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 15 May 2012

Name	Body/Association	Role
Sir Neil McKay CBE	Chair, Joint Committee of Primary Care Trusts	Chief Executive, East of England SHA (Chair)
Ms Zuzana Bates	Safe and Sustainable Team	Project Liaison Manager, Specialised Services Team
Ms Ros Banks	KPMG	Healthcare Advisory
Mr Andy Buck		Chief Executive, Yorkshire and Humber SCG
Ms Sophia Christie	West Midlands SCG	Chief Executive, Birmingham East and North PCT
Mr Jon Develing	North West SCG	Chief Officer
Ms Deborah Evans	Chief Executive, NHS Bristol	Chair, South West SCG;
Ms Deborah Fleming	Chief Executive, NHS Hampshire	Chief Executive, South Central Strategic Health Authority
Mr James Ford	Grayling	Managing Director, Public Sector
Mr Jeremy Glyde	Safe and Sustainable NHS Specialised Services	Programme Director
Mr Paul Larsen	Safe and Sustainable NHS Specialised Services	Finance Lead
Mr Eamonn Kelly	West Mercia	Chief Executive, West Mercia Cluster
Mr David Mason	Legal Advice	Lawyer, Capsticks
Ms Teresa Moss	NHS Specialised Services	Director of NHS Specialised Services
Mr Dan Phillips (on behalf of Cerilan Rogers)	Welsh Health Specialised Services Committee	Representative, Welsh Local Health Directorate
Ms Ann Radmore	South West London, Chief Executive	Chair, London SCG
Mr Chris Reed	Chair, North East SCG	Chief Executive, NHS North of Tyne
Ms Christy Rowley	ACHD Programme	Assistant Programme Manager, National Specialised Commissioning Team
Ms Heather White	Department of Health	
Ms Justine Windsor	Department of Health	

Apologies

Name	Body/Association	Role
Professor Roger Boyle CBE	Department of Health	National Director for Heart Disease and Stroke
Ms Catherine Griffiths	Chair, East Midlands SCG	Chief Executive, Leicestershire County & Rutland PCT
Mr Leslie Hamilton	President, Society for Cardiothoracic Surgery in Great Britain and Ireland	Vice Chair, Paediatric Cardiac Surgery Steering Group.
Ms Catherine O'Connell	COO, Midlands and East SCG	
Ms Ann Sutton	East Coast SCG	Chief Executive, Eastern and Coastal Kent PCT

1. Introductions and apologies	The Chair opened the meeting and welcomed attendees. Apologies were announced as recorded above.	
2. Matters arising: Response to University Hospital Leicester NHS Trust	A further letter had been received from University Hospital Leicester NHS Trust urging that the Committee recognise in the scoring process its proposal to move Ear, Nose and Throat services from the Royal Infirmary to Glenfield Hospital and its 'revised recruitment strategy' for the paediatric intensive care unit (PICU) at Glenfield. Mr Glyde said that he had written to UH Leicester NHST during consultation encouraging it to specifically address the issue of co-location in its response, but that it had failed to do so adequately. It was agreed that the Chair would respond to the Chief Executive of Leicester University Hospitals NHS Trust.	
3. Scoring process	Mr Glyde highlighted that the four aspects to be covered were: sensitivities, Option I, Newcastle networks and London scoring. **Option I** Ms Banks explained that the Option I viability issue had only recently been identified. Option I was viable according to the rules that had been adopted and/or retained following consultation. It consisted of the same sites as Option B, with the addition of Leicester. The configuration map presented for Option I in November 2011 had erroneously shown Oxford and Reading postcodes being split between Bristol and Southampton, when in fact they would both flow to Southampton. The impact of the correction meant that Bristol's total caseload was 385 procedures, which undermined the viability of Option I. This analysis was based on the consistent application of the networks for each centre across every option. Mr Glyde explained that the Committee had previously agreed to include Option I despite the comparatively low numbers that Birmingham achieved in this option (below the minimum of 400 procedures). Mr Glyde highlighted that Option I emerged as the third highest scoring option in the proposed conclusions to scoring, as the concerns regarding feasibility were masked by scores for other criteria. It was proposed that the Committee retain Option I in the scoring process, but that it bear in mind the continued deliverability risk of the option. Ms Christie commented that under Option I the highest scoring units for quality achieved the smallest caseloads nationally. It was proposed that both the deliverability and the quality aspects of	**R Banks**

	Option I should be highlighted at the meeting in public and the business case. This approach was agreed. **Sensitivity Testing** Ms Banks recapped that sensitivity testing had been applied to Options A to L, as described at the previous meeting. The sensitivities tested had been grouped by criteria: quality, deliverability/sustainability and travel and access. ***Quality*** The first sensitivity test involved rescoring high quality services using a revised co-location weighting from the assessment visits. The test was a response to feedback given during consultation that co-location had not been given sufficient weighting. This had the affect of making Newcastle a bottom-three scoring centre instead of Liverpool, lowering the scores of options including Newcastle. The second test involved weighting quality sub-criteria equally, which lessened the gap between Option B and Option G's scores, but not their ranking in first and second place respectively. The third test was based on Pricewaterhouse Cooper's (PwC) analysis; it was assumed there were significant risks to the manageability of Newcastle's network and it was scored down for the manageability of clinical networks. This only made a difference to scores if the quality sub-criterion were weighted equally. Test four examined the impact of removing manageable clinical networks from the quality criteria and weighing equally the research and innovation and high quality services criteria. Ms Evans asked how manageability was taken account of in this test. Ms Banks said it was assumed under test four that all options scored were manageable. Ms Christie explained that, effectively, manageability was dealt with under sustainability and access, rather than within the quality criteria in test four. ***Deliverability*** Test five assumed that Glenfield's PICU was not sustainable, reflecting the advice of Professor Kennedy's panel, and lowered the deliverability scores to 1 for those options that included Leicester.	

	Test six apportioned greater dominance to nationally commissioned services (NCS) under the deliverability sub-criteria. The seventh test scored deliverability on the basis that moving either ECMO or Transplant presented an equal risk to deliverability, using NCS as the dominant sub-criteria. Members challenged the validity of this test given that no evidence to date supported the assumption upon which it was based and was contrary to professional advice. The Chair highlighted that the sensitivity analyses undertaken reflected the issues raised during consultation. Ms Banks explained that the Committee was free to disregard any tests it deemed non-evidenced base. ***Sustainability*** Test eight used only the number of centres undertaking 400-499 paediatric surgical procedures per option to score sustainability, whereas test nine used only the number of centres undertaking 500 or more paediatric surgical procedures to score sustainability. These tests neutralised the effect of the total number of sites in an option upon the sustainability scores. Test 10 had been slightly altered since the previous meeting. Based on PwC analysis, it dealt with the risk around networks in the North and their impact on Newcastle's procedure numbers. The test was based on a worst-case scenario that around three quarters of the patients from Sheffield, Doncaster, Leeds and Wakefield postcodes would not travel to Newcastle. Ms Christie noted that over 90% of referring paediatricians had confirmed to PwC that they would refer within the designated networks. Mr Glyde explained that the risk to Newcastle's numbers was identified in patients' and families' response to PwC and other stakeholder responses. Mr Reed highlighted that evidence showed patient survey response rates had been low and patients from the contended postcodes accessed other services at Newcastle. He asked the Committee to consider the impact of bias in consultation responses. ***Travel and Access*** Tests 12 and 13 had used different time brackets for assessing elective travel and access: increased journey times by up to 60 minutes and over 60 minutes; and up to 30 minutes and over 30 minutes and up to 90 minutes and over 90 minutes.	

	Combined sensitivities Ms Banks explained that, generally, combining sensitivity tests was not a helpful or robust method for testing the original scoring in that it was an arbitrary approach. Mr Glyde advised that sensitivity one would definitely be included in the advice offered to members on 4 July as it was a such a contentious issue. ***Sensitivity test three*** assumed that there were significant risks to the manageability of Newcastle's network, based on the views offered to PwC. The drop in score to 1 for clinical networks impacted the overall quality scores for options A, B, C, E, H, I and J, provided all three quality sub-criteria were weighted equally; otherwise, no impact was seen on overall quality scores. Under test three, Option G's score increased significantly and came closer to that of Option B, which remained the highest scoring option. Asked what the implications of accepting this test were, Mr Glyde responded that this would mean the Committee considered there were reasonable grounds for testing the manageability of the network. Mr Reed commented that managed clinical networks would eliminate risk posed by the exercise of patient choice. The Chair noted that the Committee had previously discussed that it was unlikely but possible that parents would exercise choice against the recommendation of the referring consultant. Ms Christie suggested that most parents would follow the advice of their cardiologist or paediatrician; those that exercised an alternative choice were likely to do so for travel or access reasons. Therefore, the most significant issue was whether any groups were disproportionally disadvantaged, the location of any such groups and their travel behaviours. Mr Buck urged that it was important to establish how many families would be travelling further than they would under other configurations. It was noted that the evidence regarding patient flows was conflicting and the Committee would ultimately have to make a judgment. ***Sensitivity test 4***, removing manageable clinical networks from the quality criteria, only impacted scores if the quality sub-criteria were weighted equally. Option B scored 3 overall and Option G scored second highest, but with greater differentiation than under the previous sensitivity.	

	Sensitivity test 5 was based on assuming Glenfield's PICU was currently not sustainable and only affected scores of options that included Leicester. Options A, H, I, J, K and L's scores fell to 1 for deliverability irrespective of the NCS deliverability criteria. Option B remained the highest scorer, with Option G in second place. Assuming that three quarters of the patients from the Sheffield, Doncaster, Leeds and Wakefield postcodes did not travel to Newcastle, ***sensitivity test 10*** showed activity at Newcastle dropping from in excess of 500 patients to between 400 and 500 procedures. This translated to options A, H I and L scoring poorly for sustainability. Overall, Option B still scored most highly and Option G moved closer to Option B but remained in second place. Mr Buck suggested that this test provided convincing evidence that the Newcastle network would be viable in option B if the managed network boundaries were extended to incorporate Leeds and Wakefield postcodes. Dr Shribman stated it appeared from the evidence that there was minimal risk that clinicians would refer outside the networks or that patient choice would undermine them. The test showed that even in a worst-case scenario the Newcastle network remained viable. Ms Banks said that ***sensitivity test 11*** considered that none of the patients from the four postcodes flowed to Newcastle. The network activity fell below 400 procedures and the Newcastle network was no longer viable. The Chair asked what evidence existed in support of adherence by referring clinicians to the proposed Newcastle network. Ms Moss said that PwC had surveyed paediatricians in the DGHs. Dr Shribman suggested the Committee consider whether patients from the postcodes in question flowed to Newcastle for other paediatric services. Mr Reed said that evidence existed that this was the case. Ms Moss highlighted that adherence to networks was an issue for implementation and formal governance would be in place. It was noted that, in any event, under reconfiguration clinicians would need to develop new referring relationships. Ms Christie urged that the Committee use this opportunity to consider the best fit for postcodes in the areas concerned. **Analysis of Newcastle, Birmingham and Liverpool Networks**	

	At the previous meeting, Mr Buck had asked what assumptions were needed to make Newcastle's caseload viable. Referring to the map of the Option B's networks, Ms Banks explained that with Leeds, Sheffield, Doncaster and Wakefield postcodes flowing to Newcastle, it achieved 559 procedures. However, if each of the three centres were assigned only the full postcodes nearest to them geographically, Newcastle reached only 315 procedures. If the same exercise was applied at a sub-postcode level, Newcastle's activity dropped to 284. Ms Banks confirmed that geographical proximity for this exercise was based on 24-hour average road journey times, as was the case throughout the analyses. To enable Newcastle to reach 407 procedures (or the 400 minimum), it was necessary for its network to include some of Leeds and Sheffield and quite a lot of Doncaster. Patients in Wakefield could flow to Liverpool. Shortest travel times to Newcastle had been used to determine which postcodes should be part of its network, based on no more than a 31-minute increase to journey times. Ms Banks highlighted that Lancashire had always been in the proposed Newcastle network and would continue to be, but was closer to Liverpool with regard to travel times. Ms Moss reminded the Committee that the journey times related to surgical and interventional care only. Turning to increased journey times to cardiology centres, Ms Banks explained that designing one-to-one relationships between networks and cardiology centres would lead to increases in journey times for a small number of patients. Under the Option B configuration, to so do caused an increase in journey time of up to an hour for 125 patients and an increase of up to 82 minutes for 11 patients, based predominantly in PE and BG postcodes. However, this impact would be mitigated by the development of more Paediatricians with Expertise in Cardiology in local hospitals as proposed in the consultation document and possibly by the designation of more hospitals as Children's Cardiology Centres once standards had been developed. Mr Glyde advised that he had held discussions with the Royal College of Paediatrics and Child Health about how to scope training needs for paediatricians and resource requirements during the early stages of implementation. Ms Moss suggested that in practice some Children's Cardiology Centres would need to establish good working relationships and protocols with more than one surgical centre and that this would mitigate against the risk of increased travel times. Mr Buck summarised that the original postcode configuration of Option B would result	

	in sub-optimal travel times for a number of people. However, this impact could be mitigated and had to be considered in the context of the overall quality and outcome benefits offered by option B. An implementation issue remained of what the most sensible network configuration would be for the North, but there appeared to be no convincing evidence that supported the designation of Leeds over Newcastle. Mr Kelly said that the Committee had to be able to respond to challenges regarding implementation. Ms Moss highlighted that part of the Kennedy panel scores had related to centres' overnight accommodation provision. The cardiology referral pathways could also be reviewed to mitigate large increases in travel times. Mr Buck said the overall net savings to families as a result of developing district level services would outweigh the overall net increase of longer travel times for surgery for the small number of families affected. He suggested some more analysis was worthwhile on this point. Ms Evans noted that a lot of this work had been carried out as part of the Health Impact Assessment (HIA). There were several issues regarding numbers and network viability that would have to be addressed during implementation. **Scoring the London centres** All three centres in London had been scored equally for access and travel in the original scoring process. It was now proposed that GOSH and the Evelina be scored slightly higher for retrieval only, as existing retrieval services were currently more reliant on those two centres than on the Royal Brompton Hospital (RBH). As a result, GOSH and the Evelina would score a proposed 3 overall for travel and access, while RBH scored a proposed 2. Mr Glyde explained that CATS (Children's Acute Transport Service) was based at GOSH, while the South Thames Retrieval Service (STRS) was based in Evelina's PICU. The Group debated whether the issue was more one of deliverability or sustainability rather than of travel and access. Ms Banks explained that RBH would struggle to take on the retrieval work from either GOSH or Evelina and which risked non-compliance with the Paediatric Intensive Care Society's (PICS) standards. Ms Moss highlighted that there was no concern about the Evelina or GOSH's PICUs becoming unviable if they were de-designated. Ms Christie stated that unless there was a really distinct travel time difference the scoring should not be altered. The Group agreed not to amend the travel and access scores but retain a score of 3 for each centre.	

	Ms Banks recapped the original scores for each of the three London centres for quality, highlighting that RBH's research and innovation score had been raised to 3. As the network configuration for a two-centre London option was not yet defined, each centre had been scored 4 for clinical networks. As high quality service was the highest weighted criterion in quality, the overall scores were: GOSH and RBH, 3 and Evelina, 4. Turning to deliverability, GOSH scored a proposed 4 for NCS, whereas Evelina and RBH scored a proposed 1. RBH scored a proposed 2 for PICU owing to the risk of destabilisation of its service if surgery ceased. However, the loss of its PICU, which was primarily cardiac, would impact less overall on the overall PICU provision for London and the UK. Ms Banks explained that GOSH and Evelina's original score of 4 for PICU had been downgraded to a proposed 3 to reflect findings of the Pollitt report. Ms Christie suggested that this was the appropriate criteria under which to discuss the earlier point raised regarding retrieval support at GOSH and Evelina. Mr Glyde stated that the documentation would explain that the rationale had been to minimise the impact to local and national PICU networks by the removal of cardiac surgery from a hospital. Ms Banks recapped that total proposed scores for deliverability were: GOSH, 4; Ms RBH, 2 and Evelina, 3. On sustainability, the activity numbers between centres had not been explored as the networks in London had not been defined, but a two-centre option would enable two centres to achieve over 500 procedures, so each centre had been scored a proposed 4. ***Suggested Conclusions*** Evelina was the highest scorer, with a proposed score of 364, and GOSH was the second highest, with a proposed score of 347. RBH scored a proposed 303 overall. If the quality sub-criteria were equally weighted, the differential increased between GOSH and RBH, as RBH's proposed score fell.	
4. Draft structure for the meeting on 4 July 2012	Mr Glyde explained that structure of the meeting would follow that of the Business Case which he was writing. He would lead the Committee through the elements on which it had consulted including the standards and the model of care. There would then be a presentation on the proposed scoring method which, based on today's	

	presentation, would propose that Option B was consistently the highest scoring option. However, as the Business Case would state, the scoring process was not determinative. Mr Glyde would then invite the Committee to test Option B against the evidence submitted during consultation, such as the impact on residents in Yorkshire and Humber regarding travel times and retrieval times. Mr Glyde reminded Members that there was no obligation on them to accept the advice offered in the business case. Their role was to objectively consider all of the evidence submitted during consultation and to decide on a configuration that they considered to be the most appropriate based on a consideration of the evidence.	
5. Communications plan	Committee members were asked to submit comments on the Communication Plan to Mr Ford at Grayling, copying the Secretariat. Mr Develing recommended the term 'we' be clarified throughout the document. Ms Moss noted that it was also important to reassure the patients who were currently using the service. Mr Buck suggested it would be helpful to issue a standard one-page process briefing to all the PCT boards prior to 4 July, suitable for the public domain. Mr Develing requested that the strategic health authorities (SHA) communications and the SHA Chairs also be sent the briefing. Mr Glyde highlighted that Chief Executives and the professional associations would be briefed on 2 July. Mr Glyde confirmed that the agenda would be circulated in the public domain prior to 4 July; the decision-making Business Case would be made available on the day, but after the meeting was concluded.	**J Ford**
6. Draft structure of the Decision Making Business Case	The Group discussed which documents would be circulated in advance of the meeting in July. The Secretariat would circulate a draft text-only document by the beginning of the following week.	
7. Any other business	Mr Buck commented that the Equality Duty letter was likely to generate many responses from PCTs. Ms Christie stated that all PCTs should refer to the Equality Impact Assessment before making its response. It was noted that the link to the HIA was provided both in the letter and in emails sent to PCTs. Mr Buck asked why the PCTs could not delegate their responsibility to the JCPCT. Ms Evans explained that PCTs could not legally delegate their responsibilities under the Equality Act to another body.	

8. Future meetings	• 12 June 2012, 9.30am to 12.30pm • 4 July 2012 tbc	