## Minutes

**Present:**
- Miss Jennifer Brown (JB) Acting Chair
- Miss Diana Beard (DB) Network Manager
- Mr David Bennett (DBe)
- Mr Duncan Campbell (DC)
- Mr Michael Fitzpatrick (MF)
- Dr Helen Gooday (HG)
- Mr Gary Jenkins (GJ) (deputising for Jane Grant)
- Miss Patricia Littlechild (PL)
- Ms Roseanne McDonald (RM) (deputising for Mike Winter)
- Ms Tanith Muller (TM)
- Mr Michael Pearson (MP) (deputising for Tim Davison)
- Ms Karen Thomson via VC (deputising for Malcolm Winters)
- Ms Margaret Winters (MWi)

**Apologies:**
- Mr Eric Ballantyne
- Mr Craig Bell
- Mr Tim Davison
- Dr David Gillespie
- Mr John Greene
- Mr Mahmoud Kamel
- Dr Sue Midgley
- Mr Patrick Statham
- Ms Audrey Warden
- Ms Lorna Wiggins
- Dr Mike Winter
- Mr Malcolm Wright
- Mr Andy Wynd

**Presentations:**
- Mr David Koppel (DK), NHS GG&C
- Mr Chandru Kaliaperumal (CK), NHSL
- Mr Duncan Campbell (DC), NHSL
- Mr Richard Dobbie (RD), ISD

**Observer:**
- Dr Angus Cameron (AC), SGHSCD

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**In attendance:** Miss Ashley Strickland

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<tr>
<th>Item</th>
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<tr>
<td>1</td>
<td>Welcome and apologies</td>
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<td>The Chairman welcomed everyone to the meeting. Apologies were as noted above.</td>
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<td>Approval of the Minutes held on December 9th 2016</td>
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<td>The minutes of the meeting held on December 9th 2016 and the MSN Board Update dated 31st March 2017 were approved as correct.</td>
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<td>3</td>
<td>Matters arising</td>
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<td>Miss Jennifer Brown (National Clinical Director) is acting Chair of the MSN until such times as the Cabinet Secretary appoints a new Chair.</td>
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<td><strong>3.1 The MSN External Review</strong></td>
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<td>Dr Angus Cameron was welcomed to the Board Meeting in his capacity as Chair of the External Review Panel charged with reviewing the reporting and governance arrangements of the MSN. The first meeting of the review panel took place on 16th June. The plan is to conduct an options appraisal and hold a further meeting on August 4th 2017 with a recommendation provided to the MSN Board in September and a report provided to the Cabinet Secretary in October 2017.</td>
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<td><strong>3.2 Structural Changes</strong></td>
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<td>There is a change of structure in the MSN: the sessional payments formerly made to MSN Hub Leads will now be allocated to consultants who are leading on specific MSN objectives: eReferral, governance of paediatric neurosurgery, regionalisation of trauma, and establishing a research forum. The latter two roles will be advertised shortly. The Clinical Leads of the four centres will now be representing their respective units at the Board Meetings.</td>
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3.3 Objectives for 2017/18

DB discussed the MSN’s objectives for the forthcoming year:

Service objectives

- Respond to the findings of the External Review Panel.
- Completion of the eReferral pilot, evaluation of the suitability of SCI Gateway as a vehicle for non-elective referrals and its suitability for national roll-out.
- Audit and reporting of selected national standards: Staffing 5.1 and 5.5; Quality of Care: 10.2 and 10.3.
- Submission of validated 2016 data of named Consultant Outcomes to the Society of British Neurological Surgeons to enable a comparison of performance with the rest of the UK.
- Publication of the Scottish model for named Consultant Outcomes through utilisation of routinely collected data and the development of a novel case mix adjustment tool.
- Establish a national approach to the neurosurgical component of regionalisation of trauma services.
- The MSN website will be re-designed to ease navigation for staff and patients. The website is the host for a number of patient-related initiatives.
- A research forum will be established with trainees and a series of projects will be prioritised.
- The national Clinical Standards for Neurosurgery will be translated to key performance indicators.
- The service model for neurofibromatosis type II will be agreed.

Paediatric objectives

- The Clinical Audit of Paediatric Neurosurgical Activity (CAPNA) will be published.
- The Selective Dorsal Rhizotomy (SDR) service will be established and a mid-year review completed.
- The service model for the paediatric craniofacial service will be agreed.

Carried forward from 2016/17

- The four national pathways will be launched and compliance audited – NB dependent on the implementation of a successful electronic referral system.
- Completion of the profile of consultant workforce and subspecialty planning to include succession planning and mapping to associated specialties.
- A national review of the interventional neuroradiology service will be undertaken – NB dependent on resolution of staffing issues in NHS GG&C.

The Board members agreed these objectives.

4 The Craniofacial Service in Scotland

A bid from NHS GG&C for national service designation was submitted to NSD in 2015 however some amendments and further financial information was requested. In light of this, Mr David Koppel (Consultant Maxillo-facial Surgeon, NHS GG&C) and Mr Chandru Kaliaperumal (Consultant Neurosurgeon, NHS Lothian) were invited to present their respective views with regards to the preferred model for craniofacial services in Scotland.

4.1 NHS GG&C Presentation

DK provided a history of GG&C’s three former bids and stated that the revised bid (not yet submitted) will answer some financial questions and will focus on a paediatric craniofacial service.

DK laid out some assumptions the GG&C team have with regards to a craniofacial service:
• higher volumes equal better outcomes;
• a whole team approach has to be considered;
• patients benefit from a fully functional one stop MDT clinic;
• the service must be sustainable and robust; and
• outcome data must be available and of sufficient volume to be of value.

The service in GG&C involves 30-40 synostosis cases a year and also some procedures around the margin of craniofacial work. DK commented that there are no ‘simple’ craniosynostosis cases and that a national audit shows that single suture cases have a higher risk of unexpected complications. He added that management of craniofacial deformity is not routine for trainees and that additional post-graduate training should be required for those undertaking this work. The surgeons in the GG&C team have had dedicated post CCT fellowship training in craniofacial surgery.

DK discussed compliance with the UK standards for craniofacial surgery and showed how the team in Glasgow meets these standards. DK was of the opinion that GG&C’s proposed model has the following benefits:

• a nationally designated service on a single site makes best use of resources in a resource-intensive multidisciplinary/multispecialty service;
• it offers the Scottish patient a safe and reliable service that is patient-centred;
• it builds on existing, established structure within GG&C and improves access for patients outwith NHS GG&C;
• it concentrates cases in a single site thus providing greater opportunity for meaningful audit and outcome measurement; and
• it would provide the possibility of outreach clinics for follow up.

4.2 NHS Lothian Presentation

CK assured the Board that the Lothian service also meets the UK standards. There was no craniofacial service in Lothian for some years however a service to provide non-syndromic craniosynostosis correction was re-started in October 2014. To date the Lothian team has carried out 17 craniosynostosis procedures and undertaken a further 20 non-craniosynostosis craniofacial procedures over the course of the last three years. There has been no morbidity, mortality or reported adverse events over the three years since the service was re-started. CK gave evidence of succession planning and confirmed agreement with DK with regards to trainees. It is not clear that the members of the Lothian team have had a dedicated period of training in a craniofacial fellowship though all have worked in units performing craniofacial surgery during their general neurosurgical/OMFS training.

CK was of the opinion that Lothian’s preferred model has the following benefits:

• a nationally designated service delivered in two centres would provide a safe service with local governance;
• a locally delivered service would continue to undertake non-syndromic craniosynostosis repair in Lothian;
• syndromic cases could be performed in Scotland as a team with a “passport of movement between the two centres”;
• a national MDT would be held to discuss cases and refer patients to high volume centres (if necessary); and
• there would be national collaboration and review of results.

4.3 Questions following the presentations

There was discussion about the merits of a national MDT when case selection is largely determined by the parents’ and child’s desire to have a deformity corrected.

The Chair expressed the view that there were no safety concerns about either unit, however given the significant risk and the scale of surgery that is being performed to treat deformity, there is a need for very good cosmetic results to be demonstrated in rigorous follow up and audit. She asked how the service defines a ‘successful’ outcome. The merits of post-operative CT scans, 3D pictures and models were discussed but as the outcome is largely aesthetic, the determination of success is subjective. The lack of an objective outcome defining a successful outcome in craniofacial surgery was discussed.
MF questioned the need for a two centre model for a population of 6 million people given that NHS England provides a craniofacial service for a population of 60 million in four supraregional centres and emphasised the importance of consistency with the decision making in regard to paediatric epilepsy surgery i.e. the service should be provided in one centre.

Roseanne MacDonald (representing NSD) confirmed that the NHS GG&C proposal for national service designation should be re-submitted to NPPRG and NSSC as an amended bid and it will be re-considered in light of the new financial information. The view of the MSN Board would also be taken into account when considering the revised application. JB requested that the Board is sent the revised proposal as a matter of urgency.

**Action:** GJ to provide the MSN Board with the revised proposal.

The MSN Board concluded:

- There was a clear consensus that surgery for paediatric craniosynostosis could and should be provided in Scotland with no need to send children to supraregional centres in NHS England for this treatment;
- The MSN Board supported the provision of the service for syndromic craniosynostosis in NHS GG&C as a ‘once for Scotland’. This was not opposed by colleagues from NHS Lothian including the craniofacial group;
- There was no opposition to the concentration of single suture synostosis in GG&C from the MSN Board. The Lothian craniofacial team however consider that they can provide a safe single suture synostosis service. The MSN Board does not disagree, however there is concern about monitoring of the quality of deformity correction in a small volume service (single figures annually); and
- The MSN would support the idea of colleagues from Edinburgh who wish to practice craniofacial surgery working with the GG&C team (in the event the bid is successful).

Given the consensus view for syndromic synostosis and the lack of opposition to concentration of single suture cases on a single site, the MSN Board will support the determination of NSSC with respect to the latter component of the service.

**5 National Clinical Director's Report**

**5.1 Interventional Neuroradiology (INR) – current status and future plans**

There has been no progress in appointing to the three vacant substantive posts in NHS GG&C. There is one substantive post holder and a 0.75 locum post holder which leaves 2.25 wte vacancies.

This situation has been ongoing for two years and it continues to pose a significant risk to patient safety. Equity of access is not achievable and the ability to provide a weekend coiling service is seriously compromised.

Although staffing in NHS Lothian is about to increase to three substantive posts, the relocation of the Lothian service to the Little France site in early 2018 will result in a service down-time of six weeks.

GJ confirmed that NHS GG&C are working to address the ongoing issues including the option of a combined governance process and national MDT with colleagues in Lothian to mitigate concerns about case selection and subsequent decision making.

The MSN Board agreed that the risk level is such that a further SBAR report should be submitted to the Cabinet Secretary.

**Action:** DB to draft the SBAR report.

**5.2 Profile of Consultant Workforce and Subspecialty Planning**

The workforce profile is complete for three centres however NHS GG&C information is incomplete. GJ reported that this will be addressed with the imminent appointment of a new Chief of Medicine who will prioritise this workstrand and give consideration to the appointment of a Clinical Director for Neurosurgery rather than a joint appointment.
encompassing all neuroscience specialties. A new Clinical Service Manager has been appointed.

5.3 Deep Brain Stimulation (DBS)

The national DBS service in Glasgow was launched in April. The issues surrounding legacy patients are being addressed and each patient has been offered a clinic date. Assessment and review of each patient will be undertaken according to clinical priority. The main risk to the service is the nurse staffing establishment in theatres.

GJ commented on the nursing numbers suggesting that the Clinical Service Manager and Chief Nurse should take this forward.

6 eReferral

PL led on the discussion on eReferral as the National Lead for this objective. The NSS eHealth team presented a modified SCI Gateway option at the MSN Board Meeting on December 9th 2016 and stated that the service could be operational by January 2017 if clinicians were willing to work with the developers. The clinicians are collaborating with developers however the January start date was never feasible.

A project board has been established, a part-time project manager has been allocated, the dataset has been agreed and there have been several meetings. A key business requirement of Emergency Department colleagues has always been, and remains, that the system must pre-populate patient demographics. The current version of SCI Gateway cannot do this and the proposed launch date for Version R20, which should have this functionality, is now mid-August.

The three month pilot had been scheduled to start on June 1st however this is now delayed until Version R20 is launched.

The pilot will involve referrals from Emergency Department in the QEUH and the Institute and cross-boundary referrals will be from Monklands Hospital in Lanarkshire. The pilot will be evaluated and a decision about its capability and transferability a) around the country and b) to other specialties will be reported to the Board in due course.

TM expressed frustration that this issue has been ongoing for at least the last four years.

7 The Paediatric Service

7.1 Paediatric Advisory Group (PAG) Meeting May 23rd 2017

DB informed the Board that the Paediatric Advisory Group meeting took place in May with a much improved attendance from the paediatric neurosurgeons. There was no representation from management teams, however there was a lively and constructive discussion about the paediatric service.

7.2 Clinical Audit of Paediatric Neurosurgical Activity

At the request of the paediatric neurosurgeons, a national audit of all paediatric neurosurgical activity has now been implemented. All surgical activity will be reported: the data will be taken from the BPNG submission databases maintained in the two larger centres and more detailed information in relation to advice sought and transfers to the central belt will also be collated in Grampian and Tayside. Cases will be reviewed in a clinical audit meeting immediately following future PAG meetings and an annual report of activity will be produced.

7.3 Selective Dorsal Rhizotomy

The national SDR service has now been launched. The service is provided on a risk share basis with surgery being offered in both Glasgow and Edinburgh. The first National MDT meeting was well attended and involved discussion of five cases. Referral pathways, information for patients and families, rehabilitation plans and documentation associated with the service is available. The lead physiotherapists have undertaken a series of roadshows and received positive feedback from participants around the country. The first operation will take place in Glasgow on 30th June and the second case is scheduled for July 28th.
Named Consultant Outcomes

Richard Dobbie, Information Consultant in ISD, was invited to give a presentation to the Board on the casemix adjustment work that constitutes the final phase of development for Named Consultant Outcomes. The net result of a collaboration between the MSN and ISD has demonstrated that routinely collected data is fit for purpose when reporting on outcomes. Extensive validation procedures have demonstrated that corrections we have identified do not have a statistically significant impact on the final outcome which means that the methodology we have developed is likely to be transferable to other surgical specialties.

RD showed a variety of charts and tables to the Board demonstrating the case mix adjustment modelling that has been undertaken. RD confirmed that there were no ‘outliers’ in the 30 day case mix adjusted mortality funnel plot. Having completed the development of the model, the 2016 data will now be analysed and reported with a view to submission to the team at the University of Birmingham commissioned by the SBNS to undertake this work on behalf of the UK neurosurgical service.

The Chair commented that this is an excellent piece of work and was pleased to be able to confirm that we are delivering a safe neurosurgical service.

AOCB

9.1 Neurofibromatosis Service

There was a discussion regarding the NF2 service in Glasgow. A pathway for this is still needed however it is currently unclear as to whether there is an appetite for a national MDT. There will be a meeting over the summer at which representatives from all four units will attend.

9.2 Job description for National Leads

The job descriptions for the national leads charged with achieving MSN objectives will be circulated. These will relate to the regionalisation of trauma services and establishing a research forum.

9.3 Middle grade rotas

MP raised the issue of non-compliant middle grade rotas which have been a challenge over a number of years. He asked if the MSN should be looking for national approach to addressing this issue, particularly given the impact of non-compliant rotas on junior doctors’ well being and also the cost involved.

The problem is multifactorial:

- There must be cover for emergency procedures on all four sites overnight;
- Uninterrupted rest breaks are key to achieving compliance;
- Going home post-call is important;
- Could a single middle grade doctor take the calls for the whole of the country to enable protected rest breaks and how would we ensure this would be without communication failures; and
- A reliable electronic referral system would go some way towards making single site cover possible.

**Action:** Clinical Leads, managers and trainees from each centre are to report on the viability of single site cover to the next MSN Board meeting.

9.4 MSN External Review

TM asked if there was a timeline for the work of the External Review Panel. Dr Cameron confirmed that the recommendation of the panel will be given to the Cabinet Secretary by October 2017 at the latest. There was to be a short-life working group following the Board meeting to agree criteria for the options appraisal and a further meeting of the whole panel on 4th August.
9.5 *David Bennett demits office as the trainee representative*

DBe informed the group that this would be his last meeting as the trainee representative. He passed on his thanks to the MSN. JB congratulated DBe on his new role and thanked him for his service to the Board.

10 **Date and time of next meeting:**

The next Board meeting will be on:

**Friday 29th September 2017: 10.30 – 12.30**

Stirling Court Hotel, University of Stirling, Stirling FK9 4LA
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<th>Name</th>
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<td>Vacant</td>
<td>Chairman, MSN for Neurosurgery</td>
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<tr>
<td>Miss Jennifer Brown</td>
<td>National Clinical Director and Acting Chair</td>
<td>NHS GG&amp;C</td>
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<td>Miss Diana Beard</td>
<td>National Network Manager, MSN</td>
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<td>Mr Eric Ballantyne</td>
<td>Consultant Neurosurgeon, Clinical Lead, and MSN Paediatric Lead</td>
<td>NHS Tayside</td>
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<td>Mr Mike Fitzpatrick</td>
<td>Consultant Neurosurgeon, Clinical Director and MSN Trauma Lead</td>
<td>NHS Lothian</td>
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<td>Miss Patricia Littlechild</td>
<td>Consultant Neurosurgeon, MSN eReferral Lead</td>
<td>NHS GG&amp;C</td>
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<td>Mr Mahmoud Kamel</td>
<td>Consultant Neurosurgeon, Clinical Lead</td>
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<td>Ms Jane Grant</td>
<td>Chief Executive Officer</td>
<td>NHS GG&amp;C</td>
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<td>Deputy: Mr Gary Jenkins</td>
<td>Director Regional Services</td>
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<td>Mr Tim Davison</td>
<td>Chief Executive Officer</td>
<td>NHS Lothian</td>
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<td>Deputy: Ms Lyn McDonald</td>
<td>Site Director, Royal Infirmary of Edinburgh</td>
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<td>Deputy: Ms Karen Thomson</td>
<td>General Manager, Surgical Division</td>
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<td>Mr Craig Bell</td>
<td>National Planning Manager, Scottish Government Health Directorate</td>
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<td>Mr Patrick Statham</td>
<td>Chairman, Scottish Neuroscience Council</td>
<td>NHS Lothian</td>
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<td>Ms Laura Daniell</td>
<td>Chair, Allied Health Professionals Reference Group</td>
<td>NHS Tayside</td>
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<td>Mr Andy Wynd</td>
<td>Chief Executive Officer, Spina Bifida Hydrocephalus Scotland</td>
<td>Third Sector</td>
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<td>Dr Mike Winter</td>
<td>Associate Medical Director, National Services Division</td>
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