Safe and Sustainable

Joint Committee of Primary Care Trusts (JCPCT)

NHS

National Specialised Commissioning Group

Minutes from the Joint Committee of Primary Care Trusts Meeting
Central Hall Westminster, Story[1]s Gate, London, SW1H 9NH
Wednesday 22 February 2012

Name	Body/Association	Role
Sir Neil McKay CB	Chair, Joint Committee of Primary Care Trusts	Chief Executive, East of England SHA (Chair)
Ros Banks	KPMG	Healthcare Adviser
Andy Buck	Yorkshire and Humber SCG	Chief Executive, Yorkshire and Humber SCG
Sophia Christie (Adviser)	Adviser to JCPCT	Former Chief Executive, Birmingham East and North PCT
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, NHS Hampshire
James Ford (in attendance)	Grayling	Managing Director, Public Sector
Jeremy Glyde (secretariat)	Safe and Sustainable NHS Specialised Services	Programme Director
Mr Leslie Hamilton (adviser)	President, Society for Cardiothoracic Surgery in Great Britain and Ireland	Vice Chair, Paediatric Cardiac Surgery Steering Group.
Dr Patricia Hamilton CBE (adviser)	Chair, Safe and Sustainable Steering Group	Director of Medical Education, England
Paul Larsen (in attendance)	Safe and Sustainable NHS Specialised Services	Finance Lead
Eamonn Kelly	West Midlands SCG	Chief Executive, NHS Worcestershire
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
Chris Reed	North East SCG	Chief Executive, NHS North of Tyne
Justine Windsor (observer)	Department of Health	Cardiac and Vascular Branch
Catherine O'Connell (on behalf of Paul Watson)	East of England SCG	Director, East England SCG
Dan Philips (observer)	NHS Wales	

Apologies

Name	Body/Association	Role
Professor Roger Boyle CBE	Adviser to JCPCT	Former National Director for Heart Disease and Stroke

Catherine Griffiths	Chair, East Midlands SCG	Chief Executive, Leicestershire County & Rutland PCT
Ann Radmore	London SCG	Chief Executive, Croydon PCT
Ann Sutton	East Coast SCG	Chief Executive, Eastern and Coastal Kent PCT

1: Introductions, apologies and minutes of the previous meeting	The Chair opened the meeting and introduced Eamonn Kelly as the new West Midlands Representative. Mr Kelly had been appointed to replace Ms Christie in this role; however, due to her expertise, she had been asked to remain on the JCPCT as an additional adviser. The Chair outlined the apologies.	
2: i) Matters Arising. **ii) Meeting of NSC Team and London SCG, December 2011.** **iii) Meeting of Advisory Group for National Specialised Services, February 2012**	A meeting had taken place between Ms McLellan, Ms Radmore, Mr Glyde and Ms Moss regarding potential flows in London. Ms McLellan and Ms Radmore had confirmed that London SCG was content with the flows proposed in Mr Glyde's previous presentation. A meeting with the secretariat, London SCG and Guy's and St Thomas' had also taken place at the request of Sir Ron Kerr. These issues had not been finalised but significant progress had been made. Ms Moss advised Members that AGNSS was content to advise Ministers on the transfer of a paediatric respiratory ECMO service, if necessary, but that AGNSS had strong concerns on the possible transfer of a paediatric cardiothoracic transplantation service. Ms Moss reported that the Chief Executive of BCH had said that BCH was confident in its ability to assume a paediatric respiratory ECMO service if necessary in view of its existing expertise in this area and its plans for increasing capacity over the next two years. However, BCH had also reported that it would be unable to safely assume a paediatric cardiothoracic transplant and 'bridge to transplant' service within the required timescales due to capacity constraints and the significant clinical considerations inherent in moving this service. Mr Kelly noted that the practicalities of moving the transplant service relied on clinicians being willing to move, which required precise coordination. Ms Moss reiterated that BCH believed that they to conclude a transfer of transplant services within three years was a significant challenge. BCH had always supported Option B as their preferred option; this had not changed.	
3: i) Update on appeal against judicial review and potential timelines	Mr Mason advised Members on the current position. Preparations were being made by the secretariat for a possible further public consultation. Mr Glyde explained that a new consultation document would reflect what was needed in terms of scope. The new consultation plan proposed public	

ii Preparing for consultation II	exhibitions, rather than clinicians and Steering Group members appearing on a panel. There would be more events in the areas with centres deemed most at risk. People would be asked to book a slot to attend the exhibition and be able to talk to clinicians and patient representatives on a one-to-one basis. They were also working to commission black and minority ethnic (BAME) activities to further engagement; include online engagement for young people; and accept text message responses. The idea of networks needed to be presented more clearly in any future consultation and this meant a focus on practicality. High level detail on networks would be covered, but options showing what the network would look like in each part of England would be presented; it was critical to show pathways and non-cardiac services. Ms Evans highlighted the need to make links to the previous consultation, show this was a continuing process and keep the themes and momentum going. Ms Christie noted that the natural assumption about a re-run of the consultation would be that there had been a significant flaw in the process. There was therefore a need to reiterate that everybody had signed up to the quality standards and the importance of this process. The Committee discussed the timing of the 6 June meeting, which was during the Whitsun week; diaries would be canvassed to ensure there would be enough attendance at this meeting.	
4. Report of Sir Ian Kennedy's panel on compliance with standards relating to 'innovation and research'	Members received the report of Professor Kennedy's panel dated February 2012. Mr Glyde said that eight centres had chosen to submit new evidence and of these the scores had been changed for two: the Royal Brompton Hospital moved from a 2 to a 3; and the John Radcliffe moved from a 1 to a 2. It was noted that if RBH had received the maximum possible score of 4 for this sub-criterion it would have had no material impact on the choice of consultation options. All centres were aware of their revised scores; there had been a query from Leicester about the basis on which the score was developed and they had been told the detailed report would be shared with them after this JCPCT meeting. With the	

	Committee's permission this report would be published on the internet after it had been shared with the centres directly.	
5. Scoring viable options: the London centres	Following rescoring the current scores for evidence of compliance with the standards relating to research and innovation were: Evelina 5; GOSH 5; BCH 4; Bristol 4; Southampton 4; Newcastle 3; RBH 3; Liverpool 2; Leicester 2; Leeds 2; Oxford 2. For each option the total research and innovation scores were added together and the total number of centres included that scored 4 or 5 was recorded. As no option included Oxford, the change in their score had no impact on the options. The scores for options E, F and H had all changed as they included RBH. The total innovation scores for these options had increased by one with E now at 26, F at 25 and H at 28. However the number of centres with a score of 4 or 5 in E, F and H remained the same and therefore, for overall research and innovation, E, F and H continued to have a score 2. As innovation and research was a sub-criterion of quality, and no other scores had changed, E, F and H continued to receive the same overall scores for quality as before. The draft proposed scoring of the three London centres had been carried out due to the possible need to identify two preferred centres in London. <u>Travel and Access</u> It was not possible to differentiate between the three London centres. The London networks had not yet been defined by London commissioners and difference in distance between centres was minimal. All centres complied with standards for retrieval (save for existing areas such as Great Yarmouth) and it was proposed that it was appropriate for all to receive a score of 3. <u>Quality</u> This included three criteria: high quality service; innovation and research; and clinical networks. For high quality service, the original outputs from the Kennedy Panel assessments were: Evelina 535; GOSH 464; and RBH 464. Evelina therefore received a proposed score of 5 and both RBH and GSOH received a proposed score of 3. For evidence of innovation and research the Kennedy Panel gave GOSH and Evelina a score of 5 and RBH received a score of 3. GOSH and Evelina therefore	

	had a proposed score of 4, while RBH had a proposed score of 2. For clinical networks all three centres were deemed equally able and the network in London was yet to be fully defined. The Kennedy Panel had concluded that any differences between centres on this were immaterial, so they all received a proposed score of 4. Therefore, for quality the three London centres received proposed scores as: ▪ GOSH: 3 for high quality services; 4 for innovation and research; 4 for clinical networks. An overall proposed score of 3. ▪ RBH: 3 for high quality services; 2 for innovation and research; 4 for clinical networks. As high quality services were the most important factor it also received an overall proposed score of 3. ▪ Evelina: 4 for high quality services; 4 for innovation and research; 4 for clinical networks. An overall proposed score of 4. <u>Deliverability</u> There were two aspects of deliverability: nationally commissioned services; and PICU and interdependent services. GOSH delivered all nationally commissioned services, so received a proposed score of 4; RBH and Evelina did not deliver nationally commissioned services but were competent to deliver emergency ECMO so each received a proposed score of 1. On PICU and interdependent services, GOSH and Evelina's PICUs remained viable if de-designated to paediatric cardiac surgery. However the number of beds in their PICU would be reduced, as would the overall sustainability of the national and London PICU network. RBH's PICU would not remain viable if the centre was de-designated for paediatric cardiac surgery; however, their PICU primarily supported cardiac surgery. Therefore loss of beds at RBH's PICU would not reduce the overall sustainability of London's PICU network. GOSH and Evelina would now receive a proposed score of 3, which would be reduced from a 4 based on the findings of the Pollock report about the potential impact to a small number of respiratory patients; RBH would receive a proposed score of 2. The Committee discussed why it was proposed to reduce GOSH and Evelina's scores to reflect the findings of the Pollitt report. This had been suggested due to the impact on respiratory patients from RBH, although they were small in number. The question whether the impact was significant enough to justify reducing the scores of GOSH and Evelina was raised. This criterion concerned the network rather than any	

	centre in isolation, which was why adjusting one score affected others. The capacity review looked at options that had two centres in London and so should already take into account the change for PICUs. Mr Larsen explained they had looked at the cardiac increases in activity to calculate the capacity requirements, and then risk assessed the increasing needs. They capacity review had looked at changing the flows and the numbers but they had not taken into account the extra respiratory workload from RBH. The Chair suggested they ask the capacity planners to look at whether the number of respiratory cases would make a material difference to the options. Ms Moss disagreed with the proposed scoring, saying that the impact to the PICU network of removing surgery from GOSH or Evelina would be huge and that the difference in scoring between them and RBH should be greater than the proposed '1'. Although they noted the analysis put before them, the Committee thought it was unreasonable and did not adequately reflect differences between GOSH, Evelina and RBH. Overall proposed scores for deliverability were: ▪ GOSH: Nationally commissioned services 4; PICU and interdependent services 3 or 4. Overall proposed score would be 4. ▪ RBH: Nationally commissioned services 1; PICU and interdependent services 2. Overall proposed score of 2. ▪ Evelina: Nationally commissioned services 1; PICU and interdependent services 3 or 4. Overall proposed score would be 3. Therefore, even if the PICU and interdependent services scores for GOSH and Evelina were increased from 3 to 4, as suggested by the Committee, this would not affect their overall score for deliverability. <u>Sustainability</u> The sustainability criterion scored options based on the centres' capability to deliver 400+ or 500+ procedures. All three London centres were deemed capable of delivering this with no centres exceeding their maximum caseload, and they therefore all received a 4 based on a two centre option.	

	<u>Overall Scores</u> Absolute proposed scores for the three centres were: ▪ GOSH: Travel and Access 3; Quality 3; Deliverability 4; Sustainability 4 ▪ RBH: Travel and Access 3; Quality 3; Deliverability 2; Sustainability 4 ▪ Evelina: Travel and Access 3; Quality 4; Deliverability 3; Sustainability 4 When the weighting was applied the total proposed scores were: GOSH 347; RBH 303; and Evelina 364. This meant that RBH had increased its score from 264. The new score included the changed marks for research and innovation and the increased weighting of quality. The Chair stated that as a result of consultation they had refined their view of quality and applied a new methodology that changed the original scores. The scores had been looked at again in light of Pollitt and the research issue; the new marks showed the London centres in the same order, with RBH at the bottom. This was the case even before any adjustments had been made to increase Evelina and GOSH's score for PICU and interdependent services to 4, as suggest by the Committee. Mr Mason noted that since the consultation they now had a mass of other information, including the impact assessment, and they needed to be careful to ensure this was taken into account.	
6. University Hospitals of Leicester NHS Trust	Mr Glyde said that University Hospitals Leicester NHS Trust had put forward additional information it wished to be taken into account in scoring and it had been agreed that this should be passed to the Committee. However, if they were to decide to accept late evidence they would need a very good reason to do so. The advice was that there was no evidence submitted that had not already been addressed by the Kennedy Panel in the report of October 2011 or the letter of 2011. Members agreed that the new evidence put forward about co-location of ENT services did not seem to be credible evidence as it simply set out a high level aspiration that was not substantiated; details and timelines were unclear. The detail of the submissions and a proposed response would be written up for the Committee. They would also wait to hear Ms Griffiths' views on this matter.	**Mr Glyde to write a proposed response and circulate to Members**

7. Capacity report	Ms Newman had led a group during the consultation looking at the four options. When all the responses had been received, the JCPCT had increased the number of options they were considering to nine. They recognised that forecasts had suggested that the distribution of activity within the London centres would not be equal, and they had tried to take in to account that GOSH would take the largest share of this. They were also aware that nationally commissioned services required further work, especially regarding capacity at BCH. Risk assessment for the options showed no obvious leader, but some would be easier to implement than others and some should be avoided unless they contained other overriding benefits. Option H and Option I were the simplest to implement and required relatively little change, though there were doubts that option I could achieve the required levels of activity in all centres. Also, some of the centres would be relatively under-utilised in these options, including those in London and BCH. Option B and Option E entailed some concerns about recruitment in Newcastle as this involved a relatively high increase in activity for a relatively low population. Newcastle continued to insist that they were able to meet this, but it was still considered a potential, although low, risk. Option A and Option C were more challenging, with potential recruitment issues at Evelina, Bristol and Newcastle. These options would also see pressure building at BCH. Option D, Option F and Option G required transplantation to move from Newcastle to BCH, and ECMO to move from Leicester to BCH and also to Bristol. All of these moves entailed a greater risk in terms of capacity and these three options therefore were ranked as the highest risk. The finance report that should be read in conjunction with the capacity report would be re-circulated. Mr Reed noted that they did not yet have the assurance that all providers had capital in place to implement everything. This assurance should be sought. Ms Moss asked whether the results regarding risk needed to be added in to the scoring. Mr Larsen explained that they had considered using the capacity report to rescore one of the sub-criteria on the transition plans. However, because centres had not been informed that this information may be used for rescoring, they had received advice that they should not do this. The capacity report should therefore be separate but alongside the scoring and considered in the round when reaching a	**P Larsen**

	decision. The issue of the capacity report impacting PICU scores would be re-examined. Ms Christie noted that BCH had concerns regarding the PICU and taking on transplant services. This was not just about volume but also bed days, which increased pressure on the PICU. If they did not look at the PICU alongside moving the transplant service then these impacts would not fully be considered. The Chair noted that they had received strong advice from three sources – BCH, AGNSS and the capacity review – that moving transplantation from Newcastle to Birmingham was high risk.	
8. Update from Steering Group	Dr Hamilton reported that there had been a discussion with the Paediatric Intensive Care Society (PICS) on whether retrieval times should be calculated from surgical centres to the child's location, as they had been for the consultation, or whether it should have been calculated from the PICU in the de-designated centres in each option. The Steering Group recommended that they maintain the original method as set out in the consultation document as they could not depend upon PICS-based services being able to carry out retrievals in the absence of a cardiac surgical services The method was considered reasonable for the purpose of calculating worst case scenarios, which was the limited purpose of the exercise. The Chair informed members that this was Dr Hamilton's final meeting as she was retiring, and he paid tribute to her hard work and noted that she would be sorely missed.	
9. Any Other Business	There was no other business.	
10. Date of Next Meeting	A date for the next meeting in April had been circulated to the Committee.	