Safe and Sustainable

Joint Committee of Primary Care Trusts (JCPCT)

National Specialised Commissioning Group

Minutes from the Joint Committee of Primary Care Trusts Meeting
Central Hall Westminster, Story[1]s Gate, London, SW1H 9NH
Tuesday 12 June 2012

Name	Body/Association	Role
Sir Neil McKay CB	Chair, Joint Committee of Primary Care Trusts	Chief Executive, East of England SHA (Chair)
Zuzana Bates (in attendance)	Safe and Sustainable Team	Project Liaison Manager, Specialised Services Team
Ros Banks (in attendance)	KPMG	Healthcare Advisory Team
Andy Buck	Yorkshire & Humber SCG	Chief Executive, Yorkshire and Humber SCG
Jon Develing	North West SCG	Chief Officer, North West SCG
Deborah Evans	South West SCG	Chief Executive, Bristol PCT
Deborah Fleming	South Central SCG	Chief Executive, South Central Strategic Health Authority
James Ford (in attendance)	Grayling	Managing Director, Public Sector
Jeremy Glyde	Safe and Sustainable NHS Specialised Services	Programme Director
Catherine Griffiths	East Midlands SCG	Chief Executive, Leicestershire County & Rutland PCT
Mr Leslie Hamilton	Immediate Past President, Society for Cardiothoracic Surgery in Great Britain and Ireland	Vice Chair, Paediatric Cardiac Surgery Steering Group.
Eamonn Kelly	West Midlands SCG	Chief Executive, West Midlands Cluster
David Mason	Legal Advice	Lawyer, Capsticks
Sue McLellan	London SCG	Chief Operating Officer, London SCG
Teresa Moss	NHS Specialised Services	Director of NHS Specialised Services
Brian Niven (in attendance)	Mott MacDonald	Project Manager
Dan Phillips (on behalf of Cerilan Rogers)	Welsh Health Specialised Services Committee	Representative, Welsh Local Health Directorate
Chris Reed	North East SCG	Chief Executive, NHS North of Tyne
Ann Sutton	East Coast SCG	Chief Executive, Eastern and Coastal Kent PCT
Ms Heather White (observer)	Department of Health	

Apologies

Name	Body/Association	Role
Professor Roger Boyle CBE	Adviser to JCPCT	Former National Director for Heart Disease and Stroke
Sophia Christie	Adviser to JCPCT	Former Chief Executive, Birmingham East and North PCT
Catherine O'Connell	East of England SCG	Chief Operating Officer, Midlands and East SCG
Ann Radmore	London SCG	Chair, London SCG
Dr Sheila Shribman CBE	Adviser to JCPCT	National Clinical Director for Children, Young People and Maternity Services

1. Introductions and apologies **a) Legal Update**	The Chair opened the meeting and welcomed attendees. Apologies were announced as recorded above. Mr Mason updated the JCPCT regarding the recuperation of legal costs.	
2. Update on compliance with Public Sector Equality Duty (PSED)	Ms Bates introduced this item. At the meeting in public on 4 July the Committee would be asked to consider the PSED and Health Impact Assessment (HIA) separately. The PSED was a new legal duty that rested with PCTs as statutory bodies and could not be delegated to any other bodies. The HIA alone was not sufficient to satisfy the PSED. However, Mott MacDonald had reflected the PSED in the final HIA. The PSED was an ongoing duty for each PCT, so this would also be a consideration for implementation. Ms Griffiths suggested that the Committee should see the summarised responses, especially if the PSED was relevant for implementation. The Chair endorsed this suggestion. Ms Bates stated that she circulate the summary document to the Committee by the end of the following week. The Chair asked the Committee to check whether there was any new information in the PCT responses once these were provided and pass any comments to the Secretariat.	**Z Bates to circulate the summary of responses to the PSED and members to feedback to J Glyde**
3. Health Impact Assessment: final report	Mr Niven explained that the HIA was an integrated mechanism to assess the positive and negative affect of each option upon health outcomes, existing health inequalities and equality groups in deprived communities. It also reviewed travel and access impacts, carbon emissions and sought to redress any issues prior to implementation. The HIA was intended to assist and inform the JCPCT's decision-making process; it was not a legal duty but was considered good practice. The process had begun with a scoping exercise, carried out between October 2010 and February 2011, which had reviewed the impacts upon the nine protected equality groups to identify those which had a disproportionate need for children's heart surgery services. The scoping exercise had identified a set of vulnerable population groups, including children, socioeconomically deprived communities, Asian ethnic groups, children of mothers who smoked during pregnancy and children of mothers who were obese during pregnancy. The likelihood and duration of a range of impacts had been considered and each impact had been viewed both in terms of its affect on	

	the overall population and the vulnerable communities identified. During consultation, Mott MacDonald had held regional stakeholder events, one-to-one interviews with key stakeholders and interviews with parents of current patients. In Leeds and Leicester, additional focus groups had been held with members of vulnerable populations. Post consultation, Mott MacDonald had looked at the impacts of the additional variant options that had emerged following consultation. The conclusion of the HIA work was that all options were viable. The difference between options had ultimately been found to be marginal: all options improved health outcomes and provided a better model of care. All had some adverse impact on children and their families. At a population level, the impact of all options was small, although at an individual family level the impacts could be significant. Option I caused the fewest negative impacts, while Options C and E gave rise to slightly more negative impacts. The report had identified a number of actions that could be taken to mitigate the adverse impact on children and their families. These included: • Monitoring following implementation • Training to a wider clinical network group • Collaboration with local community groups • Communication during transition • Travel guidance • Consideration with other work being undertaken Ms Griffiths suggested that the Committee should present a general commitment paper providing assurances regarding the mitigation of the risks at the meeting on 4 July. Mr Reed noted that the list of proposed mitigations should include reference to accommodation provision for families who had to travel long distances as a result of reconfiguration. The Chair agreed that tangible evidence should be included in the Decision Making Business Case (DMBC) about how risks were to be addressed during implementation.	
4. Update on finance and capacity analysis	Mr Glyde explained that the final assessment and capacity analysis were updated and ready for inclusion in the DMBC. The outcome of the analysis was that options B and G remained superior in this regard.	**J**

	Mr Buck asked for the case on finance and capacity to be elaborated more clearly in the DMBC, especially as the document was intended to be read by a lay audience. Ms Evans urged that the work being undertaken regarding PICU capacity also be clearly explained. Mr Develing highlighted that retrieval plans should also be clarified. The Chair agreed to work with Mr Larsen and the Secretariat to review and amend the narrative on the finance section. The Group discussed whether there was any current unmet need or likely to be unmet future need. It was noted that Dr Martin Ashton-Key's paper had concluded that, notwithstanding the likelihood of population increase, with new screening techniques and developments in fetal medicine the net volume of work should remain relatively stable, at least in the short-term. Mr Glyde noted that some pockets of population, such as London, might experience an above-average population growth for various reasons. Mr Reed stated that the Steering Group had explored the matter in detail. The Chair highlighted the need to describe the JCPCT's position clearly in the DMBC. Mr Glyde reassured the Committee that total volumes of cases were low, so the impact of any population growth would be low in terms of absolute numbers.	**J Glyde and the Chair to amend the finance and capacity section of the DMBC**
5. Update on engagement by London SCG with users of paediatric respiratory services at the Royal Brompton Hospital	The Chair reminded the Committee that the Pollitt Report, commissioned by Safe and Sustainable, had found that it was entirely possible to provide respiratory services at RBH if there was no onsite PICU, provided alternative arrangements could be made for a handful of patients. London SCG had determined that the issue should be considered as part of a larger review of Tertiary Paediatric Services. Ms McLellan reiterated that a report would be delivered to the JCPCT in June.	**S McLellan**
6. Draft agenda for meeting on 4 July 2012	Mr Glyde highlighted that allocated time for the meeting on 4 July had been extended. It was now scheduled to close at 15.00. Mr Glyde explained that the papers, including the agenda, would be circulated to the Committee a week prior to the meeting on 4 July. Mr Glyde explained that the structure of the draft agenda followed the flow of the DMBC and was therefore lengthy. He would lead the Committee step by step through the elements that had been consulted upon and it would agree each aspect in turn. Mr Glyde asked for comments on the flow and content of the agenda.	**J Glyde**

	Mr Reed suggested that item 8 be moved back in the agenda, as the items on either side of it were not concerned with content of any arguments. Mr Glyde endorsed this point and suggested item 8 be moved to item 18. It was suggested that the agenda mirror precisely the sections of the DMBC. Ms Sutton asked that the meeting begin with an explanation of the Committee's governance arrangements and guidance on the code of conduct for the meeting. The Chair suggested that to assist the audience it be explained at the start that the agenda would follow the flow of the DMBC and that a list of the relevant issues for agreement be given under each item of the agenda. Mr Buck suggested the word 'agree' be replaced by the word 'consider'. The Chair suggested that the agenda be amended in light of the discussion and re-circulated for agreement, noting it would be published in two weeks' time. Mr Glyde explained that the voting members were the 10 regional members of the Committee, plus the Chair and Ms Moss. He suggested that each point would be agreed by a show of hands, with the exception of agenda item 20, which related to the location and number of the surgical centres. Mr Glyde opined that it was vital to be clear whether the decision regarding item 20 was unanimous. To that end, it was proposed that either Mr Glyde or the Chair would go around the members of the JCPCT by name and ask members to state the option they preferred. The Chair highlighted that some members may not feel comfortable with the proposed approach; he suggested that following the discussion he ask whether a unanimous decision had been reached and whether any members disagreed with it. This approach was endorsed. Ms Griffiths asked whether members should be able to express regret about the closure of particular centres when delivering their final decision. It was noted that it was legitimate to express regret where a Committee member's local centre would not be designated. Ms Evans urged that the most important point to make clear was that the JCPCT had to agree a national pattern for the service.	
7. Logistics for meeting on 4 July 2012	Mr Ford explained that some organisations had been asked to nominate only five representatives, while others, such as OSCs, had not been allotted limited places. All MPs who wished to attend would be accommodated. Representatives of areas who felt most threatened had filled their places, as expected. The Chair asked what	

	arrangements had been made with regard to breaks and catering. Mr Ford confirmed that the event would be catered and security arrangements had been made.	
8. Developing the Decision Making Business Case	Mr Glyde explained that the document was intended to present a balanced analysis of the evidence submitted during consultation. The Committee endorsed the DMBC in general. Ms Evans commented that she felt slightly uncomfortable that it was not possible to be definitive regarding London networks and catchments. She also felt the DMBC needed to feature a much stronger section on implementation, as already discussed. Ms Evans urged that the language be simplified and initialisations spelled out throughout the document. Mr Buck urged that the section on Leicester should be expanded and the relevant points drawn together into one section, as they were for the other main Option B issues: Leeds/Newcastle and London. Mr Buck added that on page 109 the document referred to confidence in the ability of Leeds and Newcastle to develop a single network, but the preceding part of that section left open the issue of whether patient choice would lead to patients in Yorkshire and Humber being part of two networks. He opined that the document needed to be more definitive on this issue and the expectations on patient flow as the networks were key to creating safe and sustainable services and could not be 'fudged'. Ms Evans suggested that 'Creating Effective Networks' should be one of the key implementation headings in the document as this was a critical issue for many areas. Mr Glyde responded that the strength of the networks would depend on the strength of the relationships within the network across the centres and it was acknowledged that in this regard there was a short-term risk in Yorkshire and Humber, based on the evidence submitted. The DMBC had to explain theoretically the benefits of a well-managed clinical network as well as the impact of patient choice. The Chair stated that Safe and Sustainable believed in the concept of the networks as the key to achieving high quality, sustainable services, but it could not ignore the impact of patient choice or deny people the right to choice. Mr Reed urged that once implementation began it had to be expected that the clinical networks would be adhered to by the clinicians. The Chair added that Sir Bruce Keogh had been clear that he expected clinicians to work within the network, but it was noted that in some areas this would be challenging at first. Ms Griffiths nodded that the process would have to be managed. Ms Evans noted that the examples of working networks should	

	be drawn on as evidence of the viability of the network model. Mr Buck suggested that the final item should also address the configuration of the networks rather than solely focussing on the location and number of surgical centres. The Chair strongly endorsed this point and asked that references to networks be strengthened in the document and in the discussion in the meeting on 4 July. Mr Buck urged that expected catchments for each network be explained clearly during the discussion at the meeting. Ms Evans recommended that it be demonstrated that the Committee believed the new configuration could be made to work through commissioning arrangements. Mr Glyde proposed that more emphasis be given to Leicester's ECMO reputation to improve the balance of the document. Leicester's response to consultation had included a statement that any option other than Option A would lead to, 'at least 76 infants, children and adults', dying each year for the next five years, because of the loss of ECMO at Glenfield. Mr Glyde intended to include this statement by Leicester in the DMBC to ensure that it was clear that the Committee considers it and to explain whether it felt the assertion was supported by other expert stakeholders. Mr Glyde asked the Committee to send any high-level feedback to the Secretariat by Thursday.	**Members to send feedback to J Glyde on DMBC**
9. Draft scoring presentation	Ms Banks explained the format of the options scoring presentation she would give on 4 July. She would begin with the assumptions that had been adopted in establishing viability and show the list of viable options. She would present Option I in more detail, highlighting the potential risks regarding achieving the 400-case minimum for Bristol and Birmingham. Ms Banks would then turn to the scoring process, and lead the Committee through the proposed scoring of the sub criteria and criteria. The un-weighted scores would then be summarised for each of the options. Ms Banks would then remind the Committee of the weighting and show the overall weighted scores of each of the options. The proposed conclusions would then be shown on a linear graph, which would be a key moment in the meeting. Ms Banks would then lead the Committee through the most critical sensitivity tests, but not all of those included in the DMBC. Travel, access and deliverability sensitivities would not be covered at the meeting in public as they were immaterial, but re-scoring of high-quality services using the revised co-location weighting would	

	be covered. The sensitivity around weighting quality sub-criteria equally would also be covered. They would also test the sensitivity whereby it was assumed there were significant risks to the manageability of Newcastle's network combined equal weighing of the quality sub criteria. The sensitivities around sustainability would be dealt with under a separate agenda item. Ms Fleming urged that it be made very clear that these sensitivities were being tested in light of consultation responses as this may not be clear to the audience. She also asked whether posters could be put up in the room that referred to the four criteria, etc, so that attendees had something to refer to. Ms Banks endorsed this suggestion and added that a grid would also be posted which showed the details of each of the options. Ms Banks explained that she would present the two sensitivity tests regarding the Newcastle network in Option B under a later agenda item, led by Mr Glyde. She would present the broad impacts with regard to sustainability of the assumed catchments, but she would not cover the detailed postcode information that had been shared at the previous meeting. This agenda item would follow the presentation of by PwC of its analysis, which confirmed the majority of referring consultants had stated they would refer in line with the networks. Ms Evans highlighted that the DMBC referred to the PwC report on page 108 and used the two examples of 50% and 75%, whereas KPMG's sensitivity test used 75% and 100%. The Chair agreed that the figures referred to should be consistent. The Chair queried the referrer sample size and breadth used by PwC. Ms Moss said the sample had been taken from every potential network across the country. The Chair asked that the sample size be confirmed prior to the meeting on 4 July. Ms Banks continued that once the discussion on 4 July reached the point of considering a two-centre London option, she would remind the Committee of the proposed scoring and criteria for the London centres. She would also lead the testing of the certain sensitivities around the London centres, the number of which had also been rationalised since previous meeting. The sensitivity whereby the quality scores were equally weighted had the effect of lowering the overall score of RBH. She would also explore the effect on the overall scores of awarding RBH the maximum score for evidence of research and innovation.	**PwC's referrer sample size to be confirmed**

10. Draft communications/media handling plan	Mr Ford updated members on the communications plan.	
11. Draft implementation plan	Ms Moss said she was holding discussions with Chief Operating Officers regarding implementation. There would need to be strong national coordination on legal issues and clear regional level management in each area, working with providers to facilitate change and the development of care plans.. The Clinical Steering Group had agreed that the Clinical Implementation Advisory Group should continue to oversee and work on implementation, not in a trust capacity but in a representative capacity, to ensure issues that arose could be considered and addressed in the round. Ensuring robustness of process for implementation was critical.	
12. Any other business	There was no other business.	
13. Future meetings	The meeting in public would be held on 4 July 2012, 11am to 3pm (pre meeting 10am to 11am).	