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
Monday 23 April 2012

Name	Body/Association	Role
Sir Neil McKay CBE	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
Andy Buck	Yorkshire & Humber SCG	Chief Executive, Yorkshire and Humber SCG
Sophia Christie	Adviser to JCPCT	Former Chief Executive, Birmingham East and North PCT
Stuart Davies (observer)	Welsh Health Specialist Services Committee	Representative, Welsh Local Health Directorate
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
Mr Jeremy Glyde	Safe and Sustainable NHS Specialised Services	Programme Director
Catherine Griffiths	East Midlands SCG	Chief Executive, Leicestershire County & Rutland PCT
Paul Larsen (in attendance)	Safe and Sustainable NHS Specialised Services	Finance Lead
Eamonn Kelly	West Midlands SCG	Chief Executive, West Midlands Cluster
David Mason	Legal Advice	Lawyer, Capsticks
Ann Radmore	London SCG	Chair, London SCG
Chris Reed	North East SCG	Chief Executive, NHS North of Tyne
Ann Sutton	South East Coast SCG	Chief Executive, Eastern and Coastal Kent PCT
Catherine O'Connell	East England SCG	Chief Operating Officer, Midlands and East SCG
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
Mr Leslie Hamilton	President, Society for Cardiothoracic Surgery in Great Britain and Ireland	Vice Chair, Paediatric Cardiac Surgery Steering Group.
Teresa Moss	NHS Specialised Services	Director of National Specialised Commissioning
Dr Sheila Shribman CBE	Adviser to JCPCT	National Clinical Director for Children and Young People and Maternity

1: Introductions, apologies	The Chair opened the meeting and welcomed attendees. Apologies were announced as recorded above. The Chair was pleased that Dr Shribman would be joining future meetings as an adviser to the JCPCT, replacing Dr Hamilton.	
2: Update on appeal against the judicial review	The Court of Appeal had delivered its ruling on 19 April and found in favour of the Safe and Sustainable Review. The date set for the JCPCT's decision-making meeting was 4 July 2012. A great deal of media interest in the event was anticipated. The Chair summarised that the judicial review outcome demonstrated that NHS reviews should not fear legal challenge, provided processes were robust and the consultations comprehensive.	
3: Referral to Secretary of State by Health Overview Scrutiny Committees	Mr Mason provided Members with an update.	
4. Legal advice on process going forward	Mr Mason provided advice to Members.	
5. Matter arising: Response to University Hospital Leicester NHS Trust	The draft response to University Hospital Leicester's submission, discussed at the previous meeting, had been circulated to the Committee. Ms Griffiths noted that the only outstanding issue was the removal of the word 'aspirational' from the second paragraph.	**J Glyde to correspond with the Trust on behalf of members**
6. Matter arising: Advice from AGNSS on transplantation services	Ms Moss reminded Members that while there was an acknowledgment from AGNSS that an ECMO service could be moved with a reasonable reassurance that the high quality of the service could be maintained, there were significant concerns in AGNSS regarding the relocation of a cardiothoracic paediatric transplant service and 'bridge to transplant' service. The concerns were set out in detail in the paper presented to Members from AGNSS. Mr Glyde said that the Secretariat's advice to the Committee was that the relocation of the paediatric transplant service was not 'a showstopper'; i.e. the issue of relocation of NCS should not dictate the final list of options for consideration on 4 July. However, AGNSS's advice was very strong evidence, which should be fed into the scoring process around deliverability and into a consideration of the options	**J Glyde/D Mason**

	generally.	
7. Update on projected London caseloads	Mr Glyde said that at the request of Sir Ron Kerr his team had worked with the London SCG and the Evelina to seek to provide the Evelina with reassurance that the patient flow assumptions for Option B would see both Great Ormond Street Hospital (GOSH) and the Evelina reaching 500 paediatric procedures a year. The discussions had proceeded on the basis of there being a North London and South London network that comprised GOSH and Evelina but the London SCG would ultimately determine the network for London. Mr Glyde said that the assumptions and forecasts could be equally applied to other permutations for two centres in London that included the Royal Brompton Hospital. Mr Glyde said that while the Secretariat was confident that there was a reasonable chance of the Evelina reaching 500 procedures per year, the Evelina was less convinced and had stated in public that it preferred an option with six centres in England rather than seven, such as Option B. The Evelina's position was that there would be a lower caseload for the Evelina in option B than envisaged by the secretariat at the immediate point of implementation, but it had acknowledged that it would reach the 500-per-year caseload within a number of years. Discussions were ongoing. However, Mr Glyde advised that while the JCPCT had stated for the purpose of consultation that two London centres would be better placed to reach a caseload of 500+, it was not bound by that statement if it wished to rely on credible evidence submitted during consultation (that was the point of a genuine consultation). If the JCPCT revised its expected caseload for the Evelina down to 450 cases per year, it was still entitled to make its decision on that basis. Mr Glyde said that in any event it would remain the case that two centres were "better placed" than three centres in London to reach the preferred minimum critical mass. Asked whether this would require the Committee to revisit options that had contained centres achieving fewer than 500 cases per year, Mr Glyde confirmed that all such options had been brought back into the scoring for the purposes of decision-making. The Chair requested that the Secretariat send a note to the Committee explaining the basis of the analysis on the Evelina caseload. Ms Radmore suggested that the activity of the tertiary paediatric review and the Safe and Sustainable review be kept separate. She reported that engagement work on	**J Glyde**

	respiratory services at the Royal Brompton had commenced and it was assumed that the outcome would need to be fed into the paediatric review. The Chair noted that the feedback from London SCG's stakeholder engagement should be fed into the process prior to the 4 July meeting. Ms Radmore noted that the engagement might not have concluded by that point, but its work to date could be provided prior to 4 July.	
8. Update on potential scoring of viable options	The Chair highlighted that several additional options had been proposed during consultation. Ms Banks explained that, as the scoring process had not changed since last presented in November, she would restrict the presentation to showing the impact of the scores and the impact of applying different sensitivities. The detail would, however, be presented at the 4 July meeting. The option suggested most frequently in consultation responses had been a five-site option that included three London centres, Birmingham and Liverpool. KPMG had created a best fit network for this option, but it had been deemed unviable as Birmingham and Alder Hey's caseloads were too big and the London network stretched as far North as the edges of the Birmingham network. As such, the option had been deemed unviable and had not been scored. **Original Assumptions** During public consultation, some but not all of the assumptions used in generating the options had been verified. The following assumptions had been retained: each centre had to perform a minimum of 400 paediatric procedures; London required at least two centres; the John Radcliffe hospital did not appear in any options; Birmingham had to be included in all options; and the North required two centres but Leeds and Newcastle could not exist in the same option. The assumption that only six- or seven-centre options were viable had been disproved, along with the assumption that Southampton and Bristol could appear in the same option. It had been disproven that Bristol had to be included in every option to ensure compliance with the Paediatric Intensive Care Society's (PICS) retrieval standards. **Assumptions Suggested During Consultation**	

	In correspondence with the rejected assumptions above, the assumptions recommended during consultation that had been adopted were that six-, seven- and eight-centre options were viable; Bristol and Southampton could appear in the same option; and there was no requirement for Bristol to be in every option. Assumptions suggested during consultation but not adopted owing to lack of evidence or evidence to the contrary were: Leicester, Newcastle and GOSH services must be present in every option as ECMO services must remain in their current locations; the future location of the three Nationally Commissioned Services should not be a consideration in the JCPCT's process for identifying a preferred option; the Leeds centre should be present in every option for the same reasons as the Birmingham and Liverpool centres; the Leicester centre should be present in every option as the Birmingham centre would not have sufficient capacity; the Southampton centre should be present in every option because of the retrieval of children from the Isle of Wight; and the surgical centre in Glasgow should be included in the JCPCT's process. The last of these assumptions was to be disregarded as the review encompassed English centres only. **Potentially Viable Options** Options A-L were viable based on the set of assumptions proven. Options A-F had been scored in February 2011. Options K and L were new and contained both Leeds and Leicester, in contrast to all of the previous options. In Options K and L, the Sheffield and Doncaster postcodes flowed upwards to Leeds, making the network unviable unless some fairly southern postcodes were directed to Leicester. Mr Glyde summarised that the view had emerged during the consultation that Leeds and Leicester could not be present in the same option based on networks and patient flows; the analysis supported the view that the networks appeared unrealistic but the Secretariat could not assure the Committee that they were not viable. Options K and L had therefore been included in the scoring, but they were not high-scoring options at this stage. Ms Evans sought to confirm that the original assumption regarding the North of England had been that Liverpool had to be present in all options and that, as such,	

	Newcastle and Leeds could not co-exist in an option. Ms Banks said that it had been determined that two centres were required in the North owing to population and the need for reasonable networks. Taking Newcastle as the most northern point, it was not possible to create viable networks with both Leeds and Newcastle as surgical units, owing to the geography. **Access and Travel Times: Scoring Retrieval Times** The Committee had previously treated the retrieval sub-criterion as absolute: a pass or fail. Therefore any options that did not comply with the PICS standards had been deemed unviable. The retrieval sub-criterion was no longer required to be regarded as absolute; options could be scored according to the extent to which they met the criterion. Options that included Bristol and Southampton were scored more highly for retrieval than options that included one or the other, but the latter were no longer deemed unviable. Mr Glyde highlighted that retrieval had been a significant issue during consultation, particularly around the Isle of Wight. The consideration of retrieval as an absolute criterion had led the JCPCT to the decision to include Bristol in every option and not to acknowledge the need for the presence of Southampton in every option, owing to the error made regarding retrieval from the Isle of Wight. The Committee was now advised to relax its approach to the retrieval issue; if it maintained the absolute requirement, the list of viable options was narrowed to approximately three. Further, under the current configuration not all children could be reached in compliance with PICS standards. The only way to achieve or improve compliance with PICS would be to increase the number of centres, which was contrary to the purpose of the review. The Chair noted that the critical issue was determining what extent of compliance with the PICS standards was reasonable. Ms Banks reminded the group that options would be scored on a scale between 0 (does not meet any elements of the criterion) and 4 (exceeds the criterion). It was proposed that the reference to 'most of the criteria' in the scoring definition was deemed to refer to 'most of the population'. Scores for travel times for elective admissions had not changed. Bearing in mind current non-compliance with PICS standards in some areas, a score of 3 had been applied where an option met PICS standards to the extent met by the current	

	configuration, i.e. for options B, G and I. Those options included Bristol and Southampton. A score of 2 had been given to all the other options, as they met most of the criteria. The Group discussed the materiality of emergency procedures, given the high ratio of planned to emergency cases. Mr Glyde explained that the new scoring approach avoided the need for a discussion of materiality. It was noted that the Steering Group had urged that a worst-case scenario be considered for the purposes of retrieval and that, in reality, it probably was possible to reach Truro from Bristol in three hours. Mr Larsen confirmed that the longest journey times had been used as a basis for the analysis. Ms Christie urged that the Committee support its decisions with reference to clinical advice; however, she was comfortable adopting a relative scoring, based on clinical advice from the Paediatric Intensive Care Society that the material concern in emergencies was stabilisation and access to a clinician. Ms Christie opined that the Committee could not be seen to compromise on a clinical quality issue, based on a current sub-optimal service. Mr Davies queried what was proposed in terms of the Welsh population flows in options that did not include Bristol. Ms Banks explained that North Wales would flow to Liverpool/Birmingham and South Wales to Birmingham. Mr Develing asked whether the JCPCT could be provided with the ratio of elective and non-elective retrievals. He queried whether any improvement in retrieval times could be demonstrated under any option. Mr Glyde explained that as fewer centres would exist, the figures would necessarily show that retrieval times had increased in some areas if it were the case that retrieval teams in de-designated centres ceased to undertake retrievals, but that owing to the concentration of retrieval activity, expertise in the teams would improve. **Quality: Innovation and Research** Changes had been made to individual centres' scores for evidence of compliance with the standards relating to Research and Innovation. As a result, The Royal Brompton's score had changed from a 2 to a 3 and Oxford's score had changed from a 1 to a 2. No other centre's score had changed. This had increased the total research and innovation scores for those options that included three London centres:	

	E, F, H and L. **Summary: Suggested Conclusions** Ms Banks presented the baseline position of weighted final proposed scores for each option. Option B scored the highest, followed at some distance by Option G, which sat closely with Options I and J. Option L was the lowest scoring option. Mr Glyde explained that this summary was considered by the Secretariat as the most rigorous; it reflected all the consultation responses and it was proposed this be presented to members on 4 July to inform the Committee's eventual decision. **Sensitivity Tests** 16 sensitivity tests had been carried out and Option B had remained the highest scoring option in each, with the exception of one test in which two sensitivities had been combined. Option G's score had also increased in several tests. *Sensitivity 1* In response to consultation, high quality services had been rescored using a revised co-location weighting within Sir Ian Kennedy's assessment visit scores. Liverpool was no longer among the bottom-scoring three centres. Leicester, Leeds and Newcastle were now the lowest scoring centres. Mr Glyde said that this refuted the challenge made during consultation that Leeds would have been in the top half of the Kennedy panel's ranking had co-location been weighted more highly. Ms Banks highlighted that Option L remained the lowest scorer, with Option B as the highest. Option G's score was slightly higher. *Sensitivity 2* Assuming Leicester's PICU was not sustainable, deliverability scores had been lowered to 1 for all options that included Leicester: options A, H, I and J. Under this test, options A and H were joint lowest scoring with Option L. Option B remained the highest scoring and Option G retained its position. *Sensitivity 3* Quality sub-criteria had been weighted equally, whereas previously the high quality service criteria had been weighted more highly. The impact brought Option G's score	

	closer to that of Option B. *Sensitivity 4* Sustainability had been scored based on the number of centres in the option that achieved between 400 and 499 procedures a year against the number that achieved 500 or more. Previously, a score of 1 or 2 had been applied. By 'stretching' the scoring across 1 to 3, Options C and D's scores rose for sustainability as they were the two six-centre options. It made no difference to the ranking. *Sensitivity 5* Assuming that Sheffield and Doncaster were included in the Birmingham network and not the Newcastle network changed the activity numbers in the centres but led to material difference in sustainability score between the options. Option D had a slightly increased score as more centres achieved 500 or more. Mr Buck queried why the postcode sensitivity test had been carried out for Sheffield and Doncaster and not for other areas. Representations had been made from people living in Leeds and Bradford that they would rather travel to Liverpool than Newcastle, which was rational, based on travel times. He suggested a test be carried out for other contentious postcodes and that the optimal network between Newcastle, Birmingham and Liverpool be established where Leeds was not in an option. *Sensitivity 6* PwC's analysis around networks had confirmed that in every option over 90% of referring cardiologists had stated they would refer in the defined networks. However, given concerns voiced around the Newcastle network, the test assumed that Newcastle's caseload was below 400 and options that included it had been scored 1 for sustainability: Options B, C, E and J. Option B remained the highest scoring option by a lesser margin and Option L remained the lowest scoring option. *Sensitivity 7* Sensitivity test 7 combined sensitivity tests 3 and 6 though Ms Banks explained that this was not actually a 'sensitivity test' per se as it relied upon combining two un-related sensitivities. It had been included to illustrate what was needed in terms of 'refining' the original scores for option G to score higher than option B. This was the	

	only test and combination of sensitivities in which Option B did not rank first in the scores, owing to the impact of weighing all the quality sub-criteria the same. Option G scored highest and Option B scored second highest. Ms Christie recommended that, while the sensitivities were a useful exercise, there was a risk that they could be misinterpreted. It was important that a clinical sense check be applied. The Chair urged that the Committee was to be as objective as possible. Ms Griffiths highlighted that the sensitivities were presented to the Committee as evidence of the impact of various assumptions and the Committee was obliged only to consider the evidence and express the degree to which it was persuaded by each of the sensitivity tests. Mr Reed did not agree with the assumption in sensitivity 3; he was also unsure why sensitivity test 7 had been carried out as there was no causal link between 3 and 6. Mr Buck summarised that sensitivity 7 addressed what was needed to make Leeds score more highly than Newcastle. Ms Evans agreed; she opined that the Leeds/Newcastle issue was the next major issue for the Committee to address. She suggested the Committee review all the relevant factors for its decision on this point at the following meeting. Ms Fleming suggested that the Committee also rehearse the rationale for combining sensitivities and running the analyses. Ms Christie urged that any sensitivity analysis carried out should be in response to specific concerns raised during consultation. She did not believe testing all hypotheticals was an appropriate approach. Ms Radmore urged that it was important to have a clear audit trail about the principles deemed important and the sensitivities it had been felt necessary to test given the responses to consultation. The Chair suggested the Committee hold an additional meeting, in May, in order to discuss the issue of centres in the North of England and the sensitivity tests. Mr Buck asked that media management also be discussed at the next meeting. Ms Banks agreed to explain the analysis behind the development of the sensitivity tests at that meeting. Ms Banks and Mr Glyde would circulate relevant data to allow the Committee to be better informed prior to the meeting in May.	**J Glyde/R Banks**
9. Any other business	There was no other business.	