Specialised Services

# MINUTES

## Children's Congenital Heart Services Programme Board

**Wednesday 7 November 2012 - 10.00–12.00**

**NCL, Stephenson House, 75 Hampstead Road, London NW1 2PL, Room 4LM2**

| Attendees: | | Job title and organisation |
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| Caroline Taylor (Chair) | CT | Cluster Chief Executive, NHS North Central London |
| Ann Jarvis | AJ | COO, South of England Specialised Commissioning Group |
| Catherine O'Connell | CO | Regional Director of Commissioning, NHSCB, Midlands and East |
| Prof. Deirdre Kelly | DK | Professor of Paediatric Hepatology, The Liver Unit, Birmingham Children's Hospital |
| James Ford | JF | Managing Director of Public Sector, Grayling |
| Jeremy Glyde | JG | Programme Director, *Safe and Sustainable* |
| Jo Sheehan | JS | Acting Director of National Specialised Commissioning Team |
| Michael Wilson | MW | Interim Implementation Programme Director |
| Sue McLellen | SM | COO, London Specialised Commissioning Group |
| Ali Lawrence (Minutes) | AL | PA to Michael Wilson |

| Item No | Agenda Item | Action |
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| 1 | **INTRODUCTION AND APOLOGIES**<br><br>CT opened the meeting and thanked everyone for attending. Introductions were made and apologies noted from Jon Develing, Ann Sutton, Kate Caston.<br><br>CT stated that she wanted to set the work of this Board in context.<br><br>Its work was part of the *Safe and Sustainable* programme, a wider programme that currently covers Children's Neurosurgical Services as well as children's congenital heart services. Following the JCPCT decision on children's congenital heart services, it had been decided to separate implementation from the continued support of the decision and the work of the other areas of *Safe and* Sustainable. CT's role as the Senior Responsible Officer (SRO) for implementation was therefore to lead the process of implementation. JS and JG would continue to provide invaluable input to that process but their main focus would be on the continued support to the JCPCT's decision and the rest of the *Safe and Sustainable* programme.<br><br>DK concurred that it was important the distinction about separation was made early on and that implementation must be seen as separate.<br><br>Although the JCPCT's decision had been challenged, CT was clear that this | |

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| | did not stop the board from preparing and planning for implementation, with the appropriate checks in place to ensure that nothing was done that might prejudice the review, or which could not be reversed.<br><br>The second important context was the change in the NHS commissioning system. Given those changes, the work would start largely within the old system, but tracking and moving into the new system as quickly as possible, checking that the right people are involved with an expectation that this would change over time.<br><br>The third point to note was the scale of change envisaged. This may be the largest service change the NHS as a whole has yet attempted. The work would need to be done at multiple levels, it would be necessary to be clear what should be managed nationally, regionally or locally and to ensure that what is done is locally appropriate whilst staying true to the original decision. Achieving this would require that the work was managed within a proper programme plan. CT emphasised the need to be clear how the group worked together with clarity of roles. This was the formal programme board. Part of its role was to enable individual regions and areas to do what they need to. The programme board's approach needed to be enabling rather than constraining and to offer collective leadership. To achieve this it would be important for all members collectively to have sight of the whole programme. If there were any difficulties or tensions about roles these needed to be surfaced and sorted out. SM added that we need to work on the basis of 'no surprises'.<br><br>DK noted that there was very strong clinical support and interest in this programme, with clinicians looking to it as a potential blueprint for other specialties where they would want to see change. CT affirmed that clinical leadership was critical.<br><br>As a final point of context CT noted that everything would not go perfectly. When things went wrong our approach would be to take corrective action, learn and move on. If Programme Board members saw that something was not being done in the most helpful way by the national team, their role was to let us know. | |
| **2** | **TERMS OF REFERENCE**<br><br>MW presented the draft terms of reference, and stated that he did not have the expectation that this document was perfect and hoped that the group would review it and provide comments.<br><br>MW drew attention to the following points:<br><br>• The section on the purpose of the programme board is important as that is what we are here for<br>• The group has overall responsibility for the programme<br>• It is the group's function to monitor and manage processes<br>• Risks are owned by the programme board<br>• It is the group's responsibility to make sure that resources are available | |

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| | • This is the place where escalated issues are resolved<br>• The group collectively report upwards to the programme's sponsor | |
| | AJ said that, with reference to the 170 quality standards, we need to include all the standards rather than just 170. | **MW** |
| | The responsibility of this group is to implement the programme and the decision is not negotiable. Consequences are issues for regions to handle; we need to be aware of them but not allow them to reopen the original decision. It was agreed that it would be useful to do a linked piece on the consequences of decommissioning being the responsibility of the regions. | **MW** |
| | SM said the first bullet point in the scope should include the word 'children' and be reworded to read 'children's congenital heart networks'. | **MW** |
| | CT wanted to clarify that there are two sorts of pregnant women in this context. Those who are pregnant with a child who has been diagnosed in utero, and therefore they are part of this pathway. Then there are adults with CHD who are pregnant, who would be part of the adult pathway. It was confirmed that transition from child to adult is at the 19th birthday. DK stated that this was an important point and that we have to be careful not to pre-empt anything for the adult work. | |
| | Regarding bullet point 5 & 6 on cardiology centres and district services, JS stated if there is designation she was not sure this should be for this group. It was agreed that this group's responsibility was to ensure that implementation happened. Some aspects of the implementation would be led elsewhere. Determining the cardiology centres and district services would not be this group's decision. The final wording should be made as clear as possible. | **MW** |
| | It was agreed that roles and membership should reflect the new NHSCB structures. | **MW** |
| | It was agreed that the NHS in Wales should be asked to nominate a representative. | **MW** |
| | There was a discussion about clinical representation and patient and public representation on the programme board. | |
| | It was agreed that service users and carers should be represented, and that two representatives should be sought. | **MW** |
| | It was agreed that additional clinical representation would be invited if and when required, to support particular items under discussion. | |
| | **ACTIONS:** | |
| | **1 MW to revise the terms of reference in light of the discussion** | |
| | **2 MW to invite additional representatives to join the Board as agreed.** | |
| **3** | ***SAFE AND SUSTAINABLE* UPDATE** | |
| | JS gave a verbal update on the Safe and Sustainable project and made the | |

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| | following points.<br><br>• The Independent Reconfiguration Panel (IRP) had been asked to conduct a full review of the *Safe and Sustainable* children's congenital heart decision. The first meeting with the IRP had taken place the week prior to the programme board meeting where they set out their plan. A date was planned for the IRP to meet with JCPCT and others to discuss the case for change rationale and process. As soon as the IRP provided information about their process this would be forwarded to programme board members, along with the briefing and Terms of Reference and, when available the final report. | **JS** |
| | • CT stated that there are colleagues at NHS London who have worked with the IRP very effectively and there may be things that can be learned, so their advice should be sought. | **JG** |
| | • A preliminary judicial review hearing was scheduled soon after the IRP meeting to determine handling of costs and timetable. | |
| | **REGIONAL UPDATES**<br><br>It was agreed that there should be a new standing item on the agenda: Update from each Chief Operating Officer. | |
| | New standing item on agenda to be included: Update from Regional Leads. | **AL** |
| | **South:** There was a discussion of the recent CQC activity in Bristol. Positive work was underway to establish network arrangements in the south. | |
| | **Midlands and East**: Because of the challenge to the JCPCT decision, limited progress had been made in the Midlands network.<br><br>Two principles were noted:<br><br>1 We know that delay to changes is dangerous and we have to continue to plan and prepare.<br><br>2 It is unavoidable that different parts of the country will move at difference paces, and the early implementers will provide learning for others. | |
| | CC said that we have to take the time to start people talking and engaging, and be realistic about timetable and changes.<br><br>CT stated that we need to assess and manage the risks of maintaining current services in the interim to avoid emergency closures. Targeting risks and having honest conversations is part of creating the momentum. | |
| | **London:** SM reported that a project board was being established with commissioners from East of England and SE Coast to establish the London networks. A London steering group had also been established to work with the three trusts and involving the Regional Medical Director. A joint statement of intent and Key Performance Indicators (KPIs) to monitor ongoing safety had been developed which SM agreed to share. One of the | **SM** |

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| | actions (Dr Andy Mitchell) was to get groups of clinicians together from 3 providers. This had been a very productive meeting.<br><br>**ACTIONS:**<br><br>**1 AL to include new standing item on agenda: Update from RLs**<br><br>**2 JS to circulate the briefing and ToR of the IRP review**<br><br>**3 JS to circulate IRP report in due course**<br><br>**4 JG to seek advice from NHS London colleagues re IRP**<br><br>**5 SM to circulate copies of the joint statement of intent and KPIs** | |
| **4** | **PROGRAMME INITIATION DOCUMENT (PID)**<br><br>MW talked through the Project Initiation Document and a discussion took place.<br><br>CT suggested that after this meeting the group feedback with further comments and that MW produces a further draft. CT asked for the PID to be approved at the next meeting, and that there should be good version tracking of the document.<br><br>The following points were raised:<br><br>• **Benefits and measures:** DK felt that more work needed to be done on benefits and measures and that the clinical group could help with this.<br><br>• **Statement of requirement:** JS said that we needed to make sure that the PID was clear about the work programme the Programme Board was responsible for and what was being led elsewhere. It was agreed that the scope of implementation included the whole JCPCT decision and not just changes to the surgical centres. Identifying and commissioning cardiology centres and district services was part of that.<br><br>• CT stated that one of the board's roles was to identify dependencies for which it was not responsible, and to ensure that it managed these dependencies and linkages working with the Commissioning Board and other stakeholders.<br><br>• Delivery should be about the whole pathway. It would be important to have a clear, shared understanding of the pathway in order to ensure consistency.<br><br>• It was agreed that it was helpful that the PID sought to identify what aspects of implementation would be led nationally and what would be led regionally or locally. More work was needed to ensure that this was complete and agreed.<br><br>• 2.2, first point should be changed to '..things that we need to deliver…'. | **MW** |

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| | • 2.2 JF drew attention to the need to maintain political support. | **MW** |
| | • It was agreed that MW would work with the regional leads to further describe the workstreams and to produce a matrix of what happens nationally and regionally. DK suggested that an evaluation workstream would be needed. | **MW / RLs** |
| | • **Milestones** – The board needed to take stock of how much described in the programme plan was already underway. | |
| | • DK said that critically interdependent clinical services should have a better link into the implementation plan. CT asked that they be identified in the matrix along with other workstreams that the programme was dependent on. | **MW** |
| | • It was decided that the Northern Ireland and Scotland linkage should be managed through the Safe and Sustainable team. | |
| | • JS stated that she was not sure that it was agreed that commissioning of networks would be through surgical centres. Agreeing the approach would be part of the implementation task. | **MW** |
| | • It was agreed that work was now needed to produce an implementation plan. This would need to involve regional leads and clinical leaders. CT asked that a draft plan be brought to the next meeting. | **MW / RLs** |
| | • CT questioned whether it was realistic that all activity would have transferred to match the JCPCT's desired end state by April 2014. It was agreed that by that time it was essential that active implementation was underway and there would be a momentum that is irreversible. SM added that expectations need to be managed very carefully with regard to April 2014. | |
| | • Programme organisation: CT asked that this section be updated to describe the rest of the structure including the NHSCB's national, regional and local resources. The expectations of these teams and dependencies should be made explicit. | **MW** |
| | **ACTIONS:**<br>**1 MW to amend the PID as agreed**<br>**2 MW to work with regional leads and clinical leaders before the next meeting with a view to producing a workstreams matrix and programme plan.** | |
| **5** | **RISK REGISTER**<br>CT stated that this was a really helpful first pass at compiling the risk register, and asked for a full update for the next meeting.<br>**ACTION:**<br>**1 MW to update the risk register as agreed.** | **MW** |
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| **6** | **COMMUNICATIONS AND ENGAGEMENT PLAN**<br><br>JF presented the draft communications and engagement plan. The following points were raised:<br><br>• CT asked for any key issues to be raised at this meeting so they could be worked through.<br><br>• DK offered to review the objectives of the communications and engagement plan.<br><br>• It was agreed that we need to be really clear about who can sign off processes, that no news is released unless this group was sighted on it pre-publication.<br><br>• Similarly the plan should list approved spokespeople and be clear about what they were approved to speak about and to whom. A clear consistent voice was essential.<br><br>• It was agreed that a stakeholder analysis with a tailored approach to each stakeholder was needed.<br><br>• Once the programme plan had clear milestones, the comms plan should show what supporting communications and engagement activity should be delivered at each milestone.<br><br>**ACTIONS**<br><br>**1 DK to review the objectives of the Comms Plan**<br><br>**2 JF to amend the draft communications and engagement plan, taking account of the comments made** | **DK**<br><br>**JF**<br><br>**JF**<br><br>**JF**<br><br>**JF** |
| **7, 8, 9** | **IMPLEMENTATION ADVISORY GROUP REPORT AND MINUTES 18.9.12**<br>**CHARITIES WORKSHOP 10.9.12 REPORT**<br>**NATIONAL WORKSHOP 16.10.12 REPORT**<br><br>JG gave a summary of these meetings. Brief discussion took place on all three reports which were primarily for information.<br><br>National Workshop: It was agreed that CT should sign off report and that the verbatim transcripts which had been produced for the benefit of those who wrote the report, should not be distributed.<br><br>DK said it would be helpful to have a summary of all three reports to capture the common themes.<br><br>**ACTIONS**<br><br>**1 CT to sign off the National Workshop Report for distribution by the end of November**<br><br>**2 JF to produce a summary of all workshop reports to be produced.** | **CT**<br><br>**JF** |
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| **10** | **ANY OTHER BUSINESS**<br><br>There was no other business. | |
| **11** | **DATE AND TIME OF NEXT MEETING**: 6 December 2012: 0800-1000 Stephenson House, Room 4LM1. | |