

Minute of meeting held on Wednesday 12th November 2008 at 9.30am in the Conference Room, Summerfield House, NHS Grampian, Eday Road, Aberdeen

UNAPPROVED

Present: Miss Sandra Laurenson, Chief Executive, NHS Shetland (Chair)
Mr Richard Carey, Chief Executive, NHS Grampian
Mrs Deirdre Evans, Director, NSD
Dr Roger Gibbins, Chief Executive, NHS Highland
Dr Annie Ingram, Director of Regional Planning and Workforce Dev, NoSPG
Mr David Sullivan, Director of Corporate Planning, NHS Grampian
Dr Sarah Taylor, Director of Public Health & Planning, NHS Shetland
Mrs Roseanne Urquhart, Head of Healthcare Strategy & Planning, NHS Highland
Prof Tony Wells, Chief Executive, NHS Tayside

Videoconference: Dr Peter Baxter, Medical Director, NHS Orkney

In attendance: Mr Peter Gent, Network manager, NOSCAN (item 80/08)
Miss Sandra Hay, Corporate Services Manager, NoSPG
Mrs Martha Hay, NoSPG team
Mr Ian Hunter, SCT (item 81/08)
Mr Ken Mitchell, NoS Programme Manager, Child Health
Mrs Helen Strachan, NoS Network Manager, Oral health & Dentistry
Prof. Richard Wootton, Director, SCT

74/08 Apologies

Action

Apologies were received from Dr Roelf Dijkhuizen, Mr Iain Crozier, Mr Gordon Jamison, Ms Heidi May, Mr George McLachlan, Prof Gillian Needham, Mr Gordon Stephen, Dr Peter Williamson and Mrs Tracey Williams.

75/08 Minute of the meeting held on 14th August 2008

The minute of the meeting of the 14th August 2008 was accepted as an accurate record of the meeting.

76/08 Matters Arising

i) Action Points

The action points were noted and there were no other matters arising.

77/08 18 week RTT – Implications for Regional Working

Dr Ingram reported that Mrs Williams had been unable to attend the meeting but had submitted paper 77/08, which outlined key areas where there are risks to delivery of the 18 week RTT standard and identified where there might be synergies in a collaborative approach between NoSPG and the 18 week AST team. The paper identified oral health & dentistry and cancer as two potential areas for a joint approach.

Dr Ingram reminded members of earlier proposals to establish a specialist services SIM, which had not been identified as a priority by members but said that she and Mrs Williams had agreed to await the outcome of the event before considering how and if this should be progressed. It was agreed that Dr Ingram should pursue this further with Mrs Williams with a view to developing a proposal for consideration at the next meeting.

AKI

78/08 Oral Health & Dentistry

Mr Carey referred to paper 78/08, advising that the proposals presented a model to stabilise oral surgery and OMFS across NHS Grampian, Highland and Western Isles and sustain waiting times performance. He reflected that the investment would be a challenge for these Boards and proposed that there should be an early call on the waiting times funding by the three Boards.

Mrs Strachan reminded members that stabilisation of oral surgery and OMFS, had previously been identified by NoSPG, as the first priority in delivery of the vision, approved in November 2007 for oral health and dentistry across the NoS. She reminded members that a pragmatic solution had been sought that would sustain services and the proposals presented were the result of both lengthy and challenging discussion across the NoS and represented the only clinically acceptable model for NoS OMFS. She invited members to accept the conclusions and remit the report to Boards, with a request to report back to the next NOSP meeting.

Miss Laurenson sought the views of members in relation to the proposed model identified in the report, the proposed cost share and affordability of the model. Dr Gibbins replied that he accepted that regional colleagues had completed this work and agreed to remit the report to NHS Highland Board for consideration. He agreed with Mr Carey's point that funding should be shared between the three Boards who would directly benefit from the service and not be subject to the weighted capitation approach, which was outlined as a potential model within the report.

Prof. Wells agreed with Dr Gibbins and advised members that he had now written to Mr Carey to advise that whilst NHS Tayside might be prepared to assist NHS Highland in the delivery of an elective service and may be prepared to collaborate within a network, in relation to paediatric dentistry and restorative dentistry, NHS Tayside were keen to continue to develop core service links with NHS Fife.

Mr Sullivan asked whether the agreement included the establishment of one of the existing consultants as a clinical lead for the service and Mrs Strachan confirmed that this was integral to the model, if NoSPG approved. Members confirmed their support for the establishment of a clinical lead for this service.

In relation to the event on 17th November 2008, Mrs Strachan confirmed that the agreement to take the proposal to Boards was an important aspect of the event, in particular, the links with the other areas of challenge, including orthodontics and restorative dentistry.

In relation to a question from Miss Laurenson, in relation to the timetable for consideration by Boards, Mr Carey said that there was a need to agree a proposed job plan and split of clinical sessions, before the financial implications were clear. He suggested that he thought that current split was incorrect in relation to NHS Western Isles. Dr Gibbins questioned how the session split of 5,4,2 had been arrived at and it was confirmed by Mrs Strachan that this had been calculated using the time to clear modelling in Appendix 4, and

professional advice. She noted that there were some issues in relation to the workload undertaken in out-patients, which is not collected by ISD and that there was further work required. Dr Gibbins suggested that this undermined the veracity of the report from his point of view and intimated that he would not take the report to his Board until he could be certain that the implications for Highland were robust. Following debate, Mrs Strachan agreed to clarify the required sessions by the end of November and submit to Boards thereafter for consideration at the February Board meetings.

RC/HS

**RC/RG/
GJ**

79/08 Child Health Clinical Planning Group

i) National Delivery Plan – Year 2/3 bid

Mr Mitchell opened by advising members that the final NDP had not yet been published but that it was now expected in December. He reported that whilst initially it had been expected that the bids for both years 2 and 3 had been required by 31st December 2008, this had now been amended to refer to only year 2 bids, on the basis that there were other emerging priorities.

He referred to the paper, which outlined progress to date in developing the year 2 and 3 bids. He reported that a NoS event had been held in October, attended by a wide range of clinical colleagues from across the North. At that meeting, it had been agreed to concentrate on doing a few things well, rather than a minimal investment to a number of services. The priorities for the North remained as outlined in section 5, as follows:

- Regional Infrastructure
- Gastroenterology
- Neurology Network
- Complex respiratory
- Cystic Fibrosis
- Oncology
- Endocrinology
- Rheumatology
- General Surgery
- Metabolic

He reported that there was a further meeting of the CHCP on 26th November 2008, following which the bid would be complete, with a view to circulating to members for approval w/c 5th December. He noted that NoSPHN had developed an outcome assessment tool and bids were being prepared in this format.

KM

He reported that at this stage CAMHS was not included, as the guidance from SGHD remained that this service was excluded. Dr Ingram noted that the paediatricians were not supportive of allocating any of this funding to CAMHS, despite recognition that CAMHS did need investment. Prof Wells said that if the Cabinet Secretary decided that it could be used, then the decision of the chief executives would overrule the clinical view.

In response to a question from Dr Gibbins, Dr Ingram confirmed that two bids would be prepared, one with CAMHS infrastructure requirements in and another without. It was agreed that any further investment identified for CAMHS, if agreed, would be part of the year 3 bidding process. In response to a question regarding prioritisation, Dr Taylor said that the NoSPG Criteria process would support identification of priorities.

**AKI
KM
ST**

ii) Extraordinary Meeting of NoSPG 18th December to agree Bids

Dr Ingram reminded members that at the June meeting members had agreed the year 1 bid against the National Delivery Plan for specialist Children's services and that she had identified that year 2 and 3 bids would require to be submitted by 31st December. At that time she had intimated the potential need for an extraordinary meeting of the group to sign off the bid.

Prof Wells noted that the 18th was a Tayside board meeting but suggested that if others could do this date, either Ms Selkirk or Dr Williamson could represent Tayside's views. It was agreed that members would seek to have an appropriately authorised colleague, at least by v/c at the 18th meeting. If the numbers were not quorate an alternative date would be sought, but Miss Laurenson stressed that this would need to be before Christmas.

PW/CS

**All
NoSPG
team**

iii) NDP Children's cancer

Dr Ingram reported that she, together with colleague Regional Directors, were members of the NDP Implementation Group, chaired by Caroline Selkirk. At the first meeting of the group, it had been proposed that each of the regional directors and Mrs Evans, take a lead for one of the pan-Scotland services. Mrs Evans was leading rheumatology (assisted by Mr Mitchell) and endocrinology, Ms Knox - metabolic; Mrs Duncan – CF, complex respiratory and she had been asked to take a lead in Children's cancer.

Dr Ingram said that the reason for highlighting was the significant commitment required. She reminded members that the Minister had announced a model but that clinical colleagues are not signed up to the model and, therefore, before the investment requirements could be agreed, she felt that this needed to be tied down. She reported that she had visited all of the centres and shared care centres, except Dumfries and had circulated a self-assessment form based on NICHE draft guidelines to centres, ahead of an event on 19th November. She had also joined the CATSCAN Executive. She noted that each region and CATSCAN were identifying priorities for investment.

80/08 NOSCAN

i) National Cancer Strategy

It was noted that the National Cancer Strategy had been published in October. Mr Carey highlighted the proposal to establish the Scottish Cancer Task Force, to replace the Scottish Cancer Group and suggested that this represented a shift in approach by government towards a more directive approach.

ii) Brachytherapy

Members were reminded that NoSPG had approved a business case in June 2008 (39/08) to invest in the short term in a two-centre PDR solution for the North. The Scottish Radiotherapy Advisory Group (SRAG) had not accepted this position and had commissioned an independent review. As part of the Review, meetings with both centres had been arranged and the report compiled by Prof Hoskins had concluded that the North should introduce an HDR solution, centred on one site, in Aberdeen and NHS Tayside should not continue to offer a local service. This is based on issues of volume, available staff and the model emerging in the rest of Scotland.

Prof Rodger had written to Miss Laurenson (item 80/08 ii) on 5th November

highlighting the SRAG's preferred option for HDR:

"...would be for one centre in the North. This centre would be based in Aberdeen and an HDR should be commissioned as soon as possible. A key reason for SRAG's recommendation was that a centre run by a 'single-handed' Brachytherapist is no longer an appropriate option (as noted in Royal College of Radiotherapy guidelines), due to concerns with safety."

The letter continues:

"It is appreciated that the North of Scotland Regional Planning Group may not support SRAG's preferred option and if this is indeed the case, it is requested that a solution is provided on how the North can run two PDR centres which comply with the recommendations regarding single-handed Brachytherapist centres. SRAG would also ask that the North of Scotland Regional Planning Group ensures there is more than one consultant in both Aberdeen and Dundee trained and entitled under IR(ME)R in brachytherapy and further, that all issues outlined in the 'Hoskin review' report (including consultant cover and critical mass) are addressed within the proposed two-centre model."

And seeks a response by the end of the year.

Members agreed with Mr Carey's assessment that there remained clinical support for the proposed two-centre NOS model and any response should highlight the government policy of presumption against centralisation is a key issue in the North, that no further evidence has been presented to alter the original position adopted by NoSPG, therefore NoSPG will maintain the original decision. Mr Carey offered to provide a draft response for Miss Laurenson, which he would share with members.

RC/SL

iii) **NOSCAN Workplan**

It was reported that the workplan presented had been the product of significant engagement across the clinical communities in the North and members were asked to approve. This was confirmed.

iv) **Progress Report**

The progress report was noted, however, Mr Gent highlighted the **Generic Clinical System** issue, reminding members that NOSCAN had piloted this EPR system in Gynaecological cancer, but that there have been issues in linking systems between Boards. This together with the decision of the National e-Health Board to withdraw support for the system, despite it being identified in national policy document as the appropriate system, had left NOSCAN in a difficult position. Mr Gent asked members to support a proposal to ask Boards to continue to develop the system within Boards, with an aim to resolve the connectivity issues at a later stage. He raised concerns regarding cost and use of public monies, if all Boards had to pay separate licences.

Mrs Evans said that two of the national managed clinical networks used GCS; 3 others used "e.Case" and that it is possible to connect across Boards. She said that NSD were currently in discussion with ATOS Origin and AxSyS Technologies and other suppliers to find a way of providing all National

Managed Clinical Networks with a means of collecting data across Scotland and consolidating it into single databases to support patient care – especially when clinicians are providing outreach clinics - and clinical audit. Dr Ingram asked what the problem was and, if it could be resolved, would a consortium approach, either between NoS Boards, or linking with NSD.

Miss Laurenson said that what was needed was a substantive paper that sets out the issues, identifies the implications, together with potential solutions and costs. It was agreed that Mr Gent and Dr Doherty, NHS Highland, should link this to the scoping work identified under item 81/08 (ii).

PG/AKI

81/08 Scottish Centre for Telehealth (SCT)

i) Scoping exercise

Prof. Wootton reported that he had now visited most of the Boards across the North, in parallel with the work he was undertaking for his national study to identify the potential for telehealth pan-Scotland. He reported that he intended to complete the national report by the end of December, which would identify how telehealth technology should be rolled out and he expected that this would concentrate on 4 major areas. He said that he had not prepared a separate report for NoSPG as this would be embedded in the national report.

There ensued a discussion regarding the role of SCT as a national body, with a role to facilitate national scale telehealth services and how it can or should respond to the priorities identified by boards and regions. Mr Carey questioned to what extent Boards and regions had been sufficiently clear on their requirements.

Dr Taylor suggested that it is important that there is locally identifiable benefit to the national progress. Referring to infrastructure issues, she said that whilst some issues may be for a board to fix, there needed to be support from a body such as SCT to resolve these difficulties, particularly in relation to persuasion of national bodies. Prof. Wootton agreed that currently infrastructure is one of the most significant barriers to effective and reliable telehealth. He suggested that this has been because telehealth has been technically driven, developed differently in different organisations and said that he is not convinced that this is the way to develop infrastructure. He proposed that SCT has a role to provide national direction.

Prof Wells reminded members that when he had been chair of the national IM&T group, a National strategy had been proposed, which identified the need to invest in infrastructure and this had been rejected by SGHD. He suggested that SCT needed to provide the evidence to support telehealth solutions, including specifying the kit, to ensure a robust, high quality infrastructure that is reliable is established.

Dr Ingram agreed that the infrastructure needed to be robust and suggested that there needed to be a national solution but questioned whether this would be achieved. She referred to both letters and meetings between Dr Gibbins and SGHD in relation to the eHealth infrastructure investment required to implement Delivering for Remote and Rural Healthcare, where the Government's Director of eHealth effectively passed the problem back to Boards. She cited an example of the time taken to upload an image between Thurso and Caithness, because the connection was insufficient, and said that the cost of upgrade for R&R boards, where the connection is most needed, is proportionately higher than in central belt Boards. She continued that she supported the tele-psychiatry proposal made by SCT but said, in reply to Mr

Carey's comment regarding the ability of Boards and regions to articulate need, that whilst this was highlighted as a priority in Delivering for Remote and rural healthcare and a priority of a number of North approaches, and despite a question to Prof. Wootton for evidence in CAMHS, she struggled to know how to engage with SCT and suggested that it needed a two way approach. She concluded by agreeing with Prof Wootton's contention that telehealth had been seen as a technical issue and suggested that there needed to be greater clinical engagement.

Dr Gibbins said that the infrastructure needs transcends the clinical debate, he suggested that the NoS are seen as critical of the national approaches because they do not deliver the clinical solutions required because the bandwidth or approach is insufficient for NoS boards to deliver effective solutions and ensure clinical buy-in. He suggested that a more tactical approach is required, with the NoS working collectively with SCT. He said that SCT may have a more impactful voice and suggested that if Prof. Wootton's report reflected the needs of the North this might make more of a difference.

Miss Laurenson asked Prof. Wootton if he intended his report to be national. She said if he said that he needed to mean it. Clarifying her comments, she said that it would be a pity if any of the tele-applications he proposed were rolled-out nationally, but the bandwidth to deliver stopped at Aberdeen and this had not been highlighted in his report.

Mr Carey reminded members that SCT were subject to a review and that there were both opportunities and threats in such a process. He reminded colleagues that the vision is that Scotland become a world leader in telehealth and that within Scotland there is a pan-Scotland approach to telehealth. He suggested that this requires a robust and reliable infrastructure to be delivered and that this should be highlighted in the review.

Bringing the discussion to a close, Miss Laurenson sought assurance from Prof. Wootton that his report would be supportive of the need to invest at a national level in infrastructure and that the demands of the NoS to improve infrastructure were legitimate. Prof. Wootton agreed that this would be reflected in his report.

RW

ii) **NoS eHealth Group**

Referring to the written paper submitted by Iain Hunter, Prof. Wootton said that he hoped that this would provide a framework for the North. Miss Laurenson reminded members that this group had submitted a proposal to the last Chairs and Chief executives group to be stood down, on the basis that the needs of NoSPG could be achieved through other means. She suggested that the previous discussion suggested that this was not the case.

Dr Ingram said that there were a number of issues with the paper and possibly reflected the confusion of the NoS group. She suggested that the group needed to have a clear direction and purpose and tasks assigned by NoSPG. She reminded members that this group had been asked to undertake two functions: e-health for NoSPG and eHealth and infrastructure for RRIG. She noted that whilst both were functions of NOSPAG the aim was different and she suggested that this was not clear. She also referred to the Appendix, which were the tasks approved by RRIG, these she suggested were the high-level objectives in Delivering for Remote and Rural Health, and required refinement to identify what this group could achieve, support Boards to achieve, influence nationally to be achieved and what things they could not progress. She also suggested that, as Prof. Wootton had suggested, the group was too technically focused

and did not have good clinical representation. Each of the clinical leads from Boards had been invited but only one had attended and she suggested that Chief Executives needed to ensure that clinical leads understood the importance of engaging with this group.

She referred to a letter that had been received by David Sullivan, in his capacity as chair of the Diagnostics workstream (copy attached to Minutes). David had written to Kevin Woods, regarding infrastructure and had received a reply that asked NoS Colleagues to specify:

“Who is paying what for the current infrastructure and what specific new services are being blocked due to lack of IT infrastructure, where are these services, and what resource would deliver which benefit.”

She proposed:

1. The e-Health group be given the specific task to collect the information to enable a response to Dr Woods.
2. That she convene a small group with representatives from SCT, RRIIG, Clinical leads and technical colleagues to further clarify what is required of the NoS E-Health group.

Members agreed with Miss Laurenson that current arrangements were not sufficient and that there was a continued need for an e-Health group to support the work of NoSPG and ensure coherence between collaborating Boards, but that this needed to be effective. Members agreed with the two proposals made by Dr Ingram and asked that in addition to proposal one, that members also develop a map of what e-Health infrastructure is already in place, to develop a map for the NoS. A report was requested by the February meeting.

AKI/IH

82/08 Medical Workforce Issues

Dr Ingram apologised that the paper still had draft attached, although she said the paper did reflect work in progress. The paper highlighted issues in relation to the medical workforce that are a result of a number of inter-related issues. These include: changes to the training of doctors based on the assumption that the service would, in future, be delivered by trained doctors that have not been fully understood, accepted or acted upon by Boards, who have continued to plan for continuation of the traditional models. This, together with, significant vacancies and inaccurate medical workforce projections by Boards has created both an immediate and longer term problem.

She referred to the difficulties within Highland in paediatrics which have meant that consultants are living in, providing 24/7 and highlighted that this is not a local problem, as there are issues in other parts of the North (Tayside), in both of the other regions and in England, including in some of the large teaching hospitals, nor is it short term, as the issue will shift to Grampian in February. It is also not confined to paediatrics as it will be an issue in other specialities as the number of trainee doctors reduce.

In relation to paediatrics a core group has been established and this group are due to undertake a series of visits, with a Highland visit in November.

Mr Carey asked whether this was regional issue or confined to boards, however Dr Gibbins reminded him that the deanery was cross board and there might need to be a regional approach to agree that all trainees would be centred on a smaller number of sites, with resultant redesign in other boards. He suggested that this would need a regional approach and would require effective

partnerships between Boards.

Dr Ingram said that the training numbers came from the Board projections, but that the Speciality Training Board set the numbers for junior doctors, not the deanery. She supported Dr Gibbins suggestion and said that it would be important to model the impact of changes on the workforce. Referring to the high-level data, she said that whilst there was agreement to share data and develop a regional baseline, some data was missing. In response to a question from Miss Laurenson, Miss Hay said that she was waiting for data from NHS Grampian and Miss Laurenson asked Chief Executives to ensure that collaboration to provide data and this was agreed.

BCE

Miss Laurenson asked for a more detailed paper to the next meeting and proposed that more time should be devoted to the discussion.

AKI

83/08 NoSPG Sub-groups

i) CAMHS

Dr Ingram reported that the Regional network Manager post had been advertised and interviews were planned for 18th November 2008. There were two confirmed candidates. She also reported that NHS Tayside Capital project Department had recently agreed to provide project management support to the project. One of the qualified project managers would provide overall direction, supported by one of the trainee project manager who will lead the detailed work. A meeting was planned for 13th November to agree the details.

She reported that there had also been two other developments: Geoff Huggins had decided to call a national meeting, given the absence of progress in the east and North and had advised that he was minded to adopt the approach he had adopted in relation to medium secure. In addition, Myra Duncan had advised her, that SEAT had agreed, at their meeting in October, to develop a solution for inpatients that would be confined to that region (excluding Tayside). Mrs Duncan had agreed to write to her to ask how the North intended to manage North patients, a number of whom are routinely referred to Edinburgh, particularly from Highland and Shetland. Dr Ingram advised that she was awaiting the letter.

Dr Gibbins referred to the last meeting of chairs and chief executives in September and his subsequent letter to colleagues clarifying the Highland position. He reminded colleagues that the priority for NHS Highland was investment in tier 3 and 4 community based services. He reported that whilst he was hopeful that SGHD would agree that this priority should be included within the specialist children's funding, if this was not forthcoming, then he had no Board mandate to proceed with the regional project and the NoS project would need to progress without NHS Highland involvement and Highland would seek to spot purchase as necessary. Prof Wells thanked Dr Gibbins for his clarification.

ii) Cardiac Services

Dr Ingram reported that Fiona MacDonald had taken up post as the cardiac SIM on 6th October 2008 and had attended her first cardiac meeting on the 11th September.

Dr Gibbins asked what the group were doing in relation to Optimal Reperfusion and reported that Pauline Howie, Acting Chief Executive, SAS had asked him who to engage from the North in relation to this. Dr Ingram reported that the

west and southeast were keen to implement primary PCI but that this can only be introduced in areas within 35 minutes of an interventional laboratory and there were issues on whether there would be sufficient critical mass in any centre in the North to run a 24/7 interventional facility. The alternative is the use of thrombolysis, often administered by appropriately trained paramedics, linked by telemetry to a cardiac centre. She said she was surprised that Mrs Howie had not been in touch with her and agreed to contact Mrs Howie directly.

AKI

iii) NoS Public Health Network

Dr Taylor referred to the written report and advised that she was happy to respond to questions. She highlighted the significant work that NoSPHN were leading to develop an impact assessment tool for the NoSPG specialist children's bid. The bids submitted would be submitted using a methodology developed by NoSPHN and allowed current and future assessment. She had also met with ISD, who have been commissioned to develop tools to measure outcomes and the Chair of NoSPHN with a view to developing a coordinated methodology pan-Scotland and was due to attend a meeting, arranged by ISD, on 4th December. Dr Ingram added that she had submitted a paper to the NDP Implementation Group commending the NoSPHN approach and Dr Taylor was to be invited to the next NDP meeting on 17th December.

iv) Integrated Planning Group

Dr Ingram referred to the minute of the meeting of 30th September and the workshop session that preceded it. She reported that the group were due to meet again in January but that in Mr Crozier's absence she felt it important to seek the views of NoSPG on the emerging proposals.

Miss Laurenson opened the discussion by reminding members that NoSPG had been keen to ensure that the IPG supported the work of NoSPG but that this support had been missing for the last year. Dr Taylor said that the current group was too big and said that when the arrangements had been confined to functional groups; it had worked and met regularly. Ms Urquhart said that she was not convinced that the model was right and asked how to motivate people to attend. She reminded members that the reason for change was the need to see an integrated approach to planning and said that previously the workforce colleagues had not met regularly. She said that the meeting needed to be meaningful. Dr Ingram agreed that the group was large, but her reason for inviting the regional project leads was to provide more meaning, if there were issues to be resolved. She also said that even when work is done, there were few colleagues willing to take forward regional initiatives.

Dr Gibbins asked whether the problem lay in perceived duplication of work and suggested that NoSPG needed to be clear about what it wanted these colleagues to achieve. He also said that any revised grouping needed to take account of geography and not only functional groups.

In response to a question from Ms Urquhart, Mr Sullivan said that he was clear that IPG needed to do the work-up, monitoring and follow-through of tasks commissioned by NoSPG. He said that the group was not focussed, although not a reflection of the Regional Director, and not enough people volunteered to progress work.

Prof Wells said that if a group is dysfunctional then it should be disbanded but expressed his concern that such senior individuals were not supporting the regional agenda. The alternative would be to task individuals. Following further

debate it was agreed to remit the report back to IPG to develop a solution that had the ownership of the functional groups, reflected geography and would be prepared to take forward work on behalf of NoSPG; or to provide an alternative approach. It was agreed that whilst Dr Ingram would facilitate the work, it was not for her to take personal responsibility to do the work identified for the group.

84/08 National Update

i) National update

Mrs Evans referred to the written report, which she suggested was self-explanatory. She reported that at the Board Chief Executives on 19th November, there would be a paper on risk share for orphan drugs and the recombinant factor drugs.

ii) Orphan drugs

Referring to paper 84/08(ii), she reported that this proposal had originated in Glasgow and had been supported by both WoSPG and SEAT. The paper proposed a policy for prescribing 'orphan drugs', whereby:

1. When a patient is referred to a neighbouring NHS Board for *clinical management*, the prescribing policies of that 'treating Board' should apply without restriction.
2. 'Home Board' prescribing policies would continue to apply when:
 - the patient was referred for *clinical assessment* only
 - the patient was treated entirely by services provided by the 'home Board'.
3. These would be generic principles that would apply equally across all NHS Boards in Scotland.

Dr Taylor said that she found the principles outlined in the paper problematic, because significant number of patient pathways from Shetland into Grampian and this would allow Grampian to make decisions that committed the budget of Shetland, effectively removing local decision making and exception prescribing.

Prof. Wells disagreed, as he felt that this offered boards more security over financial risk and suggested that the key was the agreement that home board policies apply when a patient is sent only for assessment.

Mrs Evans asked if the difference related to remote and rural services, where even a significant proportion of secondary care activity is transferred, whereas, in the bigger boards this activity is managed within the Board. This was generally agreed, however, Dr Taylor added that as networks become the vehicle for more services the difficulties suggested from an island point of view could also be manifold in larger organisations. Following a debate, it was agreed that Dr Taylor and NOSPHN colleagues would undertake a focussed piece of work to describe the potential impact of this for Boards and a further paper would be considered in February 09.

ST

85/08 Any other Competent Business

i) Hub-Co Initiative

Mr Sullivan reminded members that the government was keen to develop long term public sector (health and local authorities) partnerships with private sector companies, as a means to securing capital finance. The proposal was to

establish these partnerships as separate legal entities. He noted that NHS Tayside were in the southeast for this project, although said he'd be keen to understand progress.

He reported that SGHD had identified the North as a pathfinder project but that NHS Grampian seemed to be considered the health lead, by default and he had raised concerns with both Miss Laurenson and Dr. Gibbins regarding the approach. He reported that currently SGHD were looking for letters of intent from each of the relevant parties and he had had some discussion on how the standard letter might be modified. He suggested that it should not be for one Board to lead but that the health lead should be under the auspices of NoSPG. He reported that he had secured funding from SGHD to undertake some scoping work with all partners, with a view to developing a PID and an Initial Agreement and asked members for views.

There was a short discussion and members agreed that a regional approach was appropriate, that a senior colleague should be appointed to scope the requirements and that letters of intent should be shared. Mr Sullivan agreed to share the NHS Grampian letter, from which one response form the five boards would be developed. It was agreed to share this with NHS Tayside.

DS

Prof. Wells suggested that this be a substantive agenda item at the next meeting with papers from the North group and NHS Tayside and this was agree.

AKI

ii) FlyBe – post op regulations

Dr Baxter reported that the transfer of services from Logan air to FlyBE had resulted in changes to the application of the regulations on when post-operative patients can fly. There were issues for patients with long leg casts, post caesarean section and post intra-abdominal surgery. He had arranged a meeting with the Medical Director to try to find a pragmatic solution and would report back at a future meeting.

PB

iii) Engagement of NHS Western Isles

Miss Laurenson said she had become increasingly concerned at the non-participation by NHS Western Isles, with very limited attendance in the last year and she was minded to write to the interim Chief Executive to determine whether they intended to continue as part of the collaboration. Members agreed with this proposal.

SL

86/08 Date(s) of Next Meeting

The next meeting of NoSPG will be held on 11th February 2009 at 10:00am in the Aspen Room, NES, Forest Grove House, Foresterhill, Aberdeen.

Videoconference facilities will be available.