Safe and Sustainable

NHS
National Specialised Commissioning Group

Minutes from the Clinical Implementation Advisory Group Meeting
Central Hall Westminster, Storey's Gate, London, SW1H 9NH
18 September 2012

Name	Representing	Role
Professor Deidre Kelly	Chair	Professor of Paediatric Hepatology at Birmingham Children's Hospital NHS Foundation Trust
Dr Sara O'Curry	British Psychological Society	Clinical Psychologist specialising in Paediatric Cardiology, Great Ormond Street Hospital for Children NHS Foundation Trust
Mr Michael Cumper	Somerville Foundation	Chairman, Somerville Foundation
Professor Baskan Thilaganathan	Royal College of Obstetrics and Gynaecology	Professor of Fetal Medicine, St George's Healthcare NHS Trust
Dr Ian Jenkins	Paediatric Intensive Care Society	Consultant in Paediatric Intensive Care & Anaesthesia, University Hospitals of Bristol NHS Foundation Trust
Dr Rob Martin	British Congenital Cardiac Association (President Elect)	Consultant in Paediatric and Adult Congenital Cardiology, University Hospitals of Bristol NHS Foundation Trust
Dr Venu Gopalan	Royal College of Paediatrics and Child Health	Hon Secretary of Paediatricians with Expertise in Cardiology Special Interest Group
Donna Kirwan	Fetal Anomaly Screening Programme	National Projects Officer, NHS FASP
Mr David Barron	Society for Cardiothoracic Surgery of Great Britain and Ireland	Consultant Congenital Cardiac Surgeon, Birmingham Children's Hospital NHS Foundation Trust
Anne Jarvis	NHS specialised commissioning	Chief Operating Officer, Specialised Commissioning, South of England
Dr Ravi Gill	Association of Cardiothoracic Anaesthetists	Consultant in Cardiac Anaesthesia and Intensive Care Medicine, Southampton University Hospitals NHS Foundation Trust
Gail Fortes-Mayer	NHS specialised commissioning	Assistant Director, Specialised Commissioning, Midlands and East
Jo Sheehan	NHS specialised commissioning	Acting Director of National Specialised Commissioning, National Specialised Commissioning Team
Jeremy Glyde	Secretariat	Programme Director, Safe and Sustainable National Specialised Commissioning Team
Caroline Taylor	NHS specialised commissioning	CEO, NHS North Central London
Dr Tony Salmon	British Congenital Cardiac Association (President)	Consultant in Paediatric and Adult Congenital Cardiology, Southampton University Hospitals NHS Foundation Trust

Elizabeth Aryeetey	Royal College of Nursing	Lead Nurse, East Midlands Congenital Heart Centre, University Hospitals of Leicester NHS Trust
Fiona Smith	Royal College of Nursing	Adviser in Children and Young People, Royal College of Nursing
Mr Leslie Hamilton	Society for Cardiothoracic Surgery of Great Britain and Ireland (Past President)	Consultant Cardiac Surgeon and former Deputy Chair of *Safe and Sustainable* Steering Group, Newcastle-upon-Tyne Hospitals NHS Foundation Trust
Dr Graham Stuart	Congenital Heart Services Clinical Reference Group	Consultant Cardiologist, University Hospitals of Bristol NHS Foundation Trust
Jon Develing	NHS specialised commissioning	Chief Operating Officer, North of England SCG
Anne Keatley Clarke	Children's Heart Federation	Chief Executive, Children's Heart Federation
Dr Alan McGee	British Congenital Cardiac Association	Consultant Paediatric Cardiologist, Royal Brompton & Harefield NHS Foundation Trust
Dr Vimal Tiwari	Royal College of General Practitioners	General Practitioner

Apologies

Name	**Representing**	
Dr Peter-Marc Fortune	Paediatric Intensive Care Society	Consultant Paediatric Intensivist and Clinical Director of Critical Care, Central Manchester University Hospitals NHS Foundation Trust
Dr David Mabin	Royal College of Paediatrics and Child Health	Consultant Paediatrician with Expertise in Cardiology, Royal Devon & Exeter NHS Foundation Trust

1: Welcome, introductions and apologies	Professor Kelly opened the meeting and welcomed members to the first meeting of the group. She explained that the role of the group was to provide clinical advice and leadership to NHS commissioners on the best way to deliver the decision made by the Joint Committee of PCTs on 4 July. The group's aims were to maximise benefits for children and families and ensure there was safety and continuity of services during the transition. Additionally, they had a duty to fully involve colleagues across the professions. Caroline Taylor explained that she had been asked to manage the process of implementation at national level, though local implementation would be the responsibility of the regional commissioning leads within the NHS Commissioning Board. Ms Taylor explained that her role was expected to formally commence in October. Mr Glyde reported that the Royal College of Paediatrics and Child Health had nominated Dr David Mabin and Dr Venu Gopalan to jointly represent the college.	
2: Current position with Safe and Sustainable and process of implementation	Mr Glyde advised Members that currently four separate legal challenges were expected: a judicial review from a campaign group in Leeds, and three referrals to the Secretary of State for Health by health and overview scrutiny committees in Yorkshire, Leicestershire and Lincolnshire. Implementation of the JCPCT's decision was therefore subject to these challenges. Mr Glyde explained that the national team were working on the assumption that the Court would hand down its judgment by March 2013 and that the Independent Reconfiguration Panel would provide its advice the Secretary of State by April 2013. Mr Glyde explained that, in the meantime, the NHS was able to continue to actively plan for implementation and that the work of the group was not affected in this regard.	
3: Opportunities and challenges with implementation **i. Opportunities**	Mr Dickinson explained that he would facilitate a session to ask Members to identify the most important opportunities and risks faced during implementation. A number of Members had provided Mr Dickinson with proposed 'opportunities' in advance. They were: • create sustainable units • enhance related services	

ii. Risks	• enhance quality and outcomes • improve networks • address unmet needs • avoid wasteful duplication • promote research and innovation Additional 'opportunities' suggested by Members at the meeting were: • create a consistent workforce through training • better engagement with patient groups and other forums • clarity on the care pathways from antenatal and maternity services • establishing better district level services within the networks • promoting cardiac retrieval. • improved transition from paediatric to adult services and children • integration of the commissioning of non-specialised and specialised services • a QIPP process for procurement to ensure there was purchasing power in the networks • opportunity to enhance patient choice • develop common electronic record keeping with consistent coding A number of Members had provided Mr Dickinson with proposed 'risks' in advance. They were: • capacity during the transition, including staffing and infrastructure • impact on related services in non-designated units • ongoing bitterness • impact on psychology provision • impact on retrieval services • ECMO transfer to Birmingham Children's Hospital • retaining cardiology expertise in the networks Additional 'risks' suggested by Members at the meeting were: • risks to children and families during transition, especially concerns that families would lose their support team after the transition	

	• the impact to psychology services and other support services • that pregnant women and the fetus were over-looked in the process due to a focus on the child • financial risk to NHS Trusts • impact to training structures, particularly if there is no national coordination • impact to services for adults with congenital heart disease Group work was then held. The groups reported the following: i. Opportunities - creating sustainable units • The importance of network boards; establishing the boards was considered to be the most important priority • Improving relationships and the importance of joined-up care • Developing and implementing standards for local services • Improving local infrastructure • Identifying current good practice • Identifying and filling key posts, such as the 'lead nurse' • Implementation has to be inclusive to overcome fear, anxiety and uncertainty currently felt. ii. Opportunities - enhancing quality and outcomes: • Implementation of standards and care • Data collection and reporting • Identifying risks • Key quality indicators • Development of an integrated pathway to create better services for mother, child and young adult iii. Opportunities - better networks • Children with co-morbidities and a joined-up approach to care • Making the network understandable to everyone • Developing relationships and changing the culture of how services and professional groups related to one another to develop networks • A local approach to paediatric retrieval	**Mr Dickinson to circulate his report**

	services with national oversight and coordination • The need to apply the national model of care set out by the JCPCT to the seven networks • The consistent approach needed for commissioning paediatric retrieval services iv. Risks - capacity and quality in transition • Financial stability during transition • Staffing, such as cases where nurses had not been able to move between sites; identified actions included creating staffing champions; • Communication, especially with non-surgical centres • HR risks, including what could be done to encourage staff to move; staffing plans need to be re-evaluated to identify potential staff shortages • Engaging managers in the non-surgical centres • Using the Group as a 'sounding board' for messages to clinicians and nurses v. Risks - integrated adult, children and fetal pathways • Understanding the role of the congenital heart surgeon in the pathway • Potential weaknesses in the care pathway • Ensuring personal data could be tracked • Clarifying the role of cardiology in the cardiology centres Mr Dickinson will circulate a report on the outcome of these discussions.	
4. Principles of Implementation	Professor Kelly invited comments on the proposed principles underpinning implementation. Members advised: • the word 'congenital' should be used consistently in place of 'children's' to encompass all aspects of the network, though it should be made clear that networks would also provide services for children with acquired conditions • Principle 12 will be re-written to emphasise the importance of networks • Principle 15 (which confirms that employment issues are for individual NHS	**Mr Glyde to**

	Trusts rather than NHS commissioners) will be re-written to emphasise that whilst individual NHS Trusts have sole responsibility in law for employment issues, the networks will have an important role to play in facilitating recruitment and retention policies • The principles will be re-written to explain why 'patient and referrer choice' is consistent with 'managed networks', particularly in the context of complex procedures	**revise the principles document**
5. Terms of reference and identification of key work streams	Professor Kelly asked for comments on the draft terms of reference. Members focused their discussion on paragraphs 18 to 21 which describe a national congenital heart networks group. Professor Kelly suggested that Members needed to advise commissioners what constituted an effective network, and for the outcome of this work to inform the roles of individual congenital heart network boards and a national congenital heart network group. Dr Martin suggested that there was a need for greater clarity on the future relationship between cardiology centres and surgical centres and how this would be made sustainable. Dr Stuart wanted clarification on waiting lists. He had understood that a child's waiting list 'belonged' to the trust providing the service, even if the child was based miles away. This would ensure local services met requirements. Professor Kelly extended this to a question of who was accountable for the network? Ms Sheehan noted it was important to be clear whom the group advised. If the network boards enabled implementation then the group would advise the boards. They would also advise a national group overseeing implementation. The network was an important emphasis and had to cover the whole pathway. Dr McGee noted points 18 to 21 seemed to be hierarchical. Engagement was needed throughout the network, rather than being led from the top. Professor Kelly agreed these paragraphs needed to be rewritten accordingly. Dr Jenkins noted that the Safe and Sustainable Steering Group has advised on the structure of the	

	networks; he had thought that network boards would be responsible for sub-commissioning services in the network, which he suggested needed to have robust governance and finance powers. Ms Jarvis said that a framework for operational delivery networks was currently being developed. Whilst the delivery network model was an aspiration that should be developed over time, in the immediate term she advised that the group adopt a 'strategic clinical network' model in which the network boards would provide clear clinical leadership, ensure a coordinated pathway, and be responsible for the performance of member organisations in the network. Dr Tiwari said accountability within the network had to be clarified to ease tension between networks and trusts. Ms Kirwan expressed her support for point 20, particularly highlighting the first bullet point. However, she wanted to see 'screening' added. She also noted that a mother could become pregnant again; the whole cycle had to be considered, including coming back to maternity. Mr Cumper noted that the group needed to remind itself that its core focus was patients. He noted that patients did not always need to be seen at the surgical centre; they could be seen locally. The right decision had to be taken by an expert that they were getting the right care at the right time. The wording would be better based around the patient need, rather than the profession and infrastructure. Ms Aryeetey said that access to expertise should be the same throughout the network. The current model was variable; provision had to be improved. Professor Kelly concluded that the draft terms of reference should be revised in line with the group's discussion around the future role of networks. The Chair called for volunteers to help on this via a working group. Professor Kelly noted that membership of the group did not yet include a representative from an ECMO team; she said that steps were being taken to ensure they were included in future. Professor Kelly asked Members to inform Mr Glyde of any other constituencies that should be represented. Mr Barron suggested more representation from 'de-designated' centres.	**All Members** **All Members**

6. Developing standards for Children's Cardiology Centres and District Children's Cardiology Services	Professor Kelly suggested that, following on from the previous discussion, the group needed to define the role of networks before standards could be developed for Children's Cardiology Centres and District Children's Cardiology Services. As such, Professor Kelly advised revising the implementation timeline to reflect that draft standards were not likely to be delivered until later in 2013, though she advised on the need to conclude the work as expeditiously as possible given the need for clarity particularly within the NHS Trusts that had not been designated to provide surgery. Mr Glyde advised Members that it would be premature to assume that the 'de-designated' centres could be designated as Children's Cardiology Centres until appropriate standards had been agreed and a designation process had concluded. Members agreed to prioritise the process for developing standards for Children's Cardiology Centres. Dr Gopalan agreed to share with Members the draft standards developed by the "Paediatricians with Expertise in Cardiology Special Interest Group" (PECSIG) which were currently being considered by the British Congenital Cardiac Association. Dr Gopalan volunteered to be a member of the standards working group. Professor Kelly proposed that three working groups be established: i) networks, ii) Children's Cardiology Centres and iii) District Children's Cardiology Services. She asked members to volunteer to join or to advise on appropriate membership. Dr Jenkins suggested approaching staff presently working in Children's Cardiology Centres to help write the standards for this service. Dr Thilaganathan volunteered for the network group. Professor Kelly asked Members to write to Mr Glyde with ideas for proposed membership. Mr Glyde would then report on the outcome to Members so that they can agree membership at the next meeting. Professor Kelly proposed that, ideally, the networks group should meet before the next meeting of the Implementation Advisory Group if possible.	**All Members** **Mr Glyde**
7. Sequencing of Implementation Activity	Ms Sheehan explained that there would be a need for commissioners and networks to produce a local implementation plan that was specific to each	

	network, though national coordination would be necessary given that no network can function in isolation. Early work by commissioners suggested that a phased implementation would be reasonable. Members considered a draft analysis of potential sequencing that had been produced by the national team.	
8. Next steps **i. Overview of changes in commissioning process**	Ms Sheehan explained how the transition from current commissioning arrangements to the establishment of the NHS Commissioning Board would influence the process of implementation. She suggested that leadership would be crucial: within individual centres, in networks, within the professional associations and at commissioner level. Professor Kelly reiterated the challenging nature of the group's task, but she said that she had found today's meeting to be very positive and she looked forward to working with Members on this very important work.	
9. AOB	There was no other business.	
10 Future meeting dates	The next meeting was scheduled for 28 November 2012. A further meeting would be arranged for a date in February 2013 (the date previously advised for February had been removed).	**Chair**