, develop and promote cooperative relationships between units, and with the other neuroscience disciplines which have an impact on the work of the Service Network.
- Play a key role in encouraging and promoting coordinated multi-site research and development.

3.4 A Framework to guide service development

3.4.1 This is a prerequisite of the establishment of a single service for Scotland. It will set out in detail, an action plan for the development of the service, including a system of continuous review of service provision. It will be consistent with future arrangements for regional and national planning, currently under review.

3.4.2 The Framework will be developed by working closely with patients, carers, clinical staff, NHS Boards, the Scottish Government and the public. The objective will be to ensure that the Framework is understood, owned and accepted by all those with an interest in the provision of neurosurgery services.

3.4.3 NHS Boards' proposals for service developments in neurosurgery will be developed in accordance with the Framework. Proposals will be submitted to the Network Board for approval, since it will have the main role in ensuring compliance with the Framework. The objective will be for the Network Board and the NHS Board concerned to reach agreement on the proposal. In the unlikely event that this is not possible, the Network Board will refer the issue to the Scottish Government. This mechanism will apply to all issues considered by the Network Board.

3.4.4 The Framework will address issues of best value and efficiency challenging the existing use of resources and guiding investment.

3.5 Sub specialisation

3.5.1 The development of sub-specialisation is recognised as important in encouraging advances in neurosurgical care and treatment. Development of sub-specialisation will be balanced against the need for all units to continue to be able to provide core services and emergency care. The systematic development of sub-specialisation is therefore a key task of the MSN.

3.5.2 The planned management of sub specialisation will be agreed on a national basis and this should be an essential element of the Framework.

3.5.3 Issues of patient safety, quality of outcomes and efficient use of resource will be the driving forces in sub specialisation.

3.5.4 The Network Board undertake a four-stage process;

- Sub specialties will be identified and agreed. Full clinical and managerial engagement will be vital.
- Referral guidelines will be developed so that clear pathways enable the transfer of patients to the appropriate centre, with the involvement of other relevant specialties (e.g. orthopaedics) as required. Scottish Ambulance Service resources should be considered as part of this.
- The network, and in particular the national clinical director, will, in line with the Framework, set out the services which need to be delivered for Scotland and will then, along with NHS Boards as employers, review job plans of individual neurosurgeons to make sure these are consistent with the national arrangements.

The objective should be for the Network Board and the NHS Board to reach agreement.

- NHS Boards will submit proposals for all new and replacement consultant posts, including job plans, to the Network Board for approval in the context of the Framework and agreed sub specialisation within the MSN. Other key clinical appointments will also be approved in advance by the Network Board.

3.5.5 Sub specialisation is a complex issue and requires focused effort. The Network Board will therefore establish a group to lead the work. Two important considerations will be taken into account:

- Sub specialisation will be an evolutionary process recognising that there are issues of culture and confidence and that there will be an impact on individual clinicians. The starting point will be consideration of paediatric neurosurgery as the immediate priority and then low volume elective specialties.
- The consequences of sub specialisation will be assessed, bearing in mind the need to maintain services on four sites as described in paragraph 3.1.2.

3.6 Standards, protocols and guidance including patient pathways

3.6.1 Proposals for sub specialisation must be informed by agreed standards, protocols and guidance including patient pathways. Further discussion on standards is included in section 5.

3.6.2 The Managed Service Network will work closely with relevant professional bodies and should build on best practice, including international developments. The Network will coordinate the implementation and assessment of existing standards and develop new or more detailed standards as required.

3.6.3 Review against standards and protocols will balance local operational, resource and other non-clinical reasons for variance against the importance of equity of access and service provision for all patients.

3.6.4 The Network will communicate with all concerned to ensure that standards are understood and implemented.

3.6.5 The MSN will assume responsibility for taking forward work already begin in these areas by the various working groups of the developing MCN in standards and pathways development.

3.7 Data standards and systems

3.7.1 Good quality, reliable data is fundamental to the success of the Network and is essential for the development of the Planning Framework, audit, and review against agreed standards.

3.7.2 The Network will develop outcome measures, including measures of patient experience. It will also explore opportunities created by the scale of the Network and increased cooperation between the four units for research on standards, including outcome measures.

3.7.3 The Network will be responsible for the funding and training of audit facilitators, and the Implementation Group recommends that the Scottish Government should identify funding for this function.

3.7.4 Participation in all data systems and collection will be mandatory for all centres and all clinicians.

3.7.5 The arrangements for data and audit are dealt with in more detail in section 4.

3.8 Patient involvement and patient satisfaction

3.8.1 'Better Health Better Care' set out a series of actions designed to ensure a more mutual NHS. The MSN will need to earn the confidence of patients, carers and the public and demonstrate its commitment to a nationally managed service for neurosurgery in Scotland. This can only be done if the Network ensures that patients and carers, or the organisations which represent their interests, are involved in services at all levels including the Network's own activities. In keeping with the principles of all Network developments, representatives from the voluntary sector will be included in the membership of the Network Board and the Operational Management Group.

3.8.2 Key issues for patient involvement include access to high quality care, equity of access throughout Scotland, with diagnosis, assessment, treatment and rehabilitation provided as locally as possible.

3.8.3 Patient involvement in the development of patient pathways and rehabilitation following surgery are clear examples of how such involvement of 'stakeholders' can reap significant benefit for patients.

3.8.4 The Managed Service Network will take responsibility for ensuring that patients' and carers' views are heard and that they have a real forum for influence in service design and delivery.

3.8.5 In order to achieve this, the Managed Service Network will provide training and support to ensure such stakeholders have the confidence to engage effectively with the work of the Network at all levels.

3.9 Workforce issues

3.9.1 The Network will lead on workforce planning for all staff groups, and workforce issues will be an integral part of the Framework. The Network's involvement in job planning for existing consultants and proposals for new consultant posts is set out in paragraph 3.5.4

3.9.2 The Network should oversee the provision of education and training for all staff in order to avoid duplication and to ensure equitable provision and access. Further description of workforce arrangements is given in section 6.

3.10 Mutual support

3.10.1 Good communication and mutual support, between and among surgeons and other specialties, will be essential to the success of the MSN. The Network will encourage this, and will take a lead in promoting more co-operative working to realise benefit for patients. This could include:

- Considering joint staff appointments, such as clinical nurse specialists
- Developing a protocol for assistance in emergency situations such as an outbreak of infection in a unit
- Considering the appropriate number of neurointensive care beds and other specialist facilities
- Exploring opportunities for effective use of tele-technology.
- Considering the establishment of an annual event for all involved in delivery of neuroscience services.

3.11 How the Managed Service Network will operate

3.11.1 In order to establish a single service for Scotland by taking forward the agenda set out in the paragraphs above, the Network will need the necessary powers and ways of working to take robust planning and operational decisions. The Network cannot instruct individual NHS Boards on issues of service planning and staffing, since Boards retain statutory accountability for health services. It will therefore be essential for the governance arrangements of the Network to facilitate agreement between the Network Board and the NHS Boards. As suggested in paragraph 3.4.3, in the unlikely event that this is not possible the MSN should refer the issue to the Scottish Government through its existing accountability mechanisms.

3.11.2 The structure of the Managed Service Network should include:

- A Network Board (strategic group)
- An Operational Management Group
- A National Clinical Director
- A Network Manager
- Identified resource and budget for Network activities

3.11.3 The Network Board will need to establish key links to other NHS organisations. The MSN Board will be held accountable to NHS Health Boards. It will need to feed into existing regional planning arrangements and later national planning arrangements once these are established. The governance responsibility for the provision of neurosurgical services in Scotland will remain with the local health boards providing these services.

3.12 Network Board

3.12.1 A Network Board should be established. The members of the Board will include:

- A Chair appointed by the Cabinet Secretary for Health & Wellbeing
- the Chief Executives of the four NHS Boards providing neurosurgical services
- three additional NHS Board Chief Executives representing the regional planning areas
- two members nominated by the Scottish Neuroscience Council
- two representatives nominated by the Neurological Alliance of Scotland.
- the National Clinical Director
- the Network Manager (as an observer) one representative of the Scottish Government.

3.12.2 The Chair of the Network Board will report directly to the Cabinet Secretary for Health & Wellbeing. The Network Board will be accountable to the NHS Boards collectively and to the Scottish Government, taking account of the new national arrangements currently being developed by the NHS Board Planning Directors. The Board will hold an annual stakeholders' meeting and will submit an annual report to the NHS Boards and to the Scottish Government.

3.12.3 The Network Board will seek consensus but if consensus cannot be achieved decisions should be made by majority voting. If an NHS Board is unable to accept a decision made by the Network Board, the Network Board will refer the issue to the Scottish Government.

3.13 Operational Management Group

3.13.1 An Operational Management Group will be established to be responsible for much of the detailed work of the MSN. It will report to the Network Board. Additional members may be co-opted depending on specific workstreams, but its permanent structure and members will be decided by the Network Board. It will include:

- Chair - the National Clinical Director.
- Appropriate patient representation from each of the provider Boards. These patients should be identified by working with local Board patient focus and Public Involvement (PFPI) leads and the Neurological Alliance of Scotland.
- The Lead neurosurgeons from each of the four provider units
- The Operational Managers from each of the provider units
- A senior neuroscience nurse and AHP nominated by the Scottish Neuroscience Council
- A representative of the Scottish Ambulance Service
- The Network Manager.

3.14 National Clinical Director

3.14.1 The network board will appoint a national Clinical Director, for three years in the first instance with the potential for reappointment. The post will be sessional and will be advertised. It is anticipated that the post will require four sessions per week, and the appointee will therefore require appropriate resources such as clinical backfill to be made available to enable them to carry out this role. The person appointed should carry the confidence of the neurosurgery community.

3.15 Network Manager

3.15.1 A Network Manager will be appointed, who will be accountable to the National Clinical Director and should be responsible for taking day to day operational decisions and supporting the National Clinical Director in carrying out agreed work. The Network Manager will attend meetings of the Network Board as an observer and to strengthen the links between the Network Board and the Operational Management Group.

3.15.2 As this new service network model is innovative, and its remit, responsibilities and authority are unlike that of any MCN, the Network Manager will require to have a degree of experience and responsibility over and above that of a traditional Managed Clinical Network manager. The recommendations in relation to the new MSN are extensive and the work it has to take forward is complex, will be time consuming and will require considerable communication, organisational, strategic planning and management skills. The post holder will be expected to have considerable responsibility and autonomy.

3.15.3 Equally important is a structure in which the Network Manager can be supported in progressing the work, with key working relationships including the National Clinical Director, local operational and strategic management, senior clinicians, the Network Board, Management Group, and others.

3.16 Budget

3.16.1 The Network Board will hold the budget for its own activities including staff and clinical data/audit development. It would not be practical for the Network Board to hold the operating budget for neurosurgery services.

3.16.2 The Board will influence service development through the Framework set out in paragraph 3.4.

3.16.3 The Implementation Group recommends that the Scottish Government should provide pump-priming funding for the first 2 years of the MSN's operations, and that thereafter the Network's budget should come from NHS Scotland collectively. In the event of a lack of agreement on the amount of the budget, the Network Board may refer the matter to the Scottish Government.

3.17 Clinical and staff governance arrangements

3.17.1 As statutory bodies in their own right, the NHS Boards will be responsible for clinical governance arrangements at their own neurosurgical units. Any concerns regarding clinical governance identified by the Network Board will be dealt with through NHS Boards' existing clinical governance arrangements.

3.17.2 The respective NHS Boards will continue to be the employer of clinical and other staff working within each of the units.

3.18 Effective communication

3.18.1 For the Managed Service Network to earn the confidence of stakeholders, it will need to develop and maintain effective communication channels. The Chair, members of the Network Board, the National Clinical Director and the Network Manager will all have vital roles to play. The Network Manager will have particular responsibilities in developing relationships and links with all stakeholders and in establishing effective and appropriate mechanisms to support information exchange and communication. Links with local clinical governance mechanisms will be established, with co-ordination with NHS Quality Improvement Scotland as a priority.

4 Clinical data and audit arrangements

4.1 Approach

4.1.1 As part of the work of the Implementation Group, a Data and Audit sub group was established in line with the core principles governing MCN development. Over the last year, this group has looked at ways to support clinicians in the improvement of data collection across the four sites, promote consistent audit and identify ways for the new managed service network to improve the collection of outcome and activity data in the future. The membership of and contributors to the data and audit sub group are listed in annex 7.

4.2 Recommendations for future clinical data collection

4.2.1 The sub group has produced the following recommendations, to be taken into consideration when establishing the MSN for neurosurgery, and these are endorsed by the Implementation Group.

4.3 Nationally consistent data collection

4.3.1 All centres should undertake to participate fully in nationally consistent collection of clinical data.

4.3.2 The initiation of a large scale national project such as this requires commitment from clinicians and managers alike, and the Network Board will have to be given sufficient authority to influence action at individual NHS Board level. Communication and explanation of the future benefits of audit data will also be very important. The collection of high quality data has resource implications, and the introduction of data collection must be adequately planned and supported. This work should be reflected in the Framework discussed in paragraph 3.4.

4.4 National clinical database

4.4.1 Funding should be made available for the development and maintenance of a national clinical database, to cover all neurosurgical activity including adults and children, and outcome measures where appropriate and clinically relevant. It will be the responsibility of the Network Board to ensure this is taken forward.

4.4.2 Generic demographic information and a core dataset should be collected for each neurosurgery inpatient, to build an accurate national picture of surgical activity. This could be based on the Scottish Adult Neuro-oncology Network (SANON) core dataset. The system should also be extended to collect measurable patient outcomes, balancing the need for clinically useful information against the risk of over-extending the system and over-burdening clinicians and other staff. Clinicians themselves will have to be closely involved in determining the outcome data which would be most useful.

4.4.3 The effectiveness of the system will rely on:

- agreement that the datasets are clinically useful
- adequate resource (audit support) working closely with the clinicians to improve the quality of the data collected
- the Network Board having the authority to assist or influence NHS Boards where problems may arise.

4.5 Development of nationally agreed datasets

4.5.1 This will include the development of nationally agreed datasets which are in line with the National Clinical Dataset Development Programme (NCDDP), ISD, OPCS and ICD-10.

4.5.2 NCDDP currently has no plans to develop datasets for neurosurgery and is unlikely to include this development into its work plan in the near future. However, a good deal of work has already been done in defining all the required generic patient data fields and on many relevant other individual data fields as part of dataset definition work on, for example, epilepsy and stroke. A minimum core dataset has already been developed by SANON which has used NCDDP definitions where possible and developed some further fields in consultation with ISD. This approach should be extended into the development of datasets for other neurosurgical conditions/ procedures. Diagnostic and procedure codes must be compatible with OPCS/ICD-10 and the system coding convention should be based on the pre-existing classification developed by Mr Laurence Dunn and ISD for use in Scotland.

4.6 System development

4.6.1 Any system adopted will require some refinement and development to suit the requirements of neurosurgery, but where there is a product currently in use in the NHS its ongoing use should be seriously considered.

4.6.2 At present, the e-case system is in use for around ten tumour groups and, to a smaller extent, in cancer genetics and bowel screening. Currently there are around 14,500 cancer cases recorded on e-case and it is the only NHS-owned and developed database system in use or, as far as is known, in development. E-case is one example in this area which the MSN may wish to consider.

4.6.3 The adoption of e-case would have a few key advantages and potential problems:

Potential advantages include:

- already used for neuro-oncology and spinal cord compression
- web based – can access from anywhere
- relevant datasets already built
- pre-existing expertise and experience 'in-house'
- relatively inexpensive
- would build and strengthen a pre-existing NHS resource/team

Potential problems:

- only used for cancer at the moment; development would have issues for structure/ placement of e-case team
- does require some further development
- is currently a stand-alone system

4.6.4 An initial development phase would involve the appointment of a new developer. Using e-case this is estimated at around Agenda for Change band 6 (£24103 - £32653) for 12-18 months.

4.7 Audit support for four centres

4.7.1 The funding also needs to cover ongoing dedicated audit support in all four centres. Opportunities for sharing, or developing shared resource with other neurosurgical audit (such as neuro-oncology) should be taken. The Implementation Group recommends this should be included in the Scottish Government's pump-priming funding.

4.7.2 Problems with accurate, consistent coding are well known and understood and this development should improve the quality of the activity data currently available, as well as establish clinically useful audit. This will depend on effective, nationally consistent, dedicated audit support working closely with clinicians in each centre.

4.7.3 Until the first phase of development is completed (dataset definition and system build) it will be difficult to predict how much audit support will be required in each centre. This will therefore not be required immediately. Some audit support is already in place, currently collecting data on intrinsic brain tumour.

4.7.4 Neurosurgical audit support should cover all neurosurgery patients. Some funding may be required for the initial support and development of current neurosurgical audit, to allow the process to become embedded in the four units and establish a neurosurgical audit presence. If so, the Scottish Government should provide pump-priming funding. Monitoring the neuro-oncology audit requirement while the system is developed will also allow for a more accurate prediction of the extent of audit support required in future.

4.8 Audit personnel

4.8.1 While it is recognised that the provider NHS Boards will be responsible for the employment function, the Operational Management Group should have input to the process of recruitment and training to ensure consistency of approach. This will need to be coordinated and negotiated with the provider NHS Board.

4.9 Quality assurance and validation

4.9.1 The Managed Service Network will have a framework for quality assurance and validation of the data collected.

4.9.2 This refers both to the checking of activity data and clinical outcome data. ISD's QA resource may be used, but clinical involvement will be essential in the quality assurance of outcome data. However this is structured, the Service Network will make sure that the data collected is accurate and complete, and is able to address issues where they arise.

4.10 Access to data

4.10.1 The service network will develop or adopt pre-existing policy on access to the data collected and should consider requests for access to activity and outcome data for future research against this policy, with appropriate reference to data protection legislation.

5 Standards

5.1 Approach

5.1.1 A standards group was also set up as part of the work of encouraging an MCN approach to neurosurgery. The main aim of the group was to review the existing SBNS standards for neurosurgery and edit these to make them more relevant to Scotland and ensure they were as concise and measurable as possible. Members of the standards group are listed in annex 8.

5.2 Progress to date

5.2.1 The group has produced a revised set of standards and the document has been considered by a wide range of clinicians, voluntary sector and charitable organisations, NHS and Scottish Government management and service users. These comments have now been considered by the group and an amended version of the standards document produced. The revised standards are included as annex 9.

5.2.2 The majority of the responses to the draft document have been positive and helpful, and the group was encouraged by the constructive nature of the comments received. The standards appear to have received a welcome from the neurosurgical community and service providers are in agreement with the general aims and specific statements in the document.

5.3 Recommendations

5.3.1 The Implementation Group's recommendations are:

- the MSN will work closely with NHS QIS in the next stages of development, to agree a nationally validated set of standards for clinical neuroscience.
- The MSN will ensure achievement of the clinical standards in all units and should work towards the developmental standards.
- The Network Board will take responsibility for facilitating and supporting regular and ongoing review of compliance in all centres against these standards. It will discuss with NHS QIS the Network Board's role in formal reviews of compliance with the standards.
- The Network Board will act on recommendations based on the outcome of such reviews and have the power to ensure that such recommendations are acted upon. The outcome of these reviews will also inform the next iteration of the Framework.
- Where such action has local resource implications, the view of the Network Board will influence NHS Boards' decisions on the prioritisation of funding within their development budgets.

6 Workforce issues in neurosurgery

6.1 Background

6.1.1 The Managed Service Network will have a key role to play in strategic workforce planning. This will include identifying the future workforce requirement for neurosurgery, ensuring appropriate education and training is available to those who work for the service and supporting Boards to ensure they meet the EWTD.

6.2 EWTD

6.2.1 The European Working Time Directive (EWTD), Directive 3003/88/EC, is a directive of the European Union to protect the health and safety of workers in the European Union. It lays down minimum requirements in relation to working hours, rest periods and annual leave for all workers and working arrangements for night workers. The EWTD originally did not apply to doctors in training (junior doctors) but the Amending Directive, Directive 2000/34/EC, removed this exclusion so that by August 2009, they too will be subject to a 48 hour week. Compliance with EWTD was a key issue specified by the Cabinet Secretary for Health & Wellbeing in taking forward the development of the MSN.

6.2.2 The issue of the neurosurgical units' compliance with EWTD has continued to cause concern for the Implementation Group. It is vital that the Managed Service Network continues to monitor the working patterns of consultant and junior medical staff at the units to assess compliance with EWTD. Although local arrangements such as 'hospital at night' are likely to provide the best solution to the challenges around EWTD, the network should play a key role in sharing solutions and best practice and encouraging engagement between the individual units and the Scottish Government Workforce Planning team.

6.2.3 Should EWTD compliance not be achieved, the Service Network should take a central leadership role, working with Boards on the steps needed to make rotas compliant. This issue is not only for trainees' hours, but also consultants'. It is vital to note that any potential solution cannot increase consultant numbers because of the consequent reduction in experience this would cause.

6.2.4 As a nationally managed service, the Network has a unique opportunity to provide positive and constructive leadership on the issue of EWTD compliance, which is of increasing importance to neurosurgery and other small specialties across NHS Scotland.

6.3 Teaching and training

6.3.1 Neurosurgery Specialty Training will be a nationally co-ordinated programme managed by a Lead Scottish Dean and Host Deanery with advice through the Surgical Specialties Training Board. There will be a National Training Programme Director and a single Specialty Training Committee, as already exists for Neurology.

6.3.2 The MSN will help in the promotion and provision of multidisciplinary neuroscience training and ensure that access to such training is possible in non-provider Boards. It will act as a vehicle for the education of non specialist providers in relevant areas, e.g. trauma and A&E colleagues in the management of head injuries.

6.4 Succession planning

6.4.1 It is clear that a thorough understanding of the national workforce requirement for neurosurgery in Scotland is lacking and there is a need to plan for replacement of consultant retirements, particularly in sub-specialties.

6.4.2 The MSN will play a key part in liaising with Boards to ensure a consistency of approach to workforce planning across Scotland. The MSN should take a leadership role in succession planning for the service in Scotland.

7 Transitional arrangements

7.1 Timetable

7.1.1 The Implementation Group is anxious that the next phase of work should commence as soon as possible, avoiding the problem of the hiatuses that have afflicted earlier attempts to resolve the neurosurgical issue. It therefore recommends that the Network Board should be set up in shadow form from 1 January 2009 and the Managed Service Network should become fully operational by 1 April 2009. That would involve the Cabinet Secretary for Health & Wellbeing appointing the chairman before that date. The Network Clinical Director post would need to be advertised during October.

7.1.2 The Project Team which has taken responsibility for supporting the work of the Implementation Group remains available to provide ongoing logistical support meanwhile.

7.1.3 Current work on data and audit, clinical standards and the development of the service baseline should continue, in order to help the Managed Service Network get off to the best possible start.

7.2 Moratorium on appointments

7.2.1 In order not to undermine the arrangements proposed for the MSN, especially in relation to the development of the Framework and workforce issues, the Implementation Group considers it essential that the Cabinet Secretary for Health & Wellbeing should impose a moratorium on all substantive appointments to the 4 neurosurgical units until the MSN formally begins operation. The operational managers responsible for each of the 4 units should be asked as a matter of urgency to provide information about any consultant vacancies likely to occur between now and the expected date on which the Managed Service Network begins operations.

Annex 1 Membership of the Implementation Group

Chair:

Mr John Glennie	Chief Executive, NHS Borders

Members:

Mr David Allan	Director, Queen Elizabeth National Spinal Injuries Unit, Glasgow
Dr Peter Andrews	Consultant Anaesthetist, Edinburgh
SCN Carolyn Annand	Ward Sister, Neurosciences, Aberdeen
Miss Jennifer Brown	Consultant Neurosurgeon, Glasgow
Ms Beverly Bryan	Lead Physiotherapist, Department of Clinical Neuroscience, Edinburgh
Dr Susan Copstick	Consultant Clinical Neuropsychologist, Glasgow
Professor Martin Dennis	Consultant in Stroke Medicine, Edinburgh and Chair of National Advisory Committee on Stroke
Dr Roelf Dijkhuisen	Medical Director, NHS Grampian
Mrs Myra Duncan	Director of Regional Planning, South East and Tayside Regional Planning Group
Ms Fiona Farmer	Amicus, representing Scottish Partnership Forum
Dr Alan Forster	Consultant Neurophysiologist, Aberdeen
Mr Douglas Gentleman	Honorary Consultant Neurosurgeon and Consultant in Rehabilitation Medicine, Dundee
Professor Donald Hadley	Consultant Neuroradiologist, Glasgow
Mr Mark Hazelwood	Chief Executive, MS Society Scotland and Chair of Scottish Neurological Alliance
Ms Laorag Hunter	Speech and Language Therapist, Dundee
Dr Harpreet Kohli	Medical Director, NHS Quality Improvement Scotland, also representing Directors of Public Health
Dr Robert McWilliam	Consultant Paediatric Neurologist, Glasgow
Dr Richard Metcalfe	Consultant Neurologist, Glasgow, and Chair, Scottish Neuroscience Council
Dr Colin Mumford	Consultant Neurologist, Edinburgh
Professor Gillian Needham	Postgraduate Dean, Aberdeen Medical School
Ms Alison Rae	Occupational Therapist, Glasgow Royal Infirmary
Professor Roy Rampling	Consultant Neuro-oncologist, Glasgow
Dr Richard Roberts	Reader in Neurology, University of Dundee, representing academic neuroscience

Dr Colin Smith	Consultant Neuropathologist, Edinburgh
Mr James Steers	Society of British Neurological Surgeons
Dr David Watson	GP, Aberdeen, representing Primary Care Neurology Society Scotland
Professor Ian Whittle	Consultant Neurosurgeon, Edinburgh
Mr Malcolm Wright	Chief Executive, NHS Education for Scotland
Mr Andy Wynd	Chief Executive, Scottish Spina Bifida Association

Secretariat:

Dr Aileen Keel, Deputy CMO

Mr Will Scott, Project Director, Scottish Government

Mr Mark Brady, Project Manager, Scottish Government

Mrs Fiona Warner, Policy Manager, Scottish Government

Ms Fiona Maxwell, National MCN Manager

Annex 2 Project Initiation Document

Neuroscience Implementation Project

Phase 2

Project Initiation Document (PID)

Version Control

Project:	Neuroscience Implementation Project – Phase 2	*Date:*	29/02/08
Author:	M Brady	*Version:*	3.0
Comments	Includes comments from Implementation Group 06/03/08		

1. Background

The Neuroscience Implementation Group Report (2008) set out recommendations for the future management of neurosurgical services in Scotland. The report, which contained two potential options for the future configuration of neurosurgery in Scotland was submitted to Ministers on 31st January 2008. The Minister for Public Health announced on 25th February 2008, that the recommendation in favour of option 2, the establishment of a national service network, had been accepted by the Government. The Implementation Group has been asked to provide the detail around how this model will work in practice. The group have been given a timescale of six months to complete the project.

2. Project Definition

The aim of this project is to design the new single service model for neurosurgery in Scotland and set up the appropriate mechanisms to ensure the new model can be implemented. It should result in a nationally managed "Service Network" for neurosurgery in Scotland.

In particular, the structure will be responsible for:

- Workforce planning across all four units including responsibility for approving appointments of new staff to neurosurgical units in order to plan for supply and demand. New appointments should be made to the service and costs shared by all four boards.
- Supporting a single Scottish national training programme for neurosurgeons and other groups (replacing the 2 programmes that operate currently).
- Planning and managing sub-specialities, including paediatric neurosurgery, on an all Scotland basis.
- identifying exactly what is required by European Working Time Directive (EWTD) legislation and taking steps to ensure these requirements are met by the service across all four boards
- Ensuring data collection and participation in national audit.
- Ensuring the service works to agreed standards for neurosurgical care
- Identifying and prioritising specified improvements in service in conjunction with the Scottish Government, and agreeing delivery plans to realise these improvements.
- Enhancing arrangements to manage neurosurgical emergencies
- Implementing clinical care pathways as they are developed
- Working with NHS Boards in the planning and delivery of the local neuroscience services in line with the neurological standards being developed by NHS Quality Improvement Scotland (QIS) and the implementation of the rehabilitation framework, taking account of innovative models which exist.
- Ensuring comprehensive patient and public involvement in its work.

3. Project objectives

Over the next six months, the project will:

a. Describe the new management model for neurosurgery services in Scotland including:

- the nature and composition of management structure
- roles, responsibilities and reporting arrangements
- governance issues
- key relationships to other stakeholders and organisations
- performance management arrangements
- Financial arrangements
- links with the QIS neurology standards being produced

b. Describe appropriate prospective data collection processes including specifying required data and potential options and costs for collecting this data. Data collection should be planned in co-operation with the existing Managed Clinical Network (MCN).

c. Establish a current service baseline including identification of all neurosurgical services provided on each site, equipment, support services available and activity information, which will be required to document the scope of the neurosurgical service in Scotland and clearly describe the service to be managed.

d. Through representation from the Neurological Alliance of Scotland, ensure that patients views and those of their representative organisations are incorporated in the design and specification of the Managed Service Network model.

e. Seek solutions to workforce issues including EWTD compliance, support the development of a single national training programme for neurosurgery, the possibility of rotation across units and outreach arrangements, relationships between neurosurgery and other disciplines such as interventional neuroradiology and orthopaedic surgery.

f. Continue to support the work of the neuroscience MCN.

4. Project scope

The project is concerned primarily with neurosurgical services, however the project must take into account key linkages between neurosurgery and other clinical specialities from neurosciences as a whole.

The project will describe the new service model and the relevant mechanisms required to support the nationally managed service network. The model should be of sufficient detail to allow meaningful engagement with stakeholders and the public. The project will not however, implement the new model at this stage.

5. Project deliverables and outcomes

Further detail around the products listed below and suggested templates to be completed are attached in the appendices to this document.

Deliverable	Description	Products
Operational Baseline	Identify current service baseline and in particular facilities and equipment available at each neurosurgical unit.	Define 'neurosurgical services' in Scotland documenting exactly what services are currently provided on each site. Document facilities currently available at each unit. Document staffing at each unit and treatments and procedures provided locally.
Data requirements	Agree what data will need to be available to the service network. A proposed specification of data required for the MSN is set out in **Appendix A**	Agree a comprehensive list of data required for the managed service network. Finalise the report on retrospective data with indications on accuracy of the data. describe methods of collecting prospective data. Identify resources required to collect accurate prospective data. Support the Data and Audit

		group in rolling out new coding standards for neurosurgical procedures which are compatible with NHS systems.
Workforce Planning	Identify and tackle workforce planning issues with regard to neurosurgery.	Identify workforce issues and document these. Document EWTD compliance on all four sites for junior medical and consultant staff. Documented Legal advice re EWTD compliance on four sites. Documented proposals for workforce planning over the next 10 Years. Describe future training arrangements for doctors in training.
Selection of preferred management arrangements for the model and specification and arrangements for Managed Service Network	Identify the composition of the managed service network and the detail around how it will operate.	describe similar models used elsewhere and potential models to be used. Choose preferred model Describe key relationships including relationships with regional planning groups, health boards and the managed clinical network. Describe membership of management board

		Describe commissioning arrangements if required by the new model. Describe performance management and financial management arrangements Describe operational standards required Describe governance arrangements Describe service standards Description of admin and managerial support required for network Describe employment issues / role of MSN in agreeing appointments and role of MSN in staff governance arrangements. Identify implementation timescales.
MCN arrangements within new model, including compliance with the MCN core principles set out in HDL(2007)21.	Issues for MCN to consider as part of the new model.	Objectives of MCN over 6 month period. Describe and agree working relationships and lines of responsibility under new model.

		Identify requirements for a national dataset Identify lines of responsibility and reporting arrangements.
Identifying issues at community level which the MSN should address.	Working with those responsible for implementation of the Rehabilitation framework. Implementation of the SBNS standards adapted for use in Scotland. Exploring innovative models for community services. Linking to NHS QIS neurological standards dealing with access to neurology.	

Note: Further detailed descriptions are required of each of the products listed above to ensure work produced meets the original specification and is delivered to the appropriate timescale. All product specifications must be agreed by the project team. Final products will be signed off by the Implementation Group.

6. Exclusions

Project will be about designing the process for setting up management board and will finish once firm proposals can be put in place which will then be consulted upon.

7. Constraints

The project must be completed within six months.

No further funds have been identified to assist with the new model so the new service must be able to operate within current financial arrangements.

8. Assumptions

The project will be about describing the structure of the new model which will support the current configuration of four neurosurgical sites in Scotland. This process is not aimed at providing evidence for reconfiguring the number of sites which currently provide neurosurgery. Instead, its aim will be to provide a list of priorities to be addressed to improve services and help to relieve pressures experienced in existing services.

9. Project Approach

The project processes will be planned by the project team. The neuroscience implementation group will oversee the overall project, provide advice and support and suggest staff who could work on the various work streams. As it is likely that the Implementation Group will need only meet three times over the six month period, however, members of the group will be asked to provide input into the various workstreams required by the project.

Due to clinical commitments the Implementation Group meetings will need to be scheduled in advance and should be agreed at the first meeting of the group.

The preferred approach will be for work to be carried out by appropriate members of the Implementation Group and their colleagues rather than work being carried out by formal groups. However, Sub groups may be established where this is deemed necessary with appropriate representation to take forward the various work streams. Each work stream will be given a list of products to be produced with full product specification and suggested timescale.

The Project Team will be responsible for managing the various work streams and ensuring the work is carried out to specification and allocated deadlines.

The Neuroscience Implementation Group will provide sign off for the key project stages and quality assure the work that is produced by each of the sub groups.

The Implementation Group will be held accountable to Ministers.

10. Project tolerances

Each of the workstreams will be allocated a deadline for pieces of work required. Any slippage in these deadlines must be reported to the Project Manager who in turn will take advice from the Project Team.

11. Initial Business Case

The justification for this project is set out in the report of the Neuroscience Implementation Group Report (2008).

12. Benefits expected

It is believed the establishment of an MSN will:

- Ensure that the quality of neurosurgical services can be improved by a more sustainable approach to specialisation and sub specialisation within a coherent network
- Develop a service that will promote integration between community, secondary and tertiary services, through a managed clinical network approach based on clear referral protocols which reflect integrated care pathways
- Design a service which will make best use of scarce human resources.
- Ensure distinctive skills of clinical teams providing services are utilised effectively
- Enable links between highly specialised services to be managed
- Ensure that the quality of patient outcomes is the prime consideration.

13. Risk summary

a. MSN does not lead to improvements expected

There is a risk that the managed network approach does not lead to significant changes to service provision and does not tackle the issues which need to be addressed. It is vital that the MSN is designed and placed in such a way that it has sufficient powers to implement change and meet the objectives set out in the Implementation Group Report (2008).

b. No or little staff engagement and buy-in leads to difficulties implementing service changes

It is essential that staff involved in providing the services are fully engaged in the process to ensure any proposed changes are implemented and sustainable. Regular newsletters should be distributed to staff and relevant staff groups engaged in each part of the project.

c. NHS Board opposition

The creation of the service involves NHS Boards surrendering a degree of autonomy in terms of appointment of staff and possibly in relation to financial planning. Work with [service managers] should be undertaken to help minimise this risk.

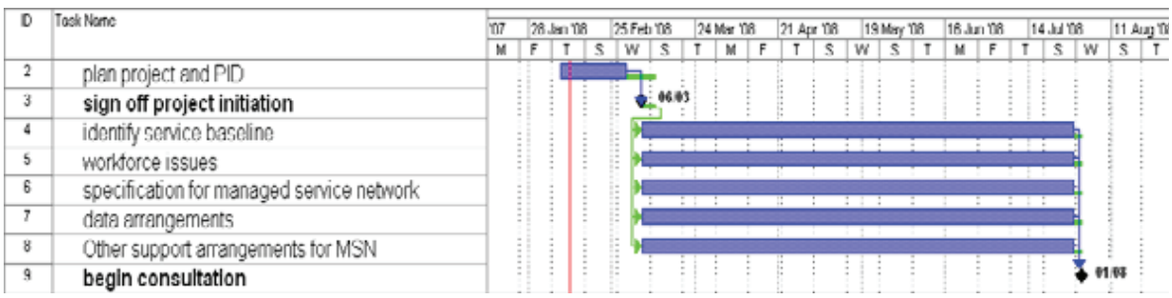
14. Cost summary

There is no formal budget for the project over the next six months. It is expected that costs associated with the project will be travel expenses of members of appropriate groups. It is also possible that consultancy support may be required, however this should be agreed by the project team, who in turn will need to agree the costs with the Scottish Government Health Directorate on a case by case basis.

15. Timescales

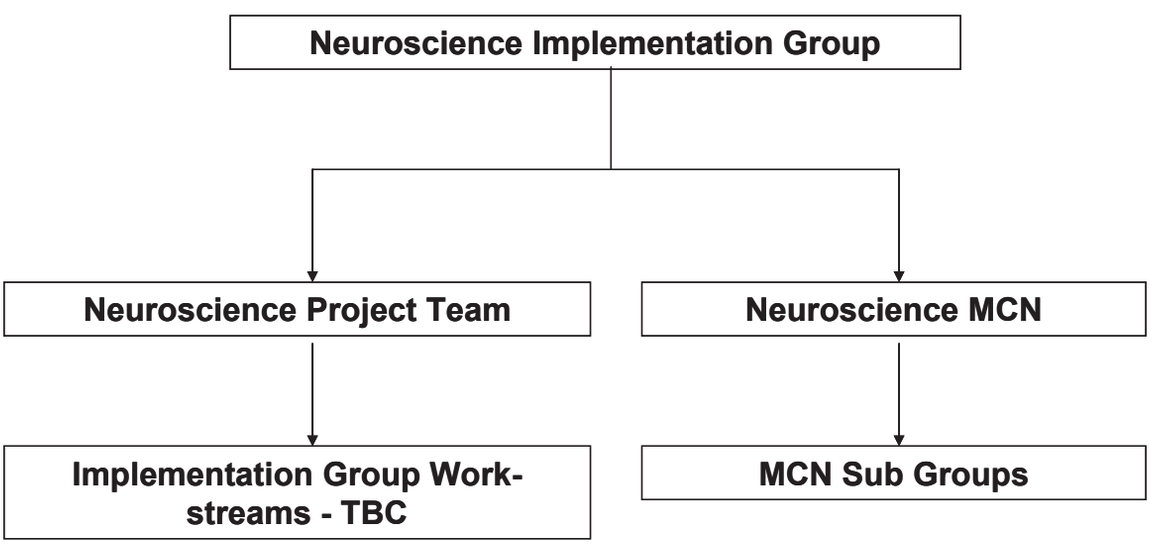
The Implementation Group have been asked to report to ministers by 6 months from the date of the March 2008 meeting. Any extension required on this deadline must be agreed with ministers well in advance of this date with clear reasons cited for any extension required.

16. Initial Project Plan



17. Project Organisation

The diagram below sets out the structure of the project. A project manager will be available to the project.



The responsibility of the Project Team will include:

Management of the individual work streams

Ensuring regular reports are provided to the Implementation Group

Monitoring progress reports from the various work streams

The Implementation Group will:

Provide relevant expertise and suggest membership and remits of the various work streams

Oversee the work of the project and sign off work once it is completed

Oversee the work of the project team

The Project Manager will:

Work on a daily basis with each of the work streams to ensure work is completed to specification and timescale

Plan the work of each of the work streams and provide managerial support

Provide regular reports to the project team on the progress of each of the work streams

18. Communication Plan

Update report from work streams

Interested parties:	Project Team, Implementation Group
Information required:	Progress against tasks assigned to each group Issues and problems faced in completing tasks Likelihood of reaching deadline
Information provider:	Professional lead for relevant work stream
When produced (frequency):	1 week before each Implementation Group meeting
Format:	Written or verbal as appropriate
Method of communication:	electronic

Project Progress Updates

Interested parties:	Patients, public, staff
Information required:	Progress of the Implementation Group, decisions reached, issues faced,

	project aims and objectives.
Information provider:	Project Team
When produced (frequency):	As and when important milestones are reached. Continually updated information on website
Format:	Newsletter
Method of communication:	Distributed on website, by e-mail and post.

19. Project Quality Plan

All products required to be produced by as part of the project will have a clear specification agreed before work is started. This specification must be agreed by the professional lead of the appropriate work stream and the Project Team.

Final products produced by each work stream must be passed to the Implementation group to be signed off. Where no Implementation Group meeting is planned, the work will be signed off by the Project Team on behalf of the Implementation Group.

[END]

Annex 3 Minutes of the meetings of the Implementation Group

SCOTTISH GOVERNMENT HEALTH DIRECTORATES

MINUTES OF THE EIGHTH MEETING OF THE NEUROSCIENCE IMPLEMENTATION GROUP HELD ON THURSDAY 6 MARCH 2008 AT 2.30 PM IN CONFERENCE ROOM 2, THE SCOTTISH GOVERNMENT, VICTORIA QUAY, EDINBURGH

Present:

Mr John Glennie (in the chair)

Dr Peter Andrews (Neuro-anaesthesia & critical care)

Ms Carolyn Annand (Neuro-nursing);

Dr Roelf Dijkhuizen (Medical Directors Group)

Dr Alan Forster (Neurophysiology)

Mr Douglas Gentleman (Neurorehabilitation);

Professor Donald Hadley (Neuroradiology)

Ms Fiona Macaulay (Speech and Language Therapy)

Dr Richard Metcalfe (Scottish Neurosciences Council);

Professor Gillian Needham (Postgraduate Deans)

Dr David Watson (Primary Care Neurology Society)

Mr Andy Wynd (Scottish Neurological Alliance)

Secretariat:

Mr Will Scott

Mrs Fiona Warner

Mr Mark Brady

Ms Fiona Maxwell

Welcome and apologies for absence

The chairman welcomed everyone to the meeting.

Apologies for absence had been received from: Dr David Allan (National Spinal Injuries Unit); Miss Jennifer Brown (Paediatric Neurosurgery); Ms Beverley Bryan (Physiotherapy); Mr Colin Cook (SGHD); Dr Susan Copstick (Neuropsychology); Professor Martin Dennis (Stroke Medicine); Mrs Myra Duncan (Regional Planning Groups); Professor Stewart Forsyth (Paediatrics); Mr Mark Hazelwood (Scottish Neurological Alliance); Mr Richard Hunter (ISD); Dr Aileen Keel, Deputy CMO; Dr Harpreet Kohli (NHS Quality Improvement Scotland); Mr Kevin Doran (Scottish Ambulance Service); Dr Alan McLean (National Spinal Injuries Unit); Dr Robert McWilliam (Paediatric

Neurology); Mrs Pauline Moore (Scottish Ambulance Service); Dr Colin Mumford (Adult Neurology); Ms Alison Rae (Occupational Therapy); Professor Roy Rampling (Neuro-oncology); Dr Richard Roberts (Academic Neuroscience); Dr Colin Smith (Neuropathology), Dr Robert Taylor (Neuropsychology); Dr Andrew Weir (Neurophysiology); Professor Ian Whittle (Academic Neurosurgery); and Mr Malcolm Wright (NES).

The Chair reported that Mr James Steers had tendered his resignation from the Implementation Group, and paid tribute to the contribution he had made to the first phase of work.

Minutes of the seventh meeting

The minutes of the sixth meeting were accepted as a correct record subject to the following amendments:

Paragraph 3, line 12, insert 'increase in' after '5%';

Paragraph 8, final sentence, amend 'Mr Steers' to 'Dr Mumford'; and

Paragraph 13, first sentence, amend 'Dr Foster' to 'Dr Forster'.

Matters Arising

Dr Forster commented that following the statement of the SPHN that they had been unable to gather information on the Scandinavian models, he had carried out some personal research and had located the address of the Scandinavian Neurosurgical Society. He offered to pass these details on to anyone who was interested.

Mr Gentleman asked about the relevance of the Business Case Sub-Group report in the light of the Cabinet Secretary's decision. The Chair suggested that it would be useful to take the report into account when considering items 8 and 9 on the agenda.

Cabinet Secretary Response to Report (Paper NSIG 01/08)

Mr Scott reported that the Cabinet Secretary had accepted the Group's preferred option of the development of a single service for Scotland, which would allow all four units to provide services locally while at the same time promoting uniformity of standards, clear referral protocols and standardised care pathways. He noted that the Cabinet Secretary had set a six month deadline for the next piece of work which should, he suggested, be interpreted as meaning six months from the date of the present meeting. He also noted the importance placed by the Cabinet Secretary on the ability of the Managed Service Network (MSN) to tackle compliance with the provisions of the European Working Time Directive (EWTD).

Given the degree of support there had been at the previous meeting of the Implementation Group for the single service option, the Cabinet Secretary's decision was welcomed, as was the understanding of the complex issues involved demonstrated in her letter to MSPs.

Professor Needham welcomed the approach to producing common standards in neurosurgery but asked for clarity about the nature of those standards, as there had been references to SBNS standards, modified SBNS standards and NHS Quality Improvement Scotland (QIS) standards. Dr Metcalfe explained that the development of QIS standards for neurological conditions was separate to the standards being developed by the neurosurgery MCN. Mr Gentleman pointed out that the standards on which the Data and Audit sub-group was working were the SBNS standards, but modified to suit the Scottish context. Mr Scott stressed the need to ensure that the modified SNBS

standards were consistent with NHS QIS methodology, and therefore acceptable to NHS QIS. The Implementation Group also recognised the need for the standards to be amenable to audit.

Dr Dijkhuizen suggested that, due to the nature of the recommendations, it would be vital to involve the Board Chief Executives in the work of the group at an early stage, particularly as the recommendations involved some loss of autonomy on the part of the 4 provider Boards.

The Chair emphasised the importance of involving staff and clinicians from an early stage. He also noted the similarity of the recommendations emanating from the consultation paper issued by the specialist children's services group. This underlined the need for both groups to work together to ensure consistency of approach, and he would be meeting representatives of the children's group to discuss the MSN model.

Action: Secretariat

Final patient focus and public involvement report

Dr Brooks of Ashbrook Research was unable, through illness, to present the final outcome of the patient and public involvement work-stream. Mr Wynd had kindly agreed to present the findings in his place, noting in the course of the presentation that the final report now included the outcomes of the paediatric user involvement exercise.

Dr Dijkhuizen asked whether those with chronic disorders were neurosurgical or neurological patients. Mr Wynd replied that while Boards had been asked to provide names of neurosurgical patients, it was possible that some neurological patients might have been included since, despite best efforts, the terms 'neurosurgery' and 'neurology' had been used interchangeably on a number of occasions. The Implementation Group recognised that this reflected the inter-relationship between the services, and did not expect the distinction to be important to patients given the range of support they required. It did indicate, though, the need for clarity about the scope of the MSN.

The Chair pointed out that while some people may see the report of the Implementation Group as being the continuation of the status quo, this was clearly not what the recommendations meant and the work of this group over the next six months would be vital to ensure the status quo was not continued. Dr Dijkhuizen noted that the recruitment of consultants on a national basis by the MSN would in itself represent a significant change to the status quo, but he expected there would be a default to the status quo if that approach failed.

Dr Metcalfe argued for recognition that the majority of patients received most of their treatment in the community, and there was therefore a need to focus on the early stages of the care pathway, where it was possible to distinguish between neurology and neurosurgery. That approach would be supported by the development of the NHS QIS generic clinical standards for neurological conditions. He had made sure that community services were represented on the standard setting group.

MCN Update

Dr Metcalfe informed the group that he had been happy to take on the post of chair of the MCN steering group on the assumption that it was for a temporary period until a neurosurgeon could be identified to take his place. He hoped that the work on patient pathways would make better progress now that the perceived threat to the 4 units had been removed. He therefore felt that now might be an appropriate time for a neurosurgeon to take over as chair.

The Implementation Group encouraged Dr Metcalfe to continue in his role, since, as a non-neurosurgeon, he was seen as neutral, with no particular axe to grind. That sort of independent

chairmanship was important at this stage in the evolution of the MCN, but buy-in from the neurosurgeons was also essential. The Chair commented that as it would take about a year until the MSN could get under way, there was a need meanwhile to drive forward the MCN.

Data and Audit

Ms Maxwell informed the group that the ISD report on coding was awaited. A diary-based audit of activity was being piloted in Glasgow during the month of March.

Dr Forster suggested there was a need to be clear about who would collect data in the future. For example, were data clerks on each site? Mr Gentlemen was keen to see an approach where coders and neurosurgeons worked together to ensure accuracy of coding. The Implementation Group expressed the hope that funding would be made available to promote data collection and clinical audit, given the central importance of data to the work of the MSN.

SBNS Standards

Mr Gentleman informed the group that the standards group had met recently and further refined the SBNS standards, which would be considered by the MCN Sub-Group on 29 April. They would then be in a form in which they could go out to consultation with neurosurgeons and other stakeholders. Following feedback, they would be put into final form. Dr Watson wondered if the standards would lead to shorter waiting times, if patients were willing to travel to other units. The Chair suggested that this should be an advantage of the MSN as a whole, rather than a product of the standards.

Update on NHS QIS Neurological Standards

Dr Metcalfe informed the Implementation Group that he had been appointed as clinical advisor to the NHS QIS group responsible for developing clinical standards for neurological conditions. The work excluded stroke and neurosurgery. One part of the standards dealt in a generic way with the early part of the patient pathway, including capacity, ease of access to investigations, quality of experience and the management of patients with unexplained symptoms. In addition, standards would be developed for 5 specific conditions: epilepsy, Multiple Sclerosis, Motor Neurone Disease, Parkinson's Disease and headache.

Mr Scott informed the Implementation Group that the Medical Director of NHS QIS had indicated a willingness to provide whatever help the organisation could during the rest of this phase of the work.

Outstanding issues, future work and management models for the MSN

The Chair drew attention to papers NSIG 02/08 and NSIG 03/08, which had been produced by the secretariat as a stimulus to discussions around the work required by this group and the process it should follow.

In relation to workforce issues, planning to meet service demand would be the responsibility of the Managed Service Network. Planning to meet EWTD compliance was required by 2009, so there was therefore a real need for the Implementation Group to begin to tackle that issue in order to pave the way for the MSN's work.

There was concern about point 6 of section 3 of the PID ('identify a single site for elective paediatric neurosurgery in co-operation with the specialist children's services group. This single site should be capable of supporting the other three existing sites to provide as many services as locally as

possible'). Members felt that this was inconsistent with the Cabinet Secretary's request for paediatric neurosurgery to be developed as a form of sub-specialisation. This was seen as a longer-term commitment, albeit one to which priority needed to be given by the MSN. To concentrate on section 3.6 as drafted could distract from the large amount of other work which the Implementation Group needed to undertake before September.

It was agreed that the terms 'levels N1 and N2', which had been included in point 7 of section 3 of the PID, were a hang-over from the previous model and that it was no longer be relevant to refer to them. It was important, however, to keep sight of the MSN's links to community services.

It was also agreed that there was a need to scope a method of data collection and to cost it. The provision of funding was perhaps something that the Regional Planning Groups might consider.

It was noted that university and research had not been mentioned in the PID but this should be looked at by the MSN once it is established.

Dr Andrews asked that any piece of work around identifying a baseline would also look at key support services such as critical care and anaesthesia. A number of detailed comments were noted and would be reflected in a further version of the documents.

It was agreed that work-streams were required around:

- Identifying a service baseline;
- Recommendations around data and audit and relevant costing;
- Recommendations around what the MSN model will look like; and
- Begin work around EWTD compliance by 2009.

Secretariat would send out a list of these work streams, inviting members to indicate in which of them they would wish to participate.

Action: Secretariat

Patient involvement was seen as integral to every part of the process. Mr Scott reported that SGHD would be discussing capacity issues with the Scottish Neurological Alliance in the near future, and that that would offer an opportunity to consider the Alliance's input into the process.

The Chair raised the issue of the fitness of the Implementation Group as presently constituted to take forward the development of the MSN arrangements. There was a need to involve the Chief Executives of the provider Boards, the clinicians and the service managers. The options were either to enhance the Implementation Group or set up other sub-groups. After some discussion, it was agreed that the Implementation Group still had a vital role in overseeing and monitoring the progress of each of the 4 main work-streams which had been identified. There was also a wish to have the lead neurosurgeons from each of the units represented on the Implementation Group. The Chair was conscious of the handling issues that would cause in relation to the Chief Executives of the provider Boards. It was therefore agreed that at the next lead neurosurgeons' meeting they would be asked whether they would all wish to join the Implementation Group, or whether they could agree to appoint one of their number as their representative on the Group.

Date and time of next meeting

In view of the supervisory role which it had been agreed the Implementation Group should adopt, it was agreed that the next meeting should be the one arranged for Thursday 22 May.

Dr Dijkhuizen suggested that one of the future meetings might be held in Aberdeen.

Secretariat

May 2008

SCOTTISH GOVERNMENT HEALTH DIRECTORATES

MINUTES OF NINTH MEETING OF THE NEUROSCIENCE IMPLEMENTATION GROUP HELD ON THURSDAY 22 MAY 2008 AT 10.30 AM IN CONFERENCE ROOM 2, SCOTTISH GOVERNMENT, VICTORIA QUAY, EDINBURGH

Present: Mr John Glennie (in the chair)

Ms Carolyn Annand (Neuro-nursing)

Miss Jennifer Brown (Paediatric Neurosurgery)

Mr Douglas Gentleman (Neurorehabilitation)

Dr Harpreet Kohli (Directors of Public Health)

Ms Heather Knox (Regional Planning Groups)

Dr Richard Metcalfe (Scottish Neurosciences Council)

Dr Colin Mumford (Adult Neurology)

Dr Richard Roberts (Academic Neuroscience)

Dr David Watson (Primary Care Neurology Society)

Mr Andy Wynd (Scottish Neurological Alliance)

By teleconference:

Dr Roelf Dijkhuizen (Medical Directors' Group)

Dr Alan Forster (Neurophysiology)

Secretariat: Dr Aileen Keel (Deputy CMO)

Mr Will Scott

Mrs Fiona Warner

Mr Mark Brady

Miss Fiona Maxwell

Welcome and apologies for absence

Apologies for absence had been received from: Prof Gillian Needham (Postgraduate Deans), Kevin Doran (Scottish Ambulance Service), Mrs Myra Duncan (Regional Planning Groups), Professor Stewart Forsyth (Paediatrics) and Professor Donald Hadley (Neuroradiology).

Minutes of eighth meeting

The minutes of the eighth meeting were accepted with the following amendments:

Paragraph 3: should refer in line 1 to the minutes of 7th meeting; and

Paragraph 8: in line 7, the reference should be to the Standards sub-group, not the Data and Audit sub-group.

Updates

Lead Neurosurgeons' Meeting (16 April)

Dr Metcalfe reported that the lead neurosurgeons seemed to have been reassured by the recommendations in the Group's report to the Cabinet Secretary. There was also considerable enthusiasm for, and a willingness to engage in designing, the single service model and to develop proposals for better, more consistent data collection across the four sites, perhaps involving audit co-ordinators on each site. It had been suggested, however, that it would take some time for the units to learn to work together. It would therefore be helpful to think about arranging a workshop at which as many of the neurosurgeons as possible could meet to engage with the next phase of work.

To promote the neurosurgeons' engagement with the process, a half-day event was being planned for early September in either Stirling or Perth. The main aim would be to share with them the essentials of the report to the Cabinet Secretary, but to look for their help in fine-tuning the arrangements. That would also be an opportunity to inform them of the Health Directorates' commitment to funding the new data collection and audit proposals.

Miss Brown noted that given the Cabinet Secretary's decision, and with a clearer direction of travel, it should be possible to get a greater degree of engagement with neurosurgeons who had not so far been involved.

Board Chief Executives' meeting

Mr Glennie informed the Group that its recommendations had been discussed at the most recent of the Board Chief Executives' monthly meetings, as a result of which it had been agreed there should be a meeting of the 4 provider Boards' Chief Executives, with himself representing the non-provider Boards. That meeting had taken place on 21 May, and had proved very constructive, especially in relation to the work on data collection and standards. The provider Chief Executives were keen to be involved personally in the development of the new model.

Managed Service Network Planning Meeting

Mr Scott reported that a meeting had been arranged by Derek Feeley, the Director of Healthcare Policy and Strategy in the Scottish Government Health Directorates, as a result of the fact that a number of projects were looking at a Managed Service Network model, including specialist children's services, diagnostics and the wheelchair and seating service. The aim of the meeting was to promote consistency of general approach to the MSN concept across these various projects. There was an acceptance, however, that each raised different considerations, and that the Implementation Group

should continue to develop its preferred model of service, while keeping in touch with progress in the Specialist Children's Services Group.

Operational managers' meeting

Mr Brady explained that he and Miss Maxwell had recently met the operational managers responsible for the 4 neurosurgical units. The meeting had been a positive one, and the operational managers had welcomed the opportunity to compare management structures and differing approaches to various common issues. It had been agreed that joint working would continue, in order to identify the service baseline (see paragraph 11 below).

The meeting had also been useful in identifying potential benefits of an MSN model for neurosurgery. On EWTD issues, it was clear that Boards were continuing to work on local solutions. The operational managers were also keen to become involved in the design of the Managed Service Network model.

Workstreams

Mr Glennie emphasised that the Group had until the end of September to complete its second and final report to the Cabinet Secretary. Progress on each of the workstreams was reviewed with that deadline in mind.

Service Baseline

Mr Brady indicated that a final draft of the baseline template would be circulated shortly for completion by the operational managers, with help from others within their departments. The purpose of this piece of work was to ensure that the Managed Service Network would have a broad overview of what the neurosurgery service in Scotland looked like under the headings of: workforce (staffing profiles), number and grade of nursing staff and specialist nurses, teaching posts, junior doctors, number of consultants, including details of PAs, special research interests, involvement in teaching, sub-specialist interests, facilities, including bed numbers, designation of ward areas and dedicated HDU beds, outpatient facilities, finance (drawing on the work already carried out by Tribal), waiting times for elective procedures and information about associated specialties. Referral pathways into the MSN would have to be considered as part of the development of the new model.

Project Initiation Document

Mr Brady introduced the revised version of the Project Initiation Document (PID), which had been amended to include comments from the previous meeting.

In relation to Section 2 (Project Definition), it was noted that the standards related to both primary and secondary care, and the importance of GPs as a resource should be borne in mind. In that context, it was important to be aware that the standards would deal with issues such as the timely issuing of discharge letters.

The reference in Section 7 to 'no further funds' having been identified referred to the completion of the present project, not to future investment to the neurosurgery service. The sentence would be amended to make this clear.

In relation to section 3.4, Mr Wynd asked whether the patient and public processes envisaged were about informing people, or consulting them. Mr Scott indicated it was essential that the Scottish Neurological Alliance and those within Boards responsible for PFPI issues should be fully involved in the design of the MSN, in keeping with the MCN core principles. Mr Wynd agreed to provide a form of words for inclusion in the PID about seeking 'lay' views on the design and specification of the MSN.

Action: Mr Wynd

Miss Brown commented, in relation to the reference in section 3.5 to a single national training programme for neurosurgery, that not all neurosurgeons agreed that a single training programme was desirable. Some would prefer to maintain 2 programmes. The Group noted, though, that on average Scotland produced 1.5 trainees each year, and wondered whether that level of output was enough to justify maintaining 2 training courses.

It was agreed that a single training programme need not necessarily mean trainees rotating to each of the units, as that would be disruptive to trainees. Glasgow trainees already undertook a year's training in Dundee, but further time in smaller units would not be beneficial, Miss Brown argued, because trainees would be denied access to sub-specialties such as paediatric neurosurgery. Others suggested that a single training programme did not mean trainees spending a year in each centre, but rather that the arrangements should be managed as a single programme, managed by the MSN. Dr Keel supported the removal of the word 'single' from the PID, since the key element was national coordination. She also suggested that it would be necessary, with NHS Education for Scotland, to explore in more detail the implications for each unit. The Group agreed that section 3.5 of the PID should be amended to refer to a 'nationally coordinated' training programme.

In reply to Miss Brown's comment that trainees needed to be recognised as competent anywhere in the UK, and that Scotland should be able to recruit from anywhere else in the UK, Dr Keel pointed out that, because of the role of PMetB, there was no question of training to a different standard in Scotland. Recruitment to Scotland was a separate issue.

Section 3.6 required modification to make clear that it was about encouraging a Network approach to the organisation of services. The Group recognised that the MCN approach, including the work on standards, audit and pathways, had been extremely useful over the past year, and it had been important to distance this process from discussions about the single centre model. However, the MSN approach should be thought of as an 'MCN plus' model and the work of the MCN should therefore be incorporated into the work on developing the MSN. To continue the 2 processes in parallel was a recipe for confusion. While the MSN would be guided by the MCN core principles, it would also have the power to manage the service nationally to meet overall need. It was agreed that standards and audit were a key part of service delivery and would be an essential element of the workings of the MSN.

It was agreed that the organogram in Section 17 (Project Organisation) needed adjustment to take account of the discussion which had just taken place about the need to incorporate the MCN work within the future work on the development of the MSN. Dr Keel was clear that the MCN core principles must be clearly articulated in the MSN model, and that point should be highlighted in the Group's report to the Cabinet Secretary.

Mr Brady would make the necessary changes to the PID and circulate the revised version to members of the Group.

ACTION: Mr Brady

Data collection

Miss Maxwell reported that the work of the audit and outcomes sub-group was continuing and some small-scale audits were underway. Dr Adam Bryson, who had been chairing the sub group, was moving to another job at the end of June, so a new chair would need to be found after its next meeting.

Mr Glennie informed the group that the provider Board Chief Executives had discussed audit and data and agreed that positive developments in this area should be encouraged, although they recognised that additional resources would be required. He had discussed this with the Health Directorates, and had been given an assurance that they would provide the funding needed to take this work forward

provided the group produced reasonable and workable recommendations for the development of clinical data collection and audit. This would be a clear recommendation in the report to the Cabinet Secretary.

Miss Brown welcomed the commitment. There was considerable mistrust about the retrospective data collected at present. If the neurosurgeons could have confidence that uniform reporting was in place, that would very much help promote mutual working.

The software involved might well be the e-case system, which was already used for neuro-oncology, but others options were also under consideration. The training of coders would be taken into account in the consideration of the resources needed. Dr Dijkhuizen emphasised the importance of agreeing prospectively the data which should be collected.

Workforce arrangements

Mr Brady explained that he had been contacted by the Workforce Planning Branch in the Health Directorates, which had provided the data about junior doctors' rotas circulated as paper NSIG 06/08. The Branch had a support team which was willing to visit Boards to help them develop local solutions to EWTD compliance. He had contacted the operational managers, encouraging them to make use of this team to build on the local solutions they were pursuing, such as better working with relevant local services, and through projects such as 'Hospital at Night'.

Mr Gentleman queried the Aberdeen data, especially the reference to a combined neurology/neurosurgery rota. Dr Dijkhuizen agreed to clarify the position.

Action: Dr Dijkhuizen

Dr Mumford noted that the 48 hour maximum under EWTD, which was likely to be applied rigorously, would present a potential stumbling block for the service. The likely solutions would either be the creation of new posts, which raised the question of where the funding for these would come from, or consultant neurosurgeons working extra hours, thereby increasing out of hours working, with a consequential impact on elective lists. Ms Knox was sceptical about the degree of compliance claimed, and agreed it seemed likely that additional resources would be needed.

Mr Glennie reminded the Group that the needs assessment had stated that all units were EWTD compliant, but that this was an issue which Boards would need to have addressed in long before the MSN was likely to become operational.

Dr Watson noted while the circulated information was useful, it would be helpful to have an explanation of the compliance bands.

Action: Secretariat

MCN update

Mr Gentleman reported that the revised SBNS draft standards had now been circulated to all neurosurgeons and asked that his thanks to all those involved in their development should be recorded. Some initial comments had already been received which seemed very constructive, with neurosurgeons welcoming the standards as a common-sense approach. The standards would be circulated more widely once feedback had been received from the neurosurgeons, and should be ready for sign-off by the Group at its September meeting for inclusion in the report to the Cabinet Secretary.

Mr Scott pointed out that since that the MCN was being incorporated into the MSN process, the possibility of having the standards validated by NHS QIS, as part of the process of accreditation of the MCN, was no longer available. An alternative approach would be to align the neurosurgical standards with the existing NHS QIS process relating to the neurological standards. Dr Kohli agreed there would be merit in such an alignment, and indicated that he would be happy to have further discussion with the secretariat about the practicalities.

Action: Secretariat to arrange meeting with NHS QIS

Specification and Design of MSN

The group noted that a facilitated workshop would take place on 27 June, to start an initial discussion about the design of the MSN model. Those invited to attend would be the provider Board Chief Executives, Ms Knox for the Regional Planning Groups, the lead neurosurgeon from each unit, the operational managers, 2 representatives of the Scottish Neurological Alliance, Fiona Farmer as the Partnership representative, a Finance Director from the Business Case sub-group, Dr Frances Elliott (or another Medical Director from a non-provider Board), and a Director of Planning from a non-provider Board.

Ms Knox suggested that in view of the meeting reported on at paragraph 7, it might be necessary to set some fixed points in advance of the workshop. These might be that ownership and control of finance and operational autonomy should stay at Board level, and there should be no plan to dislocate operational and financial management from the Boards. This would not, however, preclude identification of the overall resource envelope involved. Strategic planning and operational management should be regarded as two separate processes and there would need to be links with the more general work currently under way about planning models for NHSScotland. She suggested that cardiology and cardiac surgery work in the west of Scotland offered a good example of the regional planning of appointments on which the MSN might build.

Dr Metcalfe said it was essential that clinicians should be involved in the planning function. Mr Glennie took the view that that was an issue about the style of management which would operate within the service, and that the Group could make a recommendation in its final report that the involvement of clinicians should be a key principle of the MSN.

Dr Watson highlighted the need for engagement with primary care, in order to get the processes of referral correct. Mr Glennie agreed that representatives from primary care should be involved in the design process. He explained that after the initial afternoon workshop in June, a larger, full-day workshop would be held in early August to go into more detail around the development of the MSN. Miss Brown asked that the importance of the August event should be highlighted for neurosurgeons, if they were being asked to attend for a whole day. The Board Chief Executives would therefore be asked to encourage directly the attendance of the neurosurgeons from their Board area.

Action: Secretariat

Date and time of next meeting

It was agreed the next meeting should take place in early September to allow the report to then be circulated for comment.

Action: Secretariat

UNCONFIRMED DRAFT

Scottish Government Health Directorates

MINUTES OF THE TENTH MEETING OF THE NEUROSCIENCE IMPLEMENTATION GROUP HELD ON THURSDAY 18 SEPTEMBER AT 1.30PM IN SURGEON'S HALL COMPLEX, EDINBURGH

Present: Mr John Glennie (Chair)

Ms Carolyn Annand (neuro nursing)

Dr Alan Forster, neurophysiology

Mr Douglas Gentleman (neurorehabilitation)

Dr Richard Metcalfe (Scottish Neuroscience Council)

Dr Colin Mumford (adult neurology)

Secretariat: Dr Aileen Keel (Deputy CMO)

Mr Colin Cook

Mr Will Scott

Miss Fiona Maxwell

Apologies: Ms Heather Knox (Regional Planning Groups)

Professor Gillian Needham (Postgraduate Deans)

Mrs Myra Duncan (Regional Planning Groups)

Mr Colin Smith (neuropathology)

Dr Harpreet Kohli (NHS QiS)

Professor Martin Dennis

Dr David Watson (primary care)

Professor Stewart Forsyth

Dr Roelf Dijkhuizen (Medical Director, NHS Grampian)

Professor Peter Andrews (neuroanaesthesia)

Professon Donald Hadley (neuroradiology)

Mr Mark Hazelwood (Scottish Neurological Alliance)

Mr Andy Wynd (Scottish Neurological Alliance)

Ms Beverley Bryan (physiotherapy)

Miss Jennifer Brown (paediatric neurosurgery)

Ms Susan Copstick (neuropsychology)

1. Introduction and apologies

Mr Glennie opened the meeting noting apologies as above, and welcomed the attendees. The main focus of the meeting was to be a review of the comments that had been received on the first draft of the Group's report to the Cabinet Secretary. These would inform a second draft which would be circulated to the members of the Implementation Group for final comment, before being submitted on 30 September.

2. Minutes of previous meeting

The minutes of the meeting held on 22 May were accepted as an accurate record of the discussion.

3. Reports form the workshops to discuss the MSN model

It was agreed that this could be covered under agenda item 4.

4. Final report of the Implementation Group

Mr Glennie first asked the group if there were any major issues with the general content of the report and all were content. There were however several specific points for discussion and it was agreed that the group should go through the document page by page to pick up and discuss these. Many of the points and comments received were around the membership, size and structure of the two groups suggested in the first draft; the Network Board and the Operational Management Group. In this regard, it was agreed that the report of the Implementation Group should set out only the basic constituency and leave the further detail to the Network to decide.

The following specific additions and amendments to the report were discussed and agreed.

- There would need to be an explanation of the Group's decision to move forward from a traditional MCN approach and a clear statement that the aim was for the key principles of MCNs to be embedded within the MSN, with the MSN taking responsibility for the work which had been initiated by the MCN. It was not the intention that the MCN should continue as a separate entity.

- There would also need to be clearer guidance on what was expected of the NHS Boards in terms of cooperative working, and reference to arrangements for clinical governance, accountability and reporting, which would have to be in line with arrangements for national and regional planning, currently under review.

- Emphasis was required on the consultation aspect through this stage of development and the attendance lists form the workshops, as well as a list of invited delegates, should be included as an annex.

- Comments received from Calum Kerr of the Scottish Ambulance Service should be included to reflect the importance of their involvement in any plans which would affect the service's patient transfer needs.

- The report should also contain a clear statement of the fact that the aim of the network was to maintain safe and sustainable services in all four sites and to ensure they were able to provide core elective neurosurgical services and comprehensive emergency care.

- It was agreed that the sections on risks and benefits of the model should be amended to refer to 'potential' risks and benefits. the group felt tit was important that the potential risk section was retained in the report, as it gave an honest assessment of the key areas that would need to be considered in developing the MSN.

- The group also felt that a paragraph referring to the previous recommendations of the Action Team would be useful. With the exception of the recommendation on moving towards a single site for neurosurgery in Scotland, the group still felt that many of the recommendations had been valid and that the proposals contained within the current report reflected these.

- the group agreed that the report should refer to the network having the ability to influence both planning and operational decisions.

- Comment should be made on the ability of a single service network to encourage and promote multi-site research and development.

- Reference to a 'Planning Framework' should be changed to 'Framework' and this section should be amended to reflect the need for the MSN to formalise an action plan which would allow for continuous review and the consideration of developments on a national basis.

- It was also agreed that the Network should play a part in the promotion of training for health professionals in all specialties in non-neurosurgical referring areas.

- Professor Needham had submitted useful comments on the issue of EWTD compliance and these would be included in the report, to reflect the fact that although compliance was and remains a legal requirement, it is a current and future issue of concern in neurosurgery and other specialties. It remains an ongoing risk to the service and this should be stated.

- It was agreed that the Clinical Director post should be fixed-term in the first instance, allowing for reappointment or future rotation.

- Interim arrangements and a suggested timescale would need to be included. It was agreed that the Network Board should be established in shadow form from the ends of the year, to be in place formally by April 2009. the Clinical Director and Network manager should be in post by then.

- There were, in addition, a number of minor points of clarity and consistency to which the Secretariat would attend.

It was further agreed that the project team could remain available to provide support to the ongoing workstreams in the meantime.

This was the last meeting of the Neuroscience Implementation Group. Mr Glennie thanked everyone for their commitment and constructive input to the process and closed the meeting.

Annex 4 Workshop report (June)

Neurosciences Implementation Project - Managed Service Network for Neurosurgery

Scottish Government Health Directorates

10th July 2008

Services for life

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Appendix A – Workshop Attendees ..... **Error! Bookmark not defined.**

1 Summary Report on Workshop

1.1 Introduction

1.1.1 This report summarises the purpose and outcomes of the workshop held on 27 June 2008, facilitated by Ian Johnston of Tribal Consulting. It covers the following:

- The aims of the workshop
- A summary of the discussions around the implementation of a managed service network for neurosurgery

1.2 Aims of the workshop

1.2.1 This was the first of two workshops, the overall aims being:

- to confirm the need for change in the delivery of neurosurgery services in Scotland
- to agree approaches to the issues that need to be addressed (e.g. training, workforce planning, meeting SBNS standards)
- to consider what management arrangements for the service would best meet the delivery of those approaches
- to agree a programme of work to develop and put in place the new arrangements, including arrangements for their periodic review

1.2.2 The first workshop was designed as a planning workshop for the full day workshop on 4th August. The objectives of this first workshop were therefore:

- to confirm the matters that need to be addressed
- to have a preliminary view about different approaches to different issues
- to have a preliminary discussion about how these approaches might best be managed
- to consider process for 4th August.

1.2.3 It was agreed at the start of the workshop that the decision had been taken to deliver a managed service network for neurosurgery and that the overall purpose therefore was to work out how this network might best be implemented.

1.3 Working together differently

1.3.1 The workshop was attended by a wide range of stakeholders comprising representatives from the Scottish Government Health Directorates, the four provider Boards, regional planning functions and the Scottish Neurological Alliance. In all 27 people participated in the workshop – a full list of attendees is provided in **Appendix A**.

1.3.2 It was noted that the workshop presented the opportunity to influence the Implementation Group's report to the Cabinet Secretary for Health and Wellbeing on how a managed service network would operate. It was agreed that the development of a single service network would mean the four Boards working together differently in future.

1.3.3 The participants discussed and agreed the following attitudes that would be necessary to reach agreement about how the network should be designed and to enable its implementation in practice.

- Honesty
- Mutual respect – respecting the different contributions made by different clinical/planning/managerial perspectives, and being considerate of the impact of change on individuals and services
- Transparency
- Openness – thinking widely, challenging the status quo, and being confident to discuss problems where they exist without fearing the consequences of openness.
- A focus on the future, not going over old ground
- Grounded in reality but prepared to take risks
- Patient focus
- Not (too many) preconceptions
- Ownership by clinicians and managers

In summary: a belief in working together

1.3.4 It was noted that everyone had an obligation to adopt these positive attitudes in discussion.

1.4 Areas where change is needed

1.4.1 Presentations were given as follows on areas where change was needed in the provision of neurosurgery services:

- Mr Andy Wynd – Chief Executive - Scottish Spina Bifida Association and representing the Scottish Neurological Alliance: a patient perspective
- Miss Lynn Myles – Consultant Neurosurgeon - NHS Lothian: a clinical perspective
- Mr Colin Cook – Deputy Director - Scottish Government: a government perspective

1.4.2 On the basis of these presentations the following were identified as areas where change would be required:

- Equity of access – referral protocols / waiting lists
- Workforce planning
- Development of sub-specialities – service development
- Clinical standards (data/audit)
- Patient involvement

1.4.3 In discussion the following issues were agreed:

Figure 1-1 Areas of Change

The need for change	Factors to consider
Data/Audit	
Data is needed to provide evidence of any need for change/development and to inform planning of service	Agreement in principle required to take forward any development(s)
The current lack of clear data on clinical activity/audit, even locally	Datasets will need to be agreed (what to record, when and how)
Inconsistency across sites (coding etc)	How to achieve a national approach?
This is a key lack in current service	Need to find a nationally agreed and resourced solution
This is commonly agreed to be essential to moving forward	Priority of this problem has to be understood/accepted and acted on
Use of the data identifies any differing approaches to patient management. So data needs to be of clinical use/relevance	+ve - given agreement of datasets, consistent approaches, these problems could be addressed. Must be able to identify patients/processes for audit/follow-up.
Service development	
Better national management of sub-specialisation	If sub-specialities develop in one particular area, will need clear referral guidance for other centres. Patient travel/transport issues if any single-centre sub-specialties develop
Need better background information to guide service planning – who does what, where, for which patients	Refers back to data and audit development
Management of resources for development in neurosurgery could avoid four sites trying for same thing	Development bid management – local NHS Board/MSN/other?
Could establish clear definition/difference between 'core business' and smaller volume activity which may be different for each centre	Should consider shared care arrangements (clinics, o/p appt). Will need clear arrangements & responsibilities for ongoing care. Acknowledge this is difficult to manage

Principles:- Improving patient experience Improving outcomes Improving efficiencies Opportunity to develop specialist areas, attractive jobs, easy recruitment.	
Equity of access	
Service must meet waiting list standards	To secure equity of access the waiting list could be owned by the service?
'Equity' applies to entire patient journey, not just entry point. Follow-up, rehabilitation, etc.	Agreed pathways, and effective monitoring of these, will point to areas of need
Access is often determined by local resource/geography	Agreed standards should be met; all centres resourced to provide services up to these standards. Must recognise particular needs of remote/rural and the effect on auditable measures, e.g., length of stay, referral pathways
Highly resource dependent especially in busy centres	Clinical judgement not to be 'discounted' in favour of protocol – often resource issues also.
This is also to do with access to onward care – getting out of the neurosurgical unit to appropriate care	Agreed standards and workable pathways which are recognised should embed this in national service
Patient involvement	
Need common pathways and common assessment of outcomes to ensure that we can audit patient experience (standards of service and care).	Patient satisfaction and the audit of their experience need to be embedded within management responsibilities. Commitment to auditing patient experience and being seen to learn and improve through what you have learned
Very important to get patients involved esp in discussion on equity of access issues – this means different things to different people - not always target driven – should be what best suits the patient. Difficult to get some patient groups involved	Needs to have effective links and be able to make participation easy, especially for hard to reach groups. Look at different ways of doing this. National User Groups?
Need to recognise and effectively manage priority issues, e.g. neurorehabilitation	Issues for local *v* national management of resource. Is MSN advisory in this capacity? Where is power to influence?

One service speaks louder than four – if one centre providing 'better' patient experience is indicative of 'lack' in others – all should strive for best possible service – clear indicator of resource issue in some cases.	Service 'users' are not always patients. Referring centres/services etc. also need to be enabled to contribute to discussion on development prioritisation.
Workforce planning	
An understanding of the national workforce requirement is lacking and there is a need to plan for replacement of consultant retirements, particularly in sub-specialties	National service to have responsibility for consultant appointments/which other appointments? Be aware of clinical governance issues, although there is precedent with regional appointments. Need to look at other arrangements and learn from them. A single nationally managed training scheme? Need to train our own neurosurgeons for the future.

1.5 Organisational arrangements

1.5.1 If these were the main areas for attention by the managed service network then what organisational arrangements would best deliver them?

1.5.2 Heather Knox – Regional Planning Director, West of Scotland – gave a presentation on possible models.

1.5.3 She described a continuum from planning through a consortium approach to commissioning.

1.5.4 In discussion, the view was that the service structure should be whatever would best deliver against the identified requirements. This could possibly take the form of a 'consortium plus' which would involve, among other things:

- Governance arrangements involving all the provider Boards and some independent (non-provider) input
- Responsibility for performance management across all the areas where there is an identified need for change, with delegated authority from the Boards
- A dedicated Director of the service
- A designated clinical director
- Agreement on financial arrangements / investment

1.5.5 The details of exactly how each area requiring attention would be addressed within the new service structure would require further discussion.

2 Summary

2.1.1 There was general agreement that:

- a nationally managed, single service for neurosurgery was desirable
- the overall organisational model best placed to deliver against the identified issues could be some form of 'consortium plus'
- the service had to have the authority to deal with the areas where change is needed (identified above)
- a national approach would not resolve all problems, e.g. interdependencies with other specialities and use of facilities at each site (e.g. theatres) – some solutions would still have to be found locally
- change should benefit all and have the aim of bringing all four centres up to the level of the best in terms of access, outcome and patient experience
- better national management would inevitably involve a trade off against local autonomy on some level
- to achieve progress, positive attitudes of cooperation and forward thinking would have to be fostered and maintained

The details of exactly how each area requiring attention would be addressed within the new service structure would require further discussion, but there was clear commitment to taking this forward. This provided the basis for designing the 4th

Annex 5 Workshop report (August)

The Scottish Government Neuroscience Implementation Group

The Managed Service Network for Neurosurgery.

Workshop to discuss the managed service network for Neurosurgery

4th August 2008

Dearden Consulting Ltd

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3. How will the Managed Service Network operate? 4

4. Conclusion.....5

Appendix 1 What will the Managed Service Network do?

Appendix 2 How will the Managed Service Network operate?

1. Introduction.

1.1. The Workshop to discuss the Managed Service Network for Neurosurgery took place at the West Park Centre in Dundee on Monday 4th August. The workshop was attended by Consultants, the Chief Executive of the Scottish Spina Bifida Association representing the Neurological Alliance of Scotland, Chief Executives, Regional and Health Board planners, Operational Managers, and Scottish Government staff.

1.2. The Workshop was divided into three sessions on the following topics;

- What will the Managed Service Network do?
- How will the Managed Service Network operate?
- and Data and Audit.

1.3. This report covers the first two topics.

2. What will the Managed Service Network Do?

2.1. It was agreed that the purpose of the Network should be to improve services for patients by establishing a single service for Scotland provided on four sites and that the Network should do seven things;

1) Develop and monitor standards, protocols, and guidance including patient pathways.

2) Develop data standards and systems to support audit and other information requirements including funding and training audit facilitators to ensure consistent collection of data.

3) Ensure patient involvement at all levels including Network activities and monitor patient satisfaction.

4) Develop sub specialisation including agreeing referral guidelines and advising on all new consultant appointments.

5) Arrange mutual support between units including use of capacity and staffing cover.

6) Lead on workforce issues including good practice in the implementation of the European Working Time Directive and training programmes for all staff.

7) Develop a single service for Scotland including a planning framework and guidance on service development.

2.2. A detailed account of the discussion is given in Appendix 1.

3. How will the Managed Service Network operate?

3.1 It was agreed that the following organisational arrangements should be established;

1. A Network Board.

Two options were suggested. The details are given in Appendix 2.

2. The Network Board should be accountable to Health Boards.

An annual stakeholders meeting should be held and an annual report should be submitted to the Scottish Government.

3. A National Clinical Director should be appointed.

4. A Network Manager should be appointed.

5. The Network should not hold the operating budget for neurosurgery services.

The Network should hold the budget for its own staff and activities. The Network should be able to influence spending as described in item 7 of Appendix 1.

6. The Network Board should seek consensus but, if consensus could not be achieved, decisions should be made by majority voting.

7. The Network Board should adopt the behaviours identified in paragraph 1.3.3 of the report of the workshop held on 27th June.

8. The Network Board should connect with all Health Boards.

3.2. A detailed account of the discussion is given in Appendix 2.

4. Conclusion.

4.1. A basis of agreement exists enabling the Managed Service Network to be established. The Network Board should be established and the National Clinical Director and the Network Manager should be appointed. The Network will then need to earn the confidence of the Scottish Government, Health Boards, consultants and other staff, patients, carers and the public by taking forward the agenda set out in paragraph 2.1.

Ken Jarrold. C.B.E.

APPENDIX 1.

WORKSHOP TO DISCUSS THE MANAGED SERVICE NETWORK FOR NEUROSURGERY 4th AUGUST 2008

WHAT WILL THE MANAGED SERVICE NETWORK DO?

The purpose of the network is to improve services for patients by establishing a single service for Scotland provided on four sites.

It was agreed that the Network should be limited to Neurosurgery, and should not include other specialties such as Neurology, Neuro-radiology or Neurophsiology.

The Network should do seven things.

1. Develop and monitor standards, protocols and guidance including patient pathways.

It was agreed that the Network should be responsible for this function. Six points were made. The Network should;

1. Work closely with other bodies responsible for this function and should build on best practice including international developments. The Network should not duplicate existing work, but should co-ordinate existing standards and develop new or more detailed standards as required.

2. Monitor the application of standards, recognising the need for local variations, and ensuring equity of access and service provision.

3. Develop referral guidelines for sub specialities involving other specialities e.g. orthopaedics.

4. Develop benchmarks for nursing practice.

5. Take into account the link between best practice and the availability of resources.

6. Communicate with all concerned to ensure that standards are understood and implemented.

2. Develop data standards and systems to support audit and other information requirements including funding and training audit facilitators to ensure consistent local collection of data.

It was agreed that the Network should be responsible for this function. Four points were made.

1. The tension between national and generic systems and specialty specific systems should be recognised.

2. Outcome measures including patient experience should be developed.

3. Training for coders should be provided.

4. Participation in all data systems and collection should be mandatory for all centres and all clinicians.

3. Ensure patient involvement at all levels including Network activities and monitor patient satisfaction.

It was agreed that the Network should be responsible for this function. Eight points were made.

1. Patient involvement is required at all levels and therefore the role of the Network should be to ensure that all services involve patients. However the Network should involve patients in its own activities.

2. An effort should be made to involve the public as well as patients.

3. Although the experience of individual patients is very valuable, care should be taken in generalising from individual experience.

4. It is important to be clear about the purpose of patient involvement.

5. More effort is needed to recruit patients for initiatives.

6. A range of tools should be used including independent facilitation.

7. Carer groups should be involved.

8. Key issues for patient involvement include the development of patient pathways and rehabilitation following surgery.

4. Develop sub specialisation including agreeing referral guidelines and advising on all new consultant appointments.

It was agreed that the Network should be responsible for this function. Eight points were made.

1. The first step should be to identify and agree sub specialties.

2. It should be an evolutionary process recognising that there are issues of culture and confidence and that there will be an impact on individual clinicians. The starting point should be low volume elective specialties.

3. The knock on effect of sub specialisation should be assessed bearing in mind the need to maintain services on four sites.

4. The role of the Network in relation to new consultant appointments should be stronger than advisory given the need to develop a national service.

5. Patients and the public will have to be convinced of the need to travel.

6. Referral guidelines will be essential.

7. This is a complex issue and requires focused effort. The Network should establish a working group to take the work forward.

8. Patient safety and quality of outcomes should be the driving force in sub specialisation.

5. Arrange mutual support between units including use of capacity and staffing cover.

It was agreed that the Network should be responsible for this function. Six points were made.

1. The Network should organise an annual event at which the provision of mutual support should be reviewed.
2. Tele technology should be exploited.
3. A protocol for the provision of help in emergency situations should be developed.
4. Staff movement should be explored as well as asking patients to travel.
5. The availability of ITU beds would be an appropriate topic for mutual support.
6. The possibility of providing staffing cover between the two smaller units should be examined.

6. Lead on workforce issues including good practice in the implementation of the European Working Time Directive and education and training programmes for all staff.

It was agreed that the Network should be responsible for this function. Six points were made.

1. Compliance with the EWTD is a local responsibility. However the Network should provide a forum for discussion and sharing good practice.
2. The Network should oversee the provision of education and training to avoid duplication and to ensure equitable provision and access.
3. Allied Health Professions should be involved as well as Doctors and Nurses.
4. The further integration of the two training programmes for Junior Doctors should be explored.
5. The possibility of rotation of staff across all four units should be considered.
6. The Network should lead on workforce planning.

7. Develop a single service for Scotland including a planning framework and guidance on service development.

It was agreed that the Network should be responsible for this function.

It was agreed that the best approach would be for the Network to develop a planning framework for a single service for Scotland. The question should be what services does Scotland need? The framework should guide development proposals and the Network should advise Health Boards on development proposals from the four units.

APPENDIX 2

WORKSHOP TO DISCUSS THE MANAGED SERVICE NETWORK FOR NEUROSURGERY 4th AUGUST 2008

HOW WILL THE MANAGED SERVICE NETWORK OPERATE?

If the network is to carry out the functions described in Appendix 1 the following organisational arrangements should be established.

1. A Network Board

It was agreed that a Network Board should be established. Two options were suggested.

Option 1

Strategic Board.

Provider Health Board Chief Executives.

One Chief Executive from each Regional Planning Group

Patient Representatives

National Clinical Director

Operational Board.

Lead Clinicians from the provider units

Operational Managers from the provider units

Planners from the Provider Health Boards and the Regional Planning Groups

Network Manager

Senior Nurse

Option 2

Network Board

Provider Board Health Chief Executives

Representatives of non provider Health Boards

Patient Representatives

Lead Clinicians

Senior Nurse

Operational Managers

National Clinical Director

Medical Director

Non Neurosurgery clinician

Finance representative

Scottish Government Observer

Two other points were made.

1. A Non Executive Chair should be appointed for the Strategic/Network Board.

2. Allied Health Professions and Psychologists should be represented on the Board.

2. Mechanisms for accountability.

It was agreed that the Strategic/Network Board should be accountable to Health Boards.

It was also agreed that the Strategic/Network Board should hold an annual stakeholders meeting and should submit an annual report to the Scottish Government.

3. National Clinical Director.

It was agreed that a National Clinical Director should be appointed. In one of the six groups two of the five members of the group did not support the appointment.

Four points were made.

1. The post should be openly advertised including outside Scotland.

2. The appointments panel should include;

   Chief Executive

   Neurosurgeon

   Office of Public Appointments

   National Specialist Services

   A Neurosurgeon from England

3. The appointment should be part time and should be fixed term. One of the six groups suggested that the appointment should be rotated between the Provider Units.

4. It will be vital for the National Clinical Director to earn the support of Lead Clinicians and their colleagues.

4. Network Manager.

It was agreed that a Network Manager should be appointed. A small minority did not agree and thought that administrative support would be sufficient.

Two points were made.

1. The Network Manager should be responsible for supporting the National Clinical Director in the work of the Network as set out in Appendix 1. The Manager should have a particular focus on communications, data/ audit, and standards.

2. Two suggestions were made for the Manager's Host Board. First the same Health Board as the National Clinical Director and second a non provider Health Board.

5. Budget.

It was agreed that it would not be practical for the Network to hold the operating budget for all neurosurgery services. The Network should hold the budget for its own staff and activities including data and audit.

There were mixed views on the question of development funding. However, it was agreed that the Network should be able to influence spending as described in item 7 of Appendix 1. It was agreed that the Network should have an input to the Job Planning of all new Consultant posts including the special interest of the new post.

Two points were made.

1. Two groups agreed that the Network should hold development funding.

2. One group suggested that the Network should hold the budget for clinical redesign and for Discretionary Points.

6. Decision Making.

It was agreed that the Network Board should seek consensus, but that if consensus could not be achieved decisions should be made by majority voting. It was acknowledged that the Network could not impose its views on Health Boards and that the normal mechanisms would be used to influence a Health Board that did not accept the decisions made by the Network Board.

7. Behaviour.

It was agreed that the Network Board should adopt the behaviours identified in paragraph 1.3.3 of the report of the workshop held on the 27th June.

Two points were made.

1. Nolan principles should be observed.

2. Development activities should be organised for the members of the Board.

8. Connecting with Health Boards.

It was agreed that it was vital that the Network Board connected with all Health Boards. This would be the responsibility of the members of the Board, the National Clinical Director and the Network Manager.

Two points were made.

1. Links with local clinical governance mechanisms should be established.

2. Co-ordination with Quality Improvement Scotland should be a priority for the Network.

Annex 6 Potential models for consideration

NEUROSCIENCE IMPLEMENTATION GROUP

POTENTIAL MODELS FOR A MANAGED SERVICE NETWORK FOR NEUROSURGERY

DISCUSSION DOCUMENT

Introduction

This document is intended to aid discussion around potential management models for the nationally managed service network for neurosurgery as described in the report of the Neuroscience Implementation Group (2008). It draws from existing service models for other services. It sets out issues to be considered when designing any new models and describes three possibilities and their potential merits and drawbacks.

Issues

In order to identify the best model for neurosurgery, the following issues will need to be considered:

Finance

In order to ensure the proposed new model has the authority to implement change and ensure the service provides best value for money, the management board will require a degree of control over the finance of the service. The implementation group will need to consider to what extent finances are controlled by the network, especially in allocating funds for agreed developments.

This raises the following issues:

By what mechanism does each NHS board pay for the care of its patients?

Where does the responsibility for the financial management of the service and funding agreed developments lie? There will be a need to define levels of independence and budgetary authority.

If locally - what elements of the service's funding should be agreed nationally?

If regionally?

If nationally – on what basis do we allocate budgets to each provider?

Governance and Accountability

Responsibility for the neurosurgical service has to lie with a legal entity. This could be:

Lead NHS Board

Pre-existing entity e.g. NSD1 or other special health board (NSD does not normally commission this type of service. Neurosurgery in its entirety does not meet the criteria for designation as a national service. Nationally commissioned services are usually high cost, low volume specialties and are provided from (most commonly) one location to the whole population and funded by agreed top-slicing from NHS Boards).

With providing NHS Boards as current arrangement a number of issues will need to be considered:

Which NHS Board is responsible for clinical governance issues if staff are working outwith their NHS Board area?

There will have to be a balance between local independence and compliance with the Network's aims and objectives.

If there are appointments to the network rather than to NHS Boards, where are the employer's responsibilities?

Should these arrangements be the same as for Managed Clinical Networks?

Service definition

The elements of the service which are to be nationally managed will need to be explicitly defined and clear working relationships and allocated roles and responsibilities will have to be developed. Some key issues to consider will be:

What are the entry and exit points for the patients, i.e., what is included in the service network?

Should the service network hold contracts/service level agreements with units?

What is, and isn't managed by the service network, e.g. appointments – who? What level?

Diagnostic/supporting specialties/AHPs included? E.g. neuropsychology, neurophysiology, neuropathology?

Structure and membership

Key working relationships will exist between the management board and:

SGHD

NHS Boards

BCEs

Regional planning groups

MCN

An effective and efficient structure and appropriate membership of the management board and any supporting groups should ensure:

Best use of available expertise/experience – clinical, commissioning, finance and planning, operational management etc

Engagement at the right level

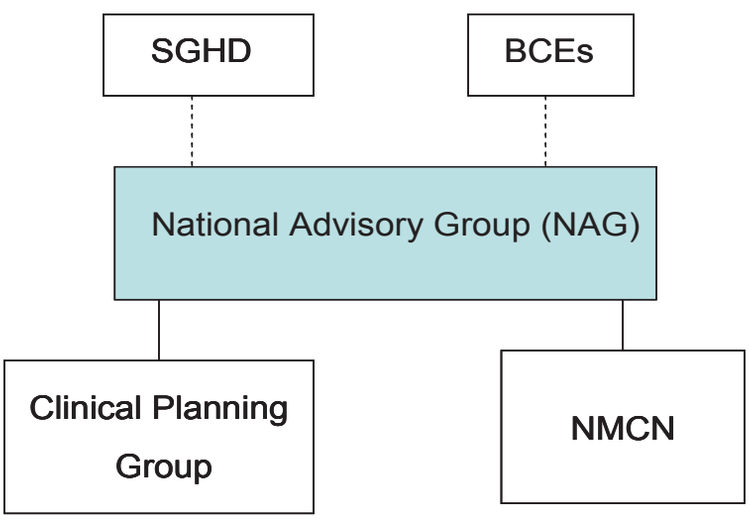
Clear description of objectives and timescales

Appropriate performance management arrangements

Appropriate employment/admin support/location of management board

The following models are described to offer some potential solutions for discussion.

'National Advisory Group' model



<u>NHS Boards retain responsibility for:</u>

Funding and service developments

Employment ((? levels)

Clinical governance

Day-to-day service provision

<u>Features:</u>

+ This leaves a high level of local autonomy with individual boards

+ Local issues can be reported to the NAG for a nationally planned solution

+/- NAG is responsible for prioritising issues and developments

+/- NAG makes recommendations for developments with financial implications to BCEs

+/- NAG remits specific work to the clinical advisory group (could be a function of NMCN?)

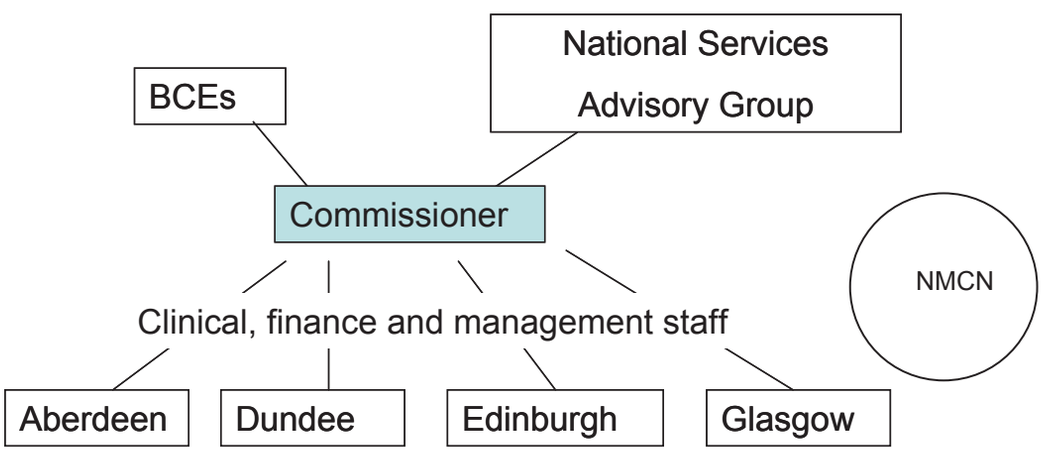
+ NMCN continues with an advisory role to the NAG to inform decision making

- The approach is not cost neutral

? The NAG can make recommendations but how are these enforced?

? Can NAG be responsible for clinical appointments? What is the mechanism for this?

'Traditional' commissioning model



Features

+ high level of coordinated national approach with local responsibility for delivery

+ good service involvement

+ clear funding arrangements approved by BCEs

+ NSAG and commissioner have authority over aspects of service provision

+ SLAs are agreed between commissioner and provider

+ pre-existing authority in NSD

+ precedent for one service, several site model, e.g. adult cystic fibrosis

+ developments agreed on a national level

+ national funding removes a competing priority at board level

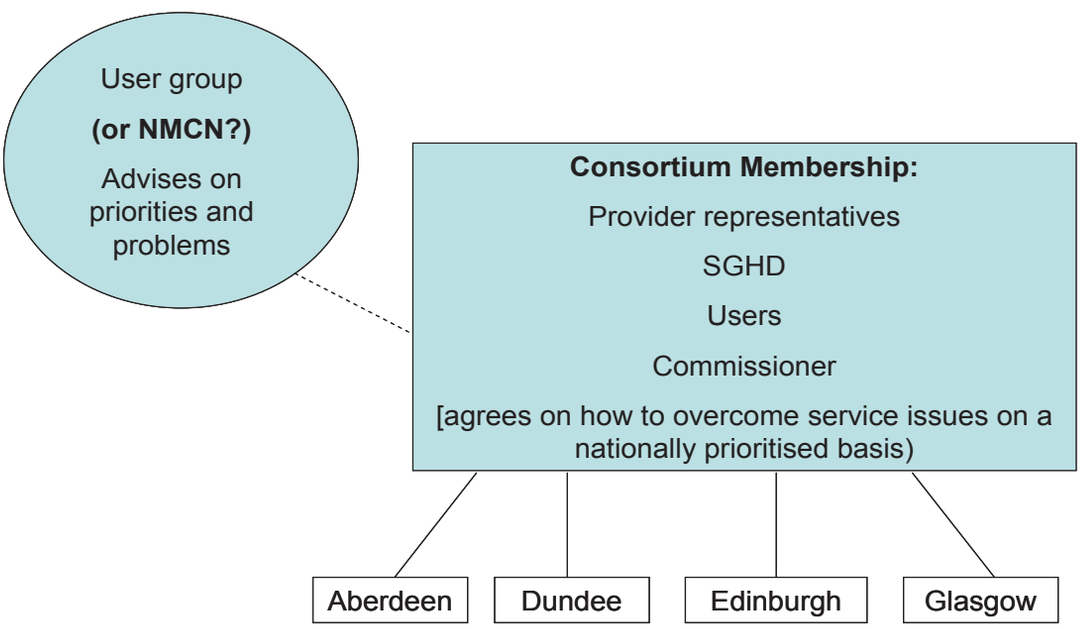
? NMCN roles, responsibilities, management lines

- neurosurgery does not fit NSAG/NSD's criteria for designation as a national service

- commissioning experience not available within other special health boards

- loss of local autonomy especially financial issues

Consortium Approach



4 sites – services commissioned separately for the four sites

Background

Existing example of molecular genetics based on a recognition that not all can be completely self sufficient. Designed to allow for planned management of sub specialisation. Services commissioned separately from four sites.

Features

+/- commissioned

+ role for SGHD in partnership with other stakeholders

+ all stakeholders working collaboratively to improve efficiency

+ provision and commissioning is advised by users

+ explicit agreement on what is delivered where?

? Who are users in neurosurgery? Patients/ A&E / other specialties? Is the ‘user group’ in neurosurgery in effect the NMCN?

Mark Brady

Fiona Maxwell

February 2008

Annex 7 Members of the Data and Audit Group

Dr Adam Bryson, Medical Director, National Services Scotland (Chair)

Mr Laurence Dunn, Consultant Neurosurgeon

Mr Douglas Gentleman, Honorary Consultant Neurosurgeon and Consultant in Rehabilitation Medicine

Dr Rustam Al-Shahi Salman, MRC Clinician Scientist and Honorary Consultant Neurologist

Mrs Dawn Weir, Clinical Group Manager, Specialist Services, NHS Tayside

Mr Calan Mathieson, SpR in neurosurgery, Southern General Hospital, Glasgow

Mr Richard Hunter, Senior Information Analyst, Information and Statistics Division, NHS National Services

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Annex 9 Current draft standards

Edited standards version 6

August 2008

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1. Information/communication – CORE STANDARDS

Rationale

In line with GMC guidance 'Consent: patients and doctors making decisions together' (GMC 2008), partnersh core of good clinical practice. The patient and/or family or carers are part of the decision making process. Th good decisions with good information, given in such a way as to minimise anxiety and foster an understandi risks and benefits – of treatment options. Good practice also requires that a record is kept of information giv the range of particular communication needs a patient may have and make information available in a format needs wherever possible.

Information should be available at all stages of the patient's journey; diagnosis, treatment and recovery/reha be aware of other sources of information and help such as charitable/voluntary sector organisations dealing condition.

Continuity of care relies on information about the patient's condition, treatment and follow-up flowing with th individuals or agencies involved in the patient's ongoing care. The patient should as far as possible experie between care providers.

1.1 Information about the diagnosis and care plan will be provided to the patient and/or their family or other carer as appropriate.

1.2 Information about support networks, outreach services, liaison with other health and community services, self-help groups, social and cultural support will be available.

1.3 Neurosurgical units will have available comprehensive and comprehensible patient information about the common neurosurgical conditions, accessible both to patients and families and will make available a professional staff member to explain its content.

1.4 Preparation for surgery will include the provision of written information about the condition, the treatment options, the role and nature of surgery, its potential benefits, limitations, consequences and risks.

1.5 Decision making in partnership with the patient commences at first assessment and is an educative process leading to treatment of the specific condition.

1.6 Information will be provided in the patient's preferred language/format wherever possible.

1.7 Regular communication with patients and their relatives will be maintained to discuss treatment plans, clinical progress, prognosis, concerns, etc.

1.8 At discharge, patients will be informed of the need and reason for follow-up arrangements.

1.9 Patients/families will have the opportunity to provide feedback on quality of care

Evidence of compliance standards 1.1 – 1.9

Evidence of available patient information and record of information communicated

(written records of discussions, evidence of informed consent, patient letter copy, results of survey(s).

1.10 General practitioners and other primary care practitioners will be appraised of the ongoing situation with patients and will receive comprehensive information on the patient's discharge and follow-up arrangements.

1.11 Patients transferring between healthcare facilities will be accompanied by high quality information, including a health record summary (with responsible clinician's name), a management or follow-up plan when appropriate and radiological information.

Evidence of compliance standards 1.10 – 1.11

GP informed by phone within one working day of any inpatient death. Interim discharge summary completed at time of discharge and formal discharge summary within 2 weks. Audit of timeliness and completeness of information sent about patient's diagnosis and management at transfer.

1.12 All relevant up to date clinical case records will be available in clinic.

1.13 IT facilities (eventually linked to EPR systems) will be in out-patient wards.

1.14 Results of laboratory tests will be available at clinic.

1.15 Imaging with consultant radiologist's report will be available at clinic.

1.16 Image linkage with rapid transfer time of base data between served DGHs and neuroscience centre will be present and used, and neuroscience centres will be linked.

Evidence of compliance standards 1.12 – 1.16

Results of regular analysis of performance against standards. Description of IT facilities and external audit. Presence of a linked image transfer system and evidence of its usage.

1. Information/communication – DEVELOPMENTAL STANDARDS

1(D).1 Support groups will be available where patients can interact with other neurosurgery patients and receive peer support.

1(D).3 The neuroscience centre will provide a directory of the services and facilities available. The directory of services will include the following:

- list of multidisciplinary teams, core members, referral and contact information
- description of facilities for post-neurosurgical outreach, follow-up and rehabilitation
- information about voluntary and support groups for patients and carers, with contact information
- referral guidelines, based on local adoption of national guidelines for referral and pre and post neurosurgical care.

Evidence of compliance standard 1(D).1 – 1(D).2

Support group available, details of information available to patients/relatives/carers. Current complete directory.

2. Access to care – timely access CORE STANDARDS

Rationale

There are many reasons why access to neurosurgical care should be timely. Whether the patient requires em routine or planned care, they will be treated within an appropriate time and by the appropriate professionals. treatment also reduces anxiety for the patient and their family/carers and minimises the additional effects of NHS Boards must also ensure that their local arrangements enable Government waiting times to be met.

Information transfer between health professionals relating to the patient's care should not be delayed. The in ensure continuity of care should travel with the patient.

2.1 There will be access to neurosurgical advice 24 hours a day, seven days a week. The point of first contact in the neurosurgical unit in an emergency will be a doctor who has specialist neurosurgical experience, and the consultant neurosurgeon on call will always be available by phone for urgent advice and able to attend the neurosurgical unit when required, within a time frame appropriate to the clinical situation.

2.2 Patients with life-threatening neurosurgical conditions will be admitted without delay.

2.3 Data sent as part of emergency consultation will be sent immediately, at most within two hours where clinically acceptable, and an action plan communicated to the referring clinician.

2.4 Less urgent opinion about data transferred to the neuroscience centre will be provided within one working day.

2.5 Units will have in place clear and workable arrangements for handover to ensure continuity of information between referring hpspital and neurosurgical unit.

2.6 The national standards governing waiting times will be met.

2.7 Regardless of method of offer (written/verbal/combination), subject to the following exceptions, patients sholud be offered up to 2 dates for outpatient, inpatient ,or daycase services. Both appointments should be at least 3 weeks in advance and within the national waiting times standard. Exceptions are urgent appointments and infrequent services, i.e., those provided once every 8 weeks or less. *('New Ways', ISD 2007)*

2.8 For outpatients, clinical letters will be sent to GP and/or referring doctors within two weeks of clinic episode.

Evidence of compliance standards 2.1 – 2.8

On call rota with defined contracts, audit of response times, waiting times and outpatient letters,

analysis of interval between assessment/investigation and action taken/admission. Evidence of established handover arrangements. Evidence and implementation of planned admission programme

2(D). Access to care – timely access DEVELOPMENTAL STANDARDS

2(D).1 Patients will be seen within 15 minutes of their appointment time in 75% of cases.

2(D).2 Bookings should be in line with the SBNS guidance of 30 minutes per new patient and 15 minutes per return should not exceed the number of patients agreed by the consultant . If this does happen on a regular basis, alternative arrangements must be investigated.

2 (D).3 Patients will be given the opportunity to agree a date for their admission at the time a decision to treat is made.

Evidence of compliance standards 2(D).1 – 2(D).2

Internal/external audit, analysis of appointments vs national guidelines.

3. Access to care – transfer and referrals CORE STANDARDS

Rationale

All patients who require neurosurgical care should reach a neurosurgical unit in a safe and timely way.

Current specific guidance relating to referrals and transfers should be followed:

- **'Recommendations for the Safe Transfer of Patients with Brain Injury' Association of Anaesthetists o 2006**
- **SIGN guideline 46 'Early Management of Patients with a Head Injury' 2000 (to be reissued 2009)**

3.1 Patients, including those with severe diffuse traumatic brain injury, will be admitted to neurocritical care according to admission criteria as defined in SIGN Guideline 46.

3.2 If the unit of first choice is unavailable the patient must be transferred to another neurosurgical unit. This should be arranged by the duty neurosurgeon who takes the referral, who will decide whether definitive neurosurgical treatment should take priority over subsequent transfer.

3.3 Transfers to the neurocritical care unit will be conducted by suitably trained personnel, with the necessary resources and skills to ensure safe and timely transfer.

3.4 To facilitate audit and as a legal requirement, referrals to and from the centre should be documented and records held for six years (subject to revision of the NHS Records Management Code of Practice (Scotland)).

Evidence of compliance standards 3.1 – 3.4

Record of admission/discharge criteria. Presence of referral records. Audit of outcome for delayed/non-transferred admissions. Guidelines for the transfer of head injured patients – AAGBI 2006

3. Access to care – transfer and referrals DEVELOPMENTAL STANDARDS

3(D).1 Transfers in and out of the neurosurgical unit should be dictated by individual patient need. Patients should not be discharged to 'make room' for new admissions except in exceptional circumstances.

Evidence of compliance standard 3(D).1

Record of delayed admissions, precipitate discharges, and lengths of stay.

4. Access to care – facilities and resources CORE STANDARDS

Rationale

Sufficient resources must be in place to ensure that treatment is available in the neurosurgical unit where an avoid unnecessary transfers for all patients requiring neurosurgery and associated specialities and minimise emergency out of hours work. Neurosurgery is a specialised field requiring dedicated expertise and resource

Patients should only be in neurosurgical units when thy require the specialised skills and facilities available dependent on effective links between the neurosurgical unit and the referring hospital or secondary site, and facilities being available on these sites to provide safe and appropriate pre-admission and post-discharge ca

4.1. Units will provide full 24 hour emergency service, sufficient to meet the needs of their catchment population.

4.2 The numbers of staffed neurosurgical beds in wards will be in accord with the standards of 'Safe Neurosurgery' (current edition)

4.3 Units will have sufficient facilities to meet the needs of all appropriate patients in their catchment area, including: access to outpatients, in-patient and day case beds, critical care facilities, radiology, operating theatres and staff and anaesthetic facilities, neuropsychology, neurophysiology, neuropathology, oncology, otology, ophthalmology etc. (This list is not intended to be exhaustive but to name some of the specialties which may commonly be required)

4.4 Neurosurgical care of in-patients will be delivered in wards dedicated to neuroscience and staffed by neuroscience trained nurses.

Evidence of compliance standards 4.1 – 4.4

'Safe Neurosurgery' standards for population served. Evidence of appropriate provision of necessary facilities. Designated neuroscience wards. Audit of 'last minute' cancellations (numbers and reasons), records of near misses, risks and incidents as a consequence of inadequate resources to support interventions.

4.5 Children and young people will be cared for in dedicated facilities, except in exceptional circumstances.

Evidence of compliance standard 4.5

There will be separate facilities for children and young people up to 16th birthday that meet the guidance listed in section 12.

4.6 Operative neurosurgery will be performed in theatres specially and specifically equipped for neurosurgery and staffed by personnel experienced in its techniques.

4.7 There will be a dedicated unit or area for the intensive care of neurosurgical patients in close proximity to neurosurgical theatres.

4.8 The neuroscience unit will have access to dedicated neuro HDU beds.

Evidence of compliance standards 4.6 – 4.8

Dedicated neurosurgical theatres, documentation of designated areas/units.

4.9 Sufficient capacity will be available to avoid non-urgent cases being performed out-of-hours.

4.10 Sufficient capacity will be available to allow urgent cases to be accommodated in daytime lists where appropriate.

4.11 Local secondary care facilities for the care of patients not needing neurosurgery (e.g., minor and many moderate head injuries) should be sufficient for local needs.

Evidence of compliance standards 4.9 – 4.11

Number of staffed neurosurgical beds, no greater that 85% occupancy, record and audit of number and

nature of cases operated on out-of-hours, audit of operative cases.

4. Access to care – facilities and resources DEVELOPMENTAL STANDARDS

4(D).1 Co-located on the same campus with the neurosurgical department will be specialist facilities and staff such as; neurology, neuroradiology/intervention, neuroanaesthesia, neurocritical care, neuropathology, neurotrauma, spinal surgery. Ready access will be available to; neurophysiology, neuropsychology, neuroophthalmology, neurootology, neurooncology, neurorehabilitation, maxillofacial surgery, endocrinology.

4(D).2 Planned admissions to the neurosurgical unit should not be delayed as a result of bed occupancy by patients not requiring neurosurgical care.

Evidence of compliance standard 4(D).1- 4(D).2

Full complement of neuro services on or close to campus. Record of admissions delayed and patients boarded to neurosurgery.

4(D).3 Direct IT access will be possible to laboratory/radiology results in all clinical areas, and to requests including electronic prescribing

Evidence of compliance standard 4(D).3

IT system in place and in use

5. Access to care – staff levels CORE STANDARDS

Rationale

All neurosurgery is delivered by a specialist multi-disciplinary team and all members of that team have a part be of a sufficient size and must have the appropriate mix of skills to ensure the best possible experience and appropriate mix of individual levels of skill and experience within specialties will ensure the provision of trair opportunities. With particular consideration for patient safety, staff in training will always have access to con supervision.

Local NHS Boards must also observe the legal requirements in relation to Working Time Directives complian

5.1 The neurosurgery unit will have sufficient accredited neurosurgery, neurology, radiology and anaesthetic consultants according to population and workload requirements and in line with professional guidelines where these exist.

5.2 Consultant neurosurgeons should not be on call without intermediate grade cover.

5.3 The neurocritical care unit will be covered by consultants with appropriate skills in neurocritical care, in numbers sufficient to allow adequate clinical cover of the unit including on-call responsibility, management, audit, teaching and follow-up.

Evidence of compliance standards 5.1 – 5.3

Lists of neurosurgical consultants and sessions worked, in accordance with 'Safe Neurosurgery'.

Records of rotas. Compliance with consultant job plans and working time directive. EWTD compliant rotas.

5.4 Each centre will have a continuous and documented availability of appropriately skilled anaesthetists including a specialist on-call rota. If children's facilities are available, these will include anaesthetists with expertise in the management of the paediatric neurosurgical patient.

Evidence of compliance standard 5.4

Accordance with specific guidelines for rota prepared by the Royal College of Anaesthetists and

related reports from the Association of Anaesthetists of Great Britain and Ireland.

5.5 Nursing staff numbers will be sufficient to allow one nurse to one bed for level 3 patients and one nurse for two patients for level 2 high dependency patients. This will allow flexibility in the number of level 3 and level 2 beds available. Neuroscience wards should have a nursing skill mix which reflects an appropriate balance of neuroscience trained nurses

5.6 Nurses and operating theatre personnel experienced in neurosurgery theatre techniques will be available 24 hours a day.

5.7 The neurosurgical unit will have physiotherapists experienced in the specialist care needed by neurosurgery patients available 24 hours, seven days a week.

5.8 Administrative support (including personal secretaries/assistants to consultants) will be available for the clinical staff working in the wards, clinic, theatre and therapy areas.

5.9 Neurosurgery units which care for children will have nurses and therapists with paediatric experience.

Evidence of compliance standards 5.5 – 5.9

Record of nurse staffing and qualifications/experience, on-call rotas, posts in place, named individuals,

presence of administrative posts.

5.10 The neurosurgical unit will also have ready access to a full range of clinical specialties, including:

- Infection control nurses experienced in the needs of neurosurgery patients
- radiographers
- physiotherapy, speech and language therapy
- occupational therapy available throughout the working week
- pain control nurse
- pharmacist
- clinical neuropsychologist
- neuro-psychiatric advice or liaison psychiatry
- link nurses for oncology, spinal, vascular, movement disorder, epilepsy and other disorders
- dietetic advice
- social work

This is not a complete list of all disciplines that may be involved in the care of a patient receiving neurosurgery and instead refers to those that are required on a regular basis, in some cases with dedicated time and skills and experiece specific to neurosurgery. Sufficient therapists should be available as identified in 'Standards for Neurosurgery – Therapy Standards Working Group 2000'.

Evidence of compliance standards 5.10

Posts in place, named individuals.

6. Access to care – outpatient clinics

Rationale

Outpatient clinics should provide quality follow up and audit and continuity of care and should ensure that th the appropriate professional(s) for his or her particular needs. The facilities in the clinic must be sufficient an including those who may have specific physical needs. Clinic attendance should be as easy and comfortable

Consultant led outpatient clinics have the potential to provide excellent training opportunities for neurosurge all levels of training and this should be used wherever possible/practical. The requirement for sufficient resc this potential should be recognised.

6.1 Clinics, and the facilities available, will reflect the needs of the patient/condition, understanding that some conditions require specialist and/or multidisciplinary follow-up.

6.2 There will be separate outpatient facilities available for the review of children under 16 years of age.

6.3 Outpatient clinics requiring a neurosurgeon will be consultant led.

6.4 Outreach clinics will be available where appropriate.

6.5 Consultant sessions will be provided for a regular follow-up clinic to allow review of patient outcomes and provide additional information where required.

6.6 Systems should be in place to monitor numbers of DNAs and reduce rates where possible.

6.7 Outpatient clinics should be resourced and planned to provide a balance between service delivery and training opportunities.

6.8 Mechanisms for auditing patient satisfaction should be in place

Evidence of compliance standards 6.1 – 6.6

List of clinics and record of new/follow up attendances and DNAs. Record of children's clinic facilities. List of consultant attendances. Consultant job plans. List of staff members, record of patient satisfaction audit.

6. Access to care – outpatient clinics DEVELOPMENTAL STANDARDS

6(D).1 Consideration should be given, wherever possible, to the development of joint clinics or other opportunities for providing a 'one stop shop' for patients to reduce the number of necessary attendances.

Evidence of compliance standard 6(D).1

Audit of patient attendance and activity at clinic appointment.

7. Access to care – rehabilitation CORE STANDARDS

Rationale

After many neurosurgical conditions or procedures, rehabilitation is vital in maximising the patient's recover rehabilitation happens and what features it has will have an effect on the patient's outcome. The aim is to ens to maximise their potential following injury/illness and to return to as normal a life as possible. Independence significantly affected after neurological illness or injury and the patient may require the help of an expert mul

7.2 Each neuroscience centre will have close links with at least one consultant in neurorehabilitation who, if not located at the neuroscience centre, will visit to assess patients and coordinate access to rehabilitation services.

7.3 A multiprofessional neurological rehabilitation team will be available to each neuroscience centre, to include clinical neuropsychology, occupational therapy, dietetics, speech and language therapy and physiotherapy, plus readily available social work and other input where required.

7.1 There shall be a model of care for those patients likely to require neurorehabilitation and follow up services, including neuropsychology services. It will include initial MDT assessment and a care plan, including:

- duration, frequency and intensity of treatment
- evidence of specific and measurable objectives of treatment
- evidence of arrangements for regular reassessment and for any necessary long-term support

Evidence of compliance standards 7.1 – 7.3

Documents setting out care plans, including evidence of specific goals and objectives, evidence of MDT assessments, discharge planning.

Agreed job plans demonstrating commitment to rehabilitation services, record of assessment of needs,

personnel in post.

7(D). Access to care – rehabilitation DEVELOPMENTAL STANDARDS

7(D).1 The regional neurorehabilitation services shall have direct links with agencies in the voluntary sector that provide rehabilitation or support facilities for those patients with neurological disability.

7(D).2 For patients who have completed rehabilitation but who have persisting neurodisability, there will be access without undue delay to appropriate levels of institutional or community care with continuing long-term support for them and their families. This should not normally involve readmission to a neurosurgical unit.

Evidence of compliance standards 7(D).1 – 7(D).2

Documented evidence of linkages and joint working, evidence of available facilities and support services,

evidence of satisfactory access and standards.

8. Quality of care - team delivered – CORE STANDARDS

Rationale

The patient's experience of being treated should be as seamless as possible. This relies on effective commu members and with other individuals or agencies providing care to the patient. As part of the team approach, accountability must be clearly defined.

8.1 Each individual's treatment will be planned and delivered by the multi-professional team and will be detailed in the patient's individual care plan.

Evidence of compliance standards 8.1

Written record of treatment planning including options of management discussed.

8.2 Care plans will include defined responsibilities for all aspects of care, arrangements for treatment and monitoring of progress.

Evidence of compliance standard 8.2

Development of integrated care pathways to enable uniformity of approach, early identification of problems and clinical audit by variance from plan.

8.3 Services will be provided by structured and managed multidisciplinary teams, with named team leaders, to include:

- neurocritical care
- neurovascular
- neuro-oncology
- diagnostic neuroradiology
- paediatric neurosurgery, etc.

8.4 The medical members of the MDT will each have regular sessional commitments defined for the care of patients with specific conditions, including time for audit, teaching, administration and other non-clinical duties.

Evidence of compliance standards 8.3 – 8.4

Membership lists of the multi-disciplinary teams, documented job plans containing sessions dedicated to the management of specific conditions.

8.5 The MDT will arrange patients' palliative care where necessary, including appropriate counselling and support for the patient's carers.

Evidence of compliance standard 8.5

Evidence of access to palliative care team, evidence of support and counselling facilities available.

8.6 A named clinician will be responsible for ensuring regular audit of the work of the team, its compliance with guidelines/care pathways and identification of any improvements to practice.

Evidence of compliance standard 8.6

Evidence of an audit cycle, regular reporting of results and a timetable for review of guidelines

8.7 Neurosurgery will have a clear process for issues of clinical governance, specifically:

- For the personal development programme process and appraisal of all staff
- team working (duty rotas and cover)
- Organisation of morbidity and mortality meetings
- Risks, incidents and near-miss reporting
- complaints and litigation

Evidence of compliance standard 8.7

Job plans, appraisal form 4s, documentation of processes, duty rotas/cover arrangements, minutes and

attendance records, agreed programme of audit.

9. Quality of care - network approaches CORE STANDARDS

Rationale

Neurosurgical units do not work in isolation. They need clear, multiprofessional lines of communication aime access, commonality of standards, and consistent participation in useful national audit. The sharing of good ensures comparable quality of care no matter where the patient lives.

All modern clinical teams are multiprofessional. Patients, carers, AHPs and referring clinicians should be inv development of the patient pathways through neurosugery. These allow the local delivery of care wherever p for referral where necessary. A network approach should also promote managed sub-specialisation.

9.1 Neurosurgical units will have agreed policies and referral criteria between primary, secondary and tertiary care.

9.2 The neurosurgicall team will have lines of communication and links with professionals such as social workers, community nurses and community based therapists.

9.3 Formalised discharge planning will include the involvement of secondary care local to the patient's home and their own GP where appropriate, and coordination with community services including social services

9.4 The neurosurgical team will communicate the patient's diagnosis and care plan to referring clinicians, GPs and teams responsible for rehabilitation and community reintegration.

Evidence of compliance standards 9.1 – 9.4

Written policies, named team members, record of referral to suitably qualified/experienced social worker.

Discharge summaries audit. 'Core ' information at the time of, or in advance of discharge, definitive discharge summary dispatched within two weeks.

9.5 The neurosurgical team will be readily available for advice to other professionals on patient care.

Evidence of compliance standard 9.5

Clear guidelines for the referral of patients within a region, communication channels identified.

9.6 The specialist departments will be linked functionally and constitute a multidisciplinary neuroscience centre.

Evidence of compliance standard 9.6

Evidence of function linking by formal arrangements, joint meetings/clinics, evidence of seamless shared care.

9.7 There should be commitment to national communication and coordination between centres and across disciplines. The centres should strive to collect standardised information.

Evidence of compliance standard 9.7

Participation in national network groups and nationally consistent participation in audit and data collectiont.

9.8 Patients and their families/carers will influence the way their care is delivered.

9.9 Network approaches must have commitment to helping patients and their families/carers to contribute to the development of services, including local guidelines for care.

Evidence of compliance standards 9.8 – 9.9

Patient, family/public involvement in network groups.

9.10 Each patient will be assessed as soon after admission as practicable for their social care requirements after discharge.

9.11 The local referring clinician will accept the patient's return within 48 hours of being informed that the special needs of neurosurgery have passed, and will ensure appropriate placement for the continuing care of the patient.

Evidence of compliance standards 9.10 – 9.11

Evidence of protocols and guidelines in secondary care facilities with named clinicians responsible for these patients. Documentary evidence of a MDT and a managed clinical network of facilities. Absence of delayed discharge to referring units, absence of unplanned readmission, absence of admissions

delayed because of over-occupancy.

9(D) . Quality of care - network approaches DEVELOPMENTAL STANDARDS

9(D).1 Services will be developed in such a way as to provide as much care as close to home as possible

Evidence of compliance standard 9(D).1

A network of services will be coordinated in such a way that care can be provided at the

appropriately located facility.

9(D).2 Neurosurgical units should support the development of a national minimum dataset for neurosurgical practice.

9(D).3 Units developing datasets for routine use should ensure that these are short, simple and focused on measurements which may be used as a proxy for quality of care, and compatible with other widely used datasets.

Evidence of compliance standards 9(D).2 – 9(D).3

Agreed dataset. Locally developed datasets are simple, coder friendly and short.

9(D).4 Information systems will be developed to ensure regular production of clinically relevant reports to support clinical governance needs.

Evidence of compliance standard 9 (D).4

Regular, clinically relevant reports.

9(D).5 Clinicians will agree and implement local and national pathways of care for neurosurgical patients.

Evidence of compliance standard 9(D).5

Documented evidence of up to date guidelines and treatment plans for the management of each specific condition in accordance with national guidance where this exists

9(D).6 There will be an outreach team of specially trained staff to give advice to community based professionals, the patient and their family, specific to the illness, injury or treatment.

Evidence of compliance standard 9(D).6

List of team members and duties.

9(D).7 The neuroscience centre will regularly review the appropriateness and timeliness of urgent referrals and provision of information from and to referring doctors and NHS Boards

Evidence of compliance standard 9(D).7

Record of outcome of review

10. Quality of care – evidence based CORE STANDARDS

Rationale

Modern clinical practice should be based on the best available evidence and should adapt and improve over emerges. Neurosurgical units should be able to demonstrate commitment to ongoing evidence-based improv participate in developing the body of evidence available.

Units should follow appropriate guidance where available:

10.1 The managed introduction of new treatments and techniques into the centres will be nationally approved (scotland).

10.2 The multi-disciplinary team will identify, modify and/or develop and implement agreed protocols and treatment plans for the management of (specific condition) in accordance with national guidance where this exists.

10.3 Guidelines for the referral of neurosurgical patients will be available to primary and secondary care staff

Evidence of compliance standards 10.1 – 10.3

Documented evidence of up to date guidelines and treatment plans, integrated care pathways where they exist, pathways and pathway audits.

10.4 Information about patients referred but not accepted (outpatients, inpatients and telephone referrals) should be recorded and included in any database to determine the scale of neurosurgical need, appropriateness of referrals and unmet demand.

Evidence of compliance standard 10.4

Collection of agreed data

10.5 Regular morbidity and mortality meetings must take place within the audit programme. Relevant clinical staff shall be provided with sufficient time to prepare for and to regularly attend such meetings.

10.6 All aspects of clinical practice where recognised standards exist, or improvements might be made, should be considered for audit.

10.7 Where there are national programmes for audit, all centres will participate.

Evidence of compliance standards 10.5 – 10.7

Registry of attendance and lessons learned/practice changed. Details of annual audit programme including outcomes, action plans and effects of changing practice. Evidence of participation in national audit

10.8 Units will follow child protection guidelines in their own activities and links with other organisations.

10.9 Units will follow good practice in order to reduce rates of hospital acquired infection.

Evidence of compliance standard 10.8 – 10.9

Evidence of compliance, annual infection rates

10.10 Research programmes will comply with national policies for research governance, including research ethical committee approval, compliance with patient confidentiality, data protection, informed consent and compliance with legislation on handling of human tissue.

10.11 Neurosurgical units participating in multicentre research programmes from elsewhere must be able to demonstrate the existence of appropriate consents, guidance and standards for the work.

10.12 Neurosurgical units should develop or be participants in local or national research/development projects relevant to neurosurgical practice to help improve the quality of service and patient outcomes.

Demonstration of compliance standards 10.10 – 10.12

List of approved projects and research active personnel, evidence of participation in research governance procedures, ethical and other approvals and appropriate documentation.
Evidence of local compliance with appropriate guidance and approvals, evidence of annual research assessment.

10.13 Consultant neurosurgeon job plans will contain sessional commitments to research and development, where the consultant wishes.

Evidence of compliance standard 10.13

Job plans.

11. Training and development CORE STANDARDS

Rationale

Skills and knowledge need to be maintined and improved, and best practice shared, to provide the best quali the patient. The time, investment and other resources necessary to support this development, for all professi care of the neurosurgical patient, must be formally recognised.

11.1 The neurosurgical unit will have nominated individuals with defined responsibilities and provided with defined administrative support and funding for the provision of programmes of continuing professional development for each professional group.

Evidence of compliance standards 11.1

Nominated individual clearly identified and recognised by management, who has written defined responsibilities. Evidence of a published programme of continuing education and training accessible for all levels and grades of staff. Attendance records for the components of the programme. Documentation of programmes of continuing education.

11.2 Staff will take part in continuing education and continuing professional development.

11.3 Each neurosurgical unit will identify its participation in the various educational and training programmes available to staff.

11.4 Access to courses provided by individual units will be available to staff in other units.

Evidence of compliance standards 11.2 – 11.3

Education CPD programmes/attendance logs. List of available training/educational programmes available in the unit.

11.4 There will be a recognised allocation of time for consultants as trainers to undertake their educational duties, including clinical teaching in the ward, operating theatre and outpatient department, as well as formal teaching.

Evidence of compliance standard 11.4

Consultant job plans. Appropriate course certification 'Training the Trainers', assessment and examiners' courses.

11.5 For doctors in training the appointed programme training director, together with the postgraduate deans, will define and implement agreed training contracts. The unit will comply with the appropriate defined requirements for training.

Evidence of compliance standard 11.5

Evidence of training and educational goals achieved by each trainee.

Evidence of regular inspections by competent authorities.

11.6 For all medical staff there will be opportunity and funding for study leave as defined in terms and conditions of service. The job plans of medical staff will identify a formal allocation of time for the specific purpose of continuing professional development to enable compliance with appraisal and revalidation.

11.7 The neurosurgical unit shall be resourced to support the educational needs of nursing and allied professionals and others working within the framework of the neurosurgical unit, and all nursing and allied health professional staff will have the opportunity of fully resourced continuing professional development.

11.8 All team members will be encouraged to develop additional skills for career advancement and for the benefit of patients.

Evidence of compliance standard 11.6 – 11.8

Audit of CME activity, CME log books, appraisal and completion of form 4.

Evidence that appraisal is carried out; required documentation e.g., KSF development reviews.

Demonstration of availability and evidence of access to educational resources, support and learning resources, library facilities etc. Record of continuing education activities and demonstration of time and funding allocated to continuing professional development.

Rationale

The standards of neurosurgical care set out in this document should apply equally to children and adults. However, the care and young people in neurosurgical units must also take into account their specific needs and requirements as laid out in:

Children (Scotland) Act 1995

Health for All Children, Fourth Edition

United Nations Convention on the Rights of the Child

Welfare of Children and Young People in Hospital 1991

The Recommendations of the Bristol Report.

Section 12: standards specific to children and young people

12.1. Children should be managed in a paediatric environment appropriate to their age. They should be cared for by fully trained paediatric nurses, paediatric surgeons and paediatric anaesthetists as part of a multidisciplinary team. They should have access to the full range of paediatric support specialties, including the professions allied to medicine.

12.2. Children should not be cared for in adult facilities except in emergency situations and paediatric areas should be identified in adult units where this may happen.

12.3. Paediatric intensive care should be available on site where major elective paediatric neurosurgery is taking place.

12.4. Children treated for neurosurgical disorders that may impinge on their development should be assessed and managed in conjunction with a paediatric neurologist or developmental paediatrician, and the multidisciplinary team should include a paediatrician experienced in neurodisability.

12.5. Formal arrangements should be in place for transfer of children to adult neurosurgical services when they reach the age of 16 years e.g. transition clinics.

12.6. Separate facilities should be identified for adolescent pateints whose needs are different to those of small children.

12.7. Facilities must be available for parents to stay in hospital with their children.